

SELF-REPORTS ON THE EFFECTIVENESS OF PSYCHOTHERAPY WITH
THERAPISTS-IN-TRAINING : AN 18 MONTH FOLLOW-UP STUDY AT A
PSYCHOLOGY TRAINING CLINIC

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ABSTRACT

The purpose of this study is to ascertain whether the clients who make use of the services of the Psychology Clinic at Rhodes University perceive the masters students being trained at the Clinic as providing adequate psychotherapy.

Using a sample of 18 clients, who underwent psychotherapy at the Rhodes Psychology Clinic during 1990, a follow-up study was conducted to ascertain the perceived success of that psychotherapy. Those variables most pertinent to the outcome of psychotherapy are examined.

The study uses both qualitative and quantitative methodology and shows that, overall, 89% of the clients who participated in this study perceived the psychotherapy at the Rhodes Psychology Clinic to be satisfactory. The study also highlights those factors which were perceived to be negative in the psychotherapeutic equation and it is hoped that the findings can be beneficial in planning more efficient services for the Clinic in the future.

* In this text the masculine gender is intended to indicate both genders. It is used only for ease of editorial style.

CHAPTER 1

INTRODUCTION

A wealth of literature exists exploring the outcome of psychotherapy but most of it pertains to quite specific studies and situations. Before exploring the variables which constitute successful outcome it is necessary to define both the terms "psychotherapy" and "successful".

1.1 **Psychotherapy.** "Psychotherapy" is the independent variable, the effectiveness of which is being assessed. No single definition of psychotherapy would conceivably be acceptable to all but this does not mean that reasonably exact and systematic psychotherapeutic procedures do not exist (Fisher, 1950). Psychotherapy includes many elements such as the client, the therapist, their interaction and situational variables. Psychotherapy has been defined by many schools of thought and perhaps the most successful broad definition is one made by Wolberg (1977, p.3):

"Psychotherapy is the treatment, by psychological means, of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with the object of (1) removing, modifying or retarding existing symptoms, (2) mediating disturbed patterns of behaviour, and (3) promoting positive personality growth and development."

Ingham and Love (1954) state that psychotherapy is centred around the very things that disturb an individual most and, that by facing these issues, the client changes. Thus, psychotherapy is a process, involving constant motion and continuity whereby an attempt is made to explore, face and resolve issues and problems. Gendlin (1961) views outcome differences as the result of this ongoing process occurring continuously in the individual. It is a learning process whereby the client learns new aspects of the self, new ways of relating to others and new ways of behaving (Rogers, 1965).

1.2 **Success.** There has been much written about 'successful outcome' in psychotherapy. Possibly one of the most well-known articles is "The Effects of Psychotherapy, an Evaluation" written by Eysenck and published in 1952. Causing considerable controversy, he stated that two thirds of neurotic clients improve no matter how they are treated or whether they are treated at all and he reinforced this view in subsequent articles in 1960 and 1965 (Malan, 1973). In the ongoing argument about these findings many authors questioned these results and Malan (1973) cites Bergin's 1966 paper which he regarded as one of the most important papers to emerge in the past twenty years. Bergin, 1966 (in Malan, 1973) concluded that most forms of psychotherapy make clients worse as well as better, that spontaneous remission does play a role in improving the symptomology of untreated clients and that some clients are not helped by interview-oriented psychotherapy.

Bergin and Garfield (1971), in evaluating the outcome of many studies including those of Eysenck, 1952; Rogers & Dymond, 1954; Cartwright & Vogel, 1960; Truax & Carkhuff, 1965 and Volsky, 1965 (in Bergin & Garfield, 1971), found that whatever happens in psychotherapy is powerful and this can have beneficial or harmful effects. There is little doubt that some clients will improve over time without psychotherapy but clearly many clients benefit from the psychotherapeutic experience (Meltzoff in Malan, 1973), especially under the right conditions (Bergin, 1966 in Malan, 1973). In fact, Bergin and Garfield (1971) found, in their review of Eysenck's studies and their own follow-up in 52 outcome studies, that the spontaneous remission rate is lower than expected and any improvement is probably caused by therapeutic-like procedures anyway.

Malan (1973) states that, purely quantitatively, positive studies outnumber the null and negative by three to one and that the evidence for the 'success' of psychotherapy is relatively strong. Bergin and Garfield (1971) further strengthen the argument for psychotherapy by stating that many positive results gained in psychotherapy are difficult to measure by conventional measuring techniques meaning that much of the value is lost because it cannot be precisely measured.

Cartwright and Roth (1957 p.20) state that Rogers and Dymond, 1954, in looking at the outcome of many studies, feel that it is "quite

impossible at the present time to define 'success' or 'adjustment' in such a way that the definition is both operationally clear and acceptable to all." In fact these authors (Rogers & Dymond, 1954) suggest that the effectiveness of psychotherapy should not be viewed in terms of 'success' or 'failure' because they are value terms. This does not necessarily limit us to being unable to do outcome studies or to obtain useful indicators as to what successful psychotherapy implies. The problem seems to lie with validity rather than reliability (Cartwright & Roth, 1957) and outcome results are only meaningful when the client's diagnosis, age, pretreatment strengths, social situation and other factors are considered.

In psychotherapy certain specific questions need to be asked when evaluating success. For example, Strupp (1971) suggests the following need to be explored. Has the client changed demonstrably over the time in which psychotherapy was conducted ? What is the nature of any change ? Can this change be reasonably attributed to the therapist's interventions ? Is this change lasting so that the effect can be seen at a subsequent follow-up?

Successful psychotherapy does, therefore, involve change. This is not a unitary phenomenon with uniform change but a mixture of positive and negative overt and covert changes (Garfield, 1989). Clients come to psychotherapy in distress, with a more or less disorganised state of being, and we can measure whether what we

have offered them has helped by the change or gain in their behaviour. Thus, "successful" psychotherapy implies a visible and significant change ie. a presentable change and not just a belief, on the client's part, that he has changed (Carkhuff, 1966). Garfield (1989) suggests that successful outcome also means increased understanding about the self and personal difficulties. Rice and Greenberg (1984) state that successful psychotherapy can be viewed as involving "the resolution of a series of affective tasks". Good psychotherapy has a wholeness and a continuity that makes it a unique experience for each client-therapist team. Successful resolution, according to Rice and Greenberg (1984), involves a sense of completion and relief and an implicit sense that something has changed. Rogers (1965) views change as having occurred when the client is able to perceive himself as a more adequate and worthwhile person, with a more realistic appraisal of himself, his relationships and the environment and as having learned to place the basis of standards within himself and accept himself as a whole including both bad and good aspects.

An important indicator of psychotherapeutic success is the symptomatic relief experienced by clients after the completion of psychotherapy. Battle, Imber, Hoenn-Sark, Stone, Nash and Frank (1966) view psychotherapeutic success as the removal or relief of psychiatric complaints with no new ones substituting them. To the extent that clients evaluate the effectiveness of psychotherapy by the degree of alleviation of the distress associated with their

problems, systematic research is possible.

Thus successful psychotherapy is a change in personality organisation, structure and behaviour, for the betterment of the client, through insight, understanding and awareness, which includes improved functioning and some degree of symptom relief (Rogers, 1965).

CHAPTER 2

THE CLIENT AS A VARIABLE IN PSYCHOTHERAPY

People react differently to the process of psychotherapy with some able to change or resolve problems whilst others are unable to change or their symptomology worsens (Wolberg, 1977). The question to be explored is what specific attributes an individual possesses which are likely to contribute to a successful outcome in psychotherapy. Many factors play an important role and, even as early as Freud, it was clear that certain characteristics, like youth, a fairly high level of intelligence, education and emotional maturity, would enhance the psychotherapeutic process and outcome (Strupp, 1971). Whilst there has been little comparability from study to study and the research on client variables has produced inconsistent results, some important factors have emerged. The following variables have been identified as being significant to the outcome of psychotherapy.

2.1 Initial state of adjustment. Luborsky, Chandler, Auerbach, Cohen and Bachrach (1971) and Astrup and Noreik, 1966 (in Luborsky et al, 1971) suggest that the client's initial state of adjustment is the highest predictor of outcome. This is supported by a 3 - '9 year follow-up study conducted by Clementel-Jones, Malan and Trauer (1990) where a clear, positive correlation was found between good initial adjustment and successful outcome. Cartwright, 1957 and

Kirtner and Cartwright, 1958 (in Bergin & Garfield, 1971) found that those clients who perceived themselves as fairly well adjusted at the start of psychotherapy and exhibited a higher level of personality integration tended to find psychotherapy more successful. Several studies support this finding that clients who are better adjusted at the beginning of psychotherapy show the greatest improvement (Gelder, Marks & Wolff 1967; Stone, Frank, Nash & Imber, 1961; Stephens & Astrup, 1965 (in Strupp, 1971) and Rogers (1965)).

2.2 Client expectation. Carkhuff (1966) agrees that the client's initial level of functioning is important but feels that his expectations are critical. Fiske et al (1970) found positive expectancy to be a necessary condition for psychotherapeutic effectiveness. O'Malley, Foley and Rounsaville (1988) found that the poorer the client's expectation of the potential to be helped, the less they rated any change as successful. Bergin and Garfield (1971) cite findings by Frank and his colleagues (Frank, 1959; Frank, Gliedman, Imber, Stone & Nash, 1959; Rosenthal & Frank, 1956) which all point to the fact that the greater the distress and need for help, the greater the expectancy or likelihood of that help being perceived as successful. Lennard and Bernstein, 1960; Lipkin, 1954; Goldstein & Shipman, 1961 (in Bergin & Garfield, 1971) all report a positive link between expectancy and perceived symptom reduction. However, this finding should be viewed cautiously as this relationship was curvilinear - clients with very

high or very low expectancy showed the smallest symptom reduction (Bergin & Garfield, 1971). Perhaps more important, is that there is congruence between the client's and therapist's expectations and this variable has been shown to be consistently related to psychotherapeutic progress (Lennard & Bernstein, 1960; Heine & Trosman 1960 (in Strupp, 1971); Heine, 1962 (in Bergin & Garfield, 1971)).

But what is it that the client is expecting from the therapist ? Rogers (1965) says that the client could expect the therapist to be a parental figure, a 'surgeon' who will probe deeply, causing pain against his wishes or an advice-giver. Or is psychotherapy viewed as a place to solve problems and thus positive or threatening ? Clearly the perception and expectancy of the psychotherapy and therapist is of critical importance.

2.3 Level of motivation. Malan (1973), in his work at the Tavistock Clinic in London, found that, of all the selection criteria studied, motivation for insight was the most important. This finding was also made by Sifneos (in Malan, 1973); Strupp (1971); Rogers and Dymond (1954); Truax and Carkhuff, 1967; White, Fichtenbaum and Dollard 1964 (in Strupp, 1971). Sifneos (1981) stresses that this should be a motivation for change within the self rather than simply a motivation for symptom relief. Malan (1963) found that 86% of the clients who scored highly in his study on outcome had a high, positive motivation and those with low

motivation scored 0 on outcome levels. Rogers & Dymond (1954) did an extensive study on motivation as a factor in personality change and found that motivation was insufficient to bring about this change alone ie. in the absence of psychotherapy.

2.4 Client involvement in psychotherapy. Mathieu-Coughlan and Klein, 1984 (in Rice & Greenberg, 1984) believe that the critical event in psychotherapy is the client's engagement in the process so that the client has a bodily, felt sense of what is occurring. Without this, the authors state, subsequent steps of struggle, shift or resolution would be both meaningless and impossible. Truax and Carkhuff (1964) found that the greater the degree of patient involvement, the greater the constructive personality change.

2.5 Referral. An important factor to consider, primarily because it is linked to motivation, is whether clients refer themselves for psychotherapy or come under duress. One could speculate that if an individual is motivated to seek help voluntarily the prognosis is better as it suggests that the symptoms are egodystonic. Bergin and Garfield (1971) point out that the more egodystonic the symptom, the higher the level of motivation to change.

2.6 Age. Bergin and Garfield (1971) did not find age to be of any major significance and Seeman, 1954 (in Cartwright, 1955) also found no significant association between the age of the client and the rated success of psychotherapy. Likewise, in a study involving

clients between the ages of 21 - 40, Rogers and Dymond (1954) found no correlation between age and movement in psychotherapy. However, Casner (1950) found a significant difference in the success rate when clients were under the age of 30 and Stone, Frank, Nash & Imber, 1961 (in Truax & Carkhuff, 1964) found that younger clients changed more positively.

2.7 Sex. Seeman, 1954 (in Cartwright, 1955) and Casner (1950) report finding a significantly higher rate of women being more successful than men in psychotherapy. This was supported by the findings of Rogers and Dymond (1954) who found women to make significantly more progress than men. However, the fact that all the counsellors bar one were male confounds these results as the results may be attributed more to the opposite sex psychotherapeutic relationship. Rosenbaum, Friedlander and Kaplan (1956) found a significantly higher number of women than men in psychotherapy and suggest that this could be because women are more likely to accept the fact that they are suffering from emotional disorder. Cartwright (1955) found a strong tendency for men to take longer in psychotherapy to achieve success than females.

2.8 Level of intelligence and education. Most studies report a positive relationship between education and length of stay and success in psychotherapy. For example, Whiteley and Hummel, 1965 (in Carkhuff, 1966) suggest that superior achievers are better able to make appropriate decisions about the correct action to take.

Although Rosenbaum et al (1956) failed to find a link between intelligence and education, they did discover that a favourable financial status was a contributory factor in successful outcome. Casner (1950) found that clients with an above-average intelligence and those with more than 12 years education gained more in psychotherapy. Keith-Spiegel and Spiegel, 1967 (in Strupp, 1971) showed that the higher educated the client was, the more the therapist was viewed as helpful. Bergin and Garfield (1971) point out that educational level is only part of a larger factor that may include verbal ability, sophistication about and interest in psychotherapy, and income.

2.9 Occupation. Cartwright (1955) found that students tend to be rated as more successful in psychotherapy but the students tended to stay in psychotherapy for longer so this fact may be confounded by the length of psychotherapy variable. Casner (1950) found reliable differences with full-time students.

2.10 Socioeconomic status. The Rosenbaum et al (1956) study found that those clients who were "much improved" following psychotherapy were of a higher social strata. Imber, Nash and Stone, 1955 (in Bergin & Garfield, 1971) found 88,9% of middle class patients stayed in psychotherapy for more than 4 interviews compared with only 57,1% of the lower class. This finding was supported by that of Gibby, Stotsky, Hiler and Miller, 1954 (in Bergin & Garfield, 1971) who also found middle-class people to stay in psychotherapy

longer than lower class clients. If staying in psychotherapy for longer is indicative of continuing growth it suggests that middle-class people would gain more from the psychotherapeutic experience. Low social class has been positively linked to a tendency to view the problem as physical rather than emotional, a desire for symptomatic relief and a lack of understanding about and desire for psychotherapy. Even more importantly, the intake interviewer was found to have less positive feelings for lower class patients and viewed them as less treatable by psychotherapy (Bergin & Garfield, 1971).

Similarity plays a role here too and several studies have shown that similarity in socioeconomic class is significant ie. therapists of lower education and socioeconomic class were found to be more effective with lower-class clients than higher-educated professionals (Poser, 1966; Deanne & Ansbacher, 1962; Carkhuff & Truax, 1965; Lohrenz, Hunter & Schwartzman, 1966 (in Strupp, 1971)). Hollingshead and Redlich, 1958 (in Bergin & Garfield, 1971) support the importance of this perceived similarity with their finding that therapists prefer upper-class clients who are more similar to them and speak their language.

2.11 Type and severity of symptoms. It is generally felt that the less severe the diagnosis and the more neurotic the symptoms, the more chance there is of psychotherapy being successful (Bergin & Garfield, 1971). Many authors, including Barron, 1953 (in Bergin &

Garfield, 1971), have found less-disturbed clients more likely to respond positively to psychotherapy. Truax and Carkhuff, 1967 (in Bergin & Garfield, 1971) offer the hypothesis that clients who perceive their symptoms as "felt" more than overtly displayed, show the greatest psychotherapeutic improvement. The more egodystonic the symptom the higher the motivation for change is likely to be and this has been found to be an accurate statement by many authors (Bergin & Garfield, 1971). However, Stone, Frank, Nash and Imber, 1961 (in Truax & Carkhuff, 1964) found that the clients who evidenced the most difficulties and problems exhibited the greatest positive change after psychotherapy.

2.12 Client's perception of the therapist/perceived similarity to client. The client's experience of the therapist and his functions are critically important to the psychotherapeutic process. Rippee, Harvey and Parker, 1965 (in Carkhuff, 1966) found that the client's perception of the therapist is influenced directly by what the therapist does in the psychotherapeutic contact. Robinson, Redlich and Myers, 1954 (in Rosenbaum et al, 1956) suggest that a similarity of culture and understanding facilitates psychotherapy and that client-therapist differences may hamper the development of the psychotherapeutic relationship and thus the effectiveness of psychotherapy. This is supported by authors cited in Lesser (1961) (Halpern, 1955; Fiedler & Senior, 1952; Normal, 1953; Notcutt & Silva, 1951; Wolf & Murray, 1937) who all note that similarity between the therapist and the client does have a positive effect on

psychotherapeutic outcome. Fiedler and Senior, 1952 (in Lesser, 1961) point out that the perceived similarity is of more importance than any actual reality as it suggests a positive feeling by the therapist towards the client which enhances the psychotherapeutic process and creates a deeper, richer understanding. This is supported by Stoler, 1963 (in Truax & Carkhuff 1964) who found that successful clients were those who were more liked by the therapist thus suggesting that this perceived similarity is reciprocal. However, Lesser (1961) cautions that the best results will not be obtained if this similarity is overestimated. Rogers (1965) comments on how the client perceives the therapist (eg. as genuine, warm, understanding) has a significant and profound effect on how much the client will reveal of himself and progress in psychotherapy. Lorr, 1965 (in Carkhuff, 1966) found a significant relationship between client improvement and client perception of the therapist as accepting and understanding. Whilst, client-therapist similarity does seem to be positively correlated with outcome, Bergin and Garfield (1971) caution that no clear conclusions can yet be drawn as more definitive research needs to be done.

2.13 Client satisfaction. How the client perceives psychotherapy and the degree of symptom reduction is critical for rating success. Cartwright (1955) found that those clients who rated themselves as "satisfied" with psychotherapy had been viewed by the therapist as having achieved success in psychotherapy. Part of the experience of

satisfaction is the client's perception of being "heard" and accepted by the therapist (Rogers, 1965). This experience allows the client to accept those previously unacceptable aspects of the self.

Based on the above literature findings some conclusion can be tentatively reached about the kind of client most likely to succeed in psychotherapy. Positive indicators on the part of the client for successful outcome include a relatively high level of adjustment, good expectation and motivation and thus involvement in the psychotherapy, middle to upper-class socioeconomic status, at least 12 years of education, female, self-referral, egodystonic symptoms and some perceived degree of similarity between client and therapist.

CHAPTER 3

THE THERAPIST AS A VARIABLE

The therapist is a basic part of the psychotherapeutic process which attempts to change the client for the better. Any technique or type of psychotherapy used will necessarily be influenced by the personality of the therapist (Bergin & Garfield, 1971). Thus, it is important to view how the therapist contributes towards this process and change and this may differ for each client that he interacts with. Kiesler, 1966 (in Bergin & Garfield, 1971) clearly demonstrates, based on a large number of studies, that some therapists produce positive client change but that the majority either effect no change or may even cause deterioration in the client's condition. Frank, 1961 (in Strupp, 1971) states that the therapist is the most important, but least understood, part of the psychotherapeutic equation. Despite the uniqueness of each therapist, it is possible to identify certain therapist variables which cut across theoretical approach and affect both the process and outcome of psychotherapy. These include both personality characteristics and skills.

Three basic characteristics are so essential that they will be dealt with together. Bergin and Garfield (1971) and Truax and Carkhuff (1964) state that virtually all phenomenologically oriented and most behaviouristically oriented therapists have

agreed to the clinical importance of these three.

3.1 Accurate empathy, non-possessive warmth, genuineness.

Whitehorn and Betz, 1954 and Rogers, 1954 (in Bergin & Garfield, 1971) were the pioneers in the study of the role that these factors play in facilitating positive psychotherapeutic change. Whitehorn and Betz, 1954 (in Bergin & Garfield, 1971) found a significant improvement of 75% compared to 27% in clients whose psychiatrists showed these qualities despite the fact that they had all had the same training. This was supported by findings made by Rogers, 1962; Truax, 1963; Gendlin and Kiesler, 1967 in studies conducted over a 5 year period (1962 - 1967) and again in follow-up studies done in 1969 by Truax; Horowitz and Tausch and his colleagues (in Bergin & Garfield, 1971). Truax and Carkhuff, 1964 (in Malan, 1973) found that the absence of these factors tended to be followed by deterioration in the client's psychological state.

3.1.1 Accurate empathy. Despite the distinct and positive advantages of self-exploration and growth which may result when a psychotherapist is empathic, it has been found that too much accurate empathy too early in the psychotherapeutic relationship may be deleterious (Truax & Carkhuff, 1964). Both Wolberg, 1954 and Bordin, 1955 (in Lesser, 1961) suggest that an optimal amount of tension is necessary for psychotherapy to progress successfully. Thus, the degree of empathy shown needs to be carefully balanced.

3.1.2 Non-possessive warmth. Two studies conducted by Wyrick and Mitchell, 1969 and Wagner and Mitchell, 1969 (in Bergin & Garfield, 1971) found a significant correlation of .40 ($p \leq 0,05$) between therapist warmth and the client's perception of therapist effectiveness. In fact, clients seen by therapists who were low on these skills exhibited deterioration in personality and behavioural functioning. Truax and Carkhuff (1964) found non-possessive warmth to be clearly correlated with constructive personality change. These findings suggest that non-possessive warmth has a significant effect on the final outcome in psychotherapy.

3.1.3 Genuineness. Truax and Carkhuff (1964) found that a lack of genuineness, on the therapist's part, actually limited self-exploration.

These qualities are important for a trusting and open rapport which is essential in allowing the client to drop his defences, gain insight and move towards the freedom of being himself.

3.2 Sex of therapist. In the Wyrick and Mitchell study, 1969 (in Bergin & Garfield, 1971) sex differences were found to be of some importance. There was a significantly high correlation between accurate empathy and the female clients' perception of female therapist effectiveness suggesting that sex-similarity played a role there. Cartwright (1955) suggests though that clients progress better in psychotherapy with a therapist of the opposite sex which

implies that successful psychotherapy depends, to some extent, on the establishment of a satisfactory heterosexual relationship. One could speculate that the nature of the problem being dealt with plays a role and perceived therapist-client congruence and similarity is more critical for self-disclosure and effective psychotherapy to occur.

3.3 Degree of therapist's experience. Joslin, 1965 (in Carkhuff, 1966) and findings by Truax & Carkhuff (1964), based on client-assessment in a study of 249 clients, found no relationship between the level of the therapist's experience and positive outcome. The clients found the inexperienced therapist to be more prone to being active and giving advice but this did not adversely affect the perceived success of the psychotherapeutic experience. Bergin and Garfield (1971) found that the more experienced therapists were more successful than the inexperienced therapists. In fact, those in psychotherapy with inexperienced therapists bordered on a significant decrease in health. Studies by Fiedler, 1950; Bradley and Stern, 1965 and Fretz, 1965 (in Carkhuff, 1966) indicate that inexperienced therapists may be less effective and that those more experienced may be better able to diagnose but appear to do less with these predictions. Fiedler, 1950 (in Rogers, 1965), in studying the characteristics that make an 'ideal' psychotherapeutic relationship, found that experts created relationships significantly closer to the 'ideal' than non-experts and were better able to maintain an appropriate emotional distance. However,

both Malan (1963) and Strupp (1971) found that neophyte therapists are often more successful due to their energy and enthusiasm despite missing valuable clues.

3.4 Therapist's ability to listen. Listening is a skill which requires attention and concentration to both the spoken and unspoken communication and is a basic component of psychotherapy (Garfield, 1989). The better the listening, the better the understanding and the better the experience for the client. Garfield (1989) believes that good listening allows the therapist to understand the client's internal frame of reference with greater clarity. Mathieu-Coughlan and Klein, 1984 (in Rice & Greenberg, 1984) feel that good listening also facilitates focusing. This suggests that if the therapist is sensitive to what the client is trying to communicate the chances of successful outcome are enhanced.

3.5 Therapist expectations. Generally, findings suggest that therapists prefer clients who are not too severely disturbed as the "less sick" client is usually more sensitive, intelligent and willing to talk about himself (Truax & Carkhuff, 1964; Bergin & Garfield, 1971). Truax and Carkhuff (1964) found that therapists tend to regard symptomatic relief and improvement in social relationships as indicative of successful outcome whilst the clients assessed their own levels of self-understanding and confidence.

3.6 Client attractiveness. Strupp (1971) supports the belief that the therapist's personal reaction to the client may influence the outcome of psychotherapy and Nash, Hoehn-Saric, Battle, Stone, Imber and Frank, 1965; Heller and Goldstein, 1961 (in Strupp, 1971) reported outcomes favouring attractive clients. Strupp and Williams, 1960 (in Strupp, 1971) found that, despite contradictions, a favourable prognosis is generally predicted for more likeable clients. Sullivan (1989) believes that it is not possible to provide a healing environment for someone one does not like as it is the therapist's love/liking that allows the client to achieve inner emotional healing.

3.7 General personality characteristics. Holt and Luborsky, 1958 (in Strupp, 1971) see a successful therapist as being one who is genuine, socially adjusted with his co-workers, free from status-mindedness, able to obtain self-objectification, has adequate emotional control and the ability to display warmth, acceptance, spontaneity and empathy. Langs (1989) also stresses the importance of neutrality and relative anonymity.

3.8 Therapist attitudes. This includes both attitudes towards the client and towards himself. Ingham and Love (1954) state that the primary function of the therapist is to promote attitudes in the client that are favourable to psychological progress. This can be done by encouraging the client to approach his own difficulties with a healthy attitude of tolerance, objectivity and sincerity.

To do this the therapist must display respect for the client so that he perceives himself as an intrinsically likeable and worthwhile person (Ingham & Love, 1954; Rogers, 1965). This respect includes an honesty in dealing with the client (Ingham & Love, 1954). Another important attitude is the degree of authoritarianism shown by the therapist as the amount of control the therapist exercises has a powerful effect on the psychotherapeutic outcome. A healthy balance of control allows the client to work at his own pace and in his own direction whilst still affording the therapist the chance to gain information and guide the client. The balance of control and permissiveness is unique to each therapeutic alliance. Wolberg (1977) states that the therapist's attitude must inspire hope, faith, trust, liking and a freedom to respond.

Ingham and Love (1954) believe that the therapist ought to be comfortable in his role, competent and have a tolerance for his own errors. This involves an optimum tension between complacency about his own competence and a feeling of capacity to do the job. An openness to his own fallibility and the honesty to accept and learn from errors is critical.

3.9 Confidentiality. Langs (1989) stresses the importance of confidentiality. If a client in any way feels that this factor is not very high on the list of the therapist's priorities there will be little trust and a psychotherapeutic alliance will be difficult,

if not impossible to form.

In conclusion, despite divergent viewpoints, most authors agree that there are basic characteristics making up an effective therapist. Bergin and Garfield (1971, p.302) give the following breakdown: "(1) an effective therapist is nonphony, nondefensive and authentic or genuine in his therapeutic encounter; (2) an effective therapist is able to provide a nonthreatening, safe, trusting, or secure atmosphere through his own acceptance, positive regard, love, valuing or nonpossessive warmth, for the client; (3) an effective therapist is able to understand, "be with", "grasp the meaning of", or have a high degree of accurate empathic understanding of the client on a moment-by-moment basis."

Basically the therapist's personality is more important than any technique he uses. But, valuable techniques in the hands of an empathic, warm and genuine therapist, are of inestimable value in assisting the client to view himself more objectively and accept all those elements which make up the whole person.

Perhaps the dictum 'primum non nocere' is the most essential baseline for any therapist to adhere to.

CHAPTER 4

SITUATIONAL VARIABLES

There is considerably less literature available dealing with the importance of the contextual or situational variables which play a critical role in defining the psychotherapeutic milieu. Clients respond not only to the therapist but to the physical conditions surrounding them which have a definite effect on the outcome (Goldstein, 1971). Goldstein (1971, p.61) defines situational variables as "all those events occurring around an individual which are not a property of the individual himself".

4.1 Length of psychotherapy. Truax and Carkhuff (1964) state that the higher the level of education of the client and the greater their experience of psychotherapy, the more likely they are to stay in psychotherapy and improve. Truax & Carkhuff (1964) suggest that the sicker clients terminate and the healthier ones stay in psychotherapy for longer periods.

Malan (1973), in his study of 'successful' cases, was able to come to the generalisation that considerable change can be obtained in certain cases in 10 - 50 sessions and this is supported by the brief-term psychotherapy done by Sifneos, 1981 and Mann, 1981 (in Ursano & Hales, 1986). Luborsky et al, 1971 (in Clementel-Jones et al, 1990), in a review of 106 cases, found the main situational

trend affecting outcome to be the number of sessions. Muench, 1965 (in Carkhuff, 1966) found that time-limited and short-term therapy was more effective than long-term and Truax, Carkhuff and Kodman, 1965 (in Carkhuff, 1966) support the fact that time-limited therapy is effective. Kirtner, Cartwright, Robertson and Fiske (1961) found that the correlation between length of time in psychotherapy and measures of change in personal integration was not significant. This finding was contrasted by McNair, Lorr, Young, Roth and Boyd (1964) whose results indicated that extent of improvement was linked to the number of sessions. Rogers and Dymond (1954) support this with their view that, with more than 20 sessions, there is considerable assurance of psychotherapeutic gain.

Perhaps it is impossible to view length of psychotherapy as a factor without taking into consideration the important factors of the initial degree of integration and level of symptom distress. Kirtner and Cartwright (1958) found a significant relationship between the personality structure of the client at the beginning of psychotherapy and the effectiveness as measured by the length of psychotherapy. Malan, 1975; Mann, 1981 and Sifneos, 1981 (in Ursano & Hales, 1986) all agree that a higher degree of integration and motivation is necessary for brief psychotherapy to be successful. Cartwright (1955) also believes that the type of problem to be dealt with is important ie. that there is a difference between clients with mainly situational problems and ones with personal adjustment problems. Clearly longer-term

therapy would be needed in the latter instance.

Kirtner and Cartwright (1958) and Cartwright (1955) speak of a 'failure-zone' which falls roughly between 13 - 20 sessions and both found that outcome was more successful if the length of psychotherapy was on either side of these figures. This seems to imply that perhaps situational problems are dealt with effectively in a short-term psychotherapy whilst personality adjustment needs longer.

4.2 Type of psychotherapy. While it is safe to argue that each school of thought probably considers its own style of psychotherapy to be the most efficacious, studies suggest that there is little proof that any one method is the best.

Eysenck, 1952 (in Wolberg, 1977) reviewed the results of psychotherapeutic treatment of over 70,000 cases and concluded that these results failed to prove conclusively that any specific form of psychotherapy facilitates the recovery of the client. In fact, Eysenck stressed that approximately two-thirds of clients will improve regardless of either the type of treatment or whether they are given psychotherapy or not. Bergin, 1971 (in Wolberg, 1977), in reviewing Eysenck's results found that if the number of clients who dropped out of psychotherapy were excluded from Eysenck's results, the improvement rate jumped to 91%. This suggests that motivation is a key to successful psychotherapy and that those who stay in

psychotherapy have more chance of improving than those who drop out early, rather than indicating that any one type of psychotherapy is more superior or effective than any other. This statement is supported by the findings of Cartwright, 1966 and Heine, 1953 (in Luborsky et al, 1971) and Wolberg (1977). Bergin and Garfield (1971) further support this view with their findings of the outcome of 52 studies as a function of the nature of the psychotherapy. These authors found that the type of psychotherapy appeared unrelated to outcome. Bergin and Garfield (1971) also studied the reports of the results of psychotherapy on 8,053 clients from psychoanalytic and eclectic schools ranging from 1920 - 1951. The findings indicate that each type of psychotherapy had both it's successes and failures and no single type of psychotherapy was found to be more successful than any other.

One could speculate rather that the process determines the outcome and the type of problem being treated plays an important role in what type of psychotherapy would be most beneficial.

4.3 Tape recorded sessions. Psychotherapy sessions can be tape-recorded by therapists to ensure an accurate chronicle of the session or for learning purposes in supervision. The question is whether the client is adversely affected by being tape recorded or not. Roberts and Benzaglia, 1965 (in Carkhuff, 1966) found that clients made more positive self-references when they knew they were being recorded and more unfavourable self-references when not being

recorded. An interesting factor here is that tape recording also affected the therapists ie. they were less client-centred or non-directive when aware of being recorded.

4.4 Setting and atmosphere. Despite the importance of the physical setting in which therapy takes place, little research has been conducted concerning this variable. The perceived comfort, atmosphere, noise level and privacy can either positively or negatively impact on the psychotherapeutic process and more research on the result of these is needed. Goldstein (1971) writes of the profound effect that these variables have on psychotherapeutic outcome but does little to identify specific factors. Langs (1989) believes that unconsciously the setting in which psychotherapy is conducted becomes part of the psychotherapeutic experience. He suggests that the setting should, ideally, be private, comfortable, soundproof, have a separate entrance and exit and be tastefully furnished.

An ideal setting combined with good initial interaction provides a secure frame for the psychotherapy to unfold in and defines the roles of both therapist and client (Langs, 1989). Again, it is less the situation itself that is of importance than how it is perceived that effects outcome.

4.5 Client's cultural setting. An important facet of outcome is the existing cultural milieu from which the client comes and will

be returning to. Wolberg (1977) comments on how the client's prevailing lifestyle can neutralise any success gained in psychotherapy or encourage success by rewarding healthy behaviour.

4.6 Payment of fees. This is usually considered to be an important part of the psychotherapeutic process as it frequently reveals negative transference issues (Langs, 1989). For example, is the client perceiving psychotherapy as a right for which he ought not to pay? Langs (1989) believes that paying a fee implies that both therapist and client accept responsibility for being present at the sessions. If fees are paid by a third party this can introduce the third party into the psychotherapeutic alliance and have a negative effect. The ideal is for the client to pay himself. The general consensus (Rosenbaum et al, 1956) is that paying clients are better motivated. In their study, Rosenbaum et al (1956), found that there were a significantly higher proportion of paying clients in the "much improved" group. He points out that fees were based on the client's income so that the association may have been between financial security and successful outcome.

Thus, the nature of the referral, the initial contact, the structure of the setting, the presence or absence of other personnel and payment of fees can have a subtle, yet profound effect on psychotherapy.

CHAPTER 5

THE PSYCHOTHERAPEUTIC ALLIANCE AS A VARIABLE

The psychotherapeutic alliance is an interpersonal relationship involving two people with the aim of producing change in the one (the client) through interaction with the other (the therapist) (Conrad, 1952). Any success or failure may be interpreted in the light of this mutual interaction. Each psychotherapeutic relationship is unique due to the inherent variability in both client and therapist. The philosopher, Martin Buber, 1953 stresses the importance of the psychotherapeutic relationship when he says "the inmost growth of the self is .. accomplished .. in the relations between the one and the other ..in the making present of another self and in the knowledge that one is made present in his own self by the other" (p.314 Bergin & Garfield, 1971). And each unique psychotherapeutic alliance occurs within a particular setting which also affects this interaction.

A positive psychotherapeutic alliance is an important requirement for a successful outcome in psychotherapy. Garfield (1989) states that this includes the client's active participation and co-operation. How the client views the therapist, and vice versa, is important. For example, if the therapist deviates too far from the client's expectations or does not inspire confidence and trust, the chances of a good, healthy psychotherapeutic alliance forming are

slim. Likewise if the therapist views the client as unmotivated it may prevent a good alliance being formed.

Fiedler, 1950 (in Rogers, 1965) holds that almost all therapists agree that the relationship is a critical factor in facilitating psychotherapy. He found that the characteristics of this 'ideal' relationship include, in order of significance, the therapist's ability to participate completely in the client's communication; his ability to make comments that are always right in line with what the client is trying to convey; viewing the client as a co-worker on a common problem; treating the client as an equal; understanding the client's feelings; always following the client's line of thought and conveying, by tone of voice, the ability to share those feelings.

From the above named characteristics it is clear that, despite the interactive quality of the psychotherapeutic relationship, the therapist has a strong responsibility to provide many positive qualities. Strupp (1971) states that it is the manner in which the therapist uses and works with this alliance that constitutes his effectiveness as a professional.

Conrad (1952) found that clients who perceived themselves as having achieved success in psychotherapy had a positive, affective relationship with the therapist. Dissatisfied clients had learned that their therapists would not dispense help and perceived them as

depriving.

It is thus clear that a good psychotherapeutic alliance is critical for change and growth as it serves as a valuable relearning experience allowing the client to take what he has learned in psychotherapy and generalise this corrective experience to relationships in the world (Wolberg, 1977).

It follows, from the above comments and chapters, that successful psychotherapy is a function of both the client, the therapist, the setting and the interaction between all these factors.

CHAPTER 6

RHODES PSYCHOLOGY CLINIC - AN OVERVIEW

The Rhodes Psychology Clinic provides a service to the community of Grahamstown and environs and the student body at Rhodes University. This includes assessments for psychotherapy, psychological testing, and individual and family psychotherapy. Each client is initially assessed by the intern psychologist to ascertain suitability for psychotherapy.

6.1 Type of Psychotherapy. At the Clinic the focus of training is on in-depth, psychodynamic psychotherapy. However, frequently the limitation of time necessitates that psychotherapy is done in a shorter time period. The focus of training is on the individual, especially on "intrapsychic" structures and processes. If a briefer time period necessitates working with the client for only 10 - 20 sessions the focus is on understanding those aspects of the client's internal world which are most closely linked to the symptomology. Family and play therapy are also offered where necessary.

6.2 Length of psychotherapy. Clients are taken on at the Clinic for psychotherapy for varied lengths of time. This is primarily due to the fact that the masters students only start seeing clients

in April of their first year and generally terminate at the end of October due to examinations. Only a few clients are taken through to the following internship year. Many students also only approach the Clinic in the latter half of the year. Thus, psychotherapy can vary from 8 - 12 sessions to 18 months.

6.3 Symptomology. The Clinic takes on clients that are deemed to be treatable by clinical psychologists in training. Thus, for example, individuals who are diagnosed as borderline, psychotic, manic-depressive or who are likely to require very long-term psychotherapy are referred to psychologists in private practice or the local psychiatric hospital. Common problems treated at the Clinic include depression, anxiety, sexual and social problems, psychosomatic symptoms, existential issues, child and family difficulties and substance abuse.

6.4 Therapists. Clients are seen at the Clinic either by first year masters in clinical psychology students or the intern. All those in training are in weekly supervision with fully-qualified, experienced therapists thus ensuring that each client's case is professionally supervised. Every client has some psychotherapy sessions recorded so that the psychologist-in-training can present the supervisor with as accurate a perception of the process of the session as possible for learning purposes.

6.5 **Payment.** The Clinic operates on a sliding scale of fees depending on income. The lowest rate charged during the year that the sample in this study was undergoing psychotherapy was R4-00 per session.

CHAPTER 7

METHODOLOGY AND OBJECTIVES

7.1 Introduction. In Chapter 1 an attempt was made to define "successful" psychotherapy and the following four chapters dealt with those variables most critically important to that success. The measurement of this complex phenomenon, "successful psychotherapy", is however difficult. One difficulty pertains to the use of the research methodology of the natural sciences. Birtchnell (1978, p.115), speaks of applying the discipline of the natural sciences to human behaviour as "reminiscent of the croquet match in Alice in Wonderland where the mallets were flamingoes, the balls hedgehogs and the hoops kept walking away".

Quantitative scales used in the measurement of psychotherapeutic qualities may be less precise than the natural sciences due to the complexities of measuring human variables. However, many of these quantitative measures are widely accepted as accurately indicating levels of symptomology, of intelligence and the like (Hatzenbuehler, Parpal & Matthews, 1983; Lambert, Hatch & Kingston, 1986). On the other hand, Birtchnell (1978) reminds us of the need to be subjective lest we lose the quality of the human and it is important to bear in mind that each individual is unique with a different set of life circumstances and experiences. Goldman (1976) thus emphasises the importance of looking at the whole, functioning human being even at the cost of absolute precision. Nichols and

Beck (1960) state that any measurement criteria are imperfect measures of psychotherapeutic change because, as Wolberg (1977) points out, the attempt is being made to validate subjective reports by objective criteria. Consequently, there are limits to the types of statistical measures that can be used and results need to be interpreted cautiously.

Bergin and Garfield's (1971) suggestion that we need to look at precise enquiry rather than a broad spectrum makes methodological sense as it allows for easier and more precise measurement of the variables in question. Instead of asking "what is the effect of psychotherapy?", the question "what are the specific effects of specific interventions by specified therapists upon specific symptoms or patient types?" would allow for more refined quantitative and qualitative measurement (Bergin & Garfield, 1971, p.246). The question in this study could be "what are the effects of psychotherapy, performed over a maximum time period of eighteen months, by clinical psychology masters students, on less severely disturbed individuals with 'neurotic' symptoms?"

Most outcome studies are based on the therapist's judgement and overall evaluation and many believe that the therapist's evaluation is the most sensible to use (Gendlin, Jenney & Shlien, 1960; Rogers & Dymond, 1954; Luborsky et al, 1971). Fiske et al (1970) point out the limitations in relying upon the therapist's rating as the only criterion of success. Although, as Bergin (1966) points out, the

client is also a biased participant, his qualitative judgment of the outcome of psychotherapy is extremely valid. In fact, Zax & Klein (1960) and Wolberg (1977) state that the client's self-report represents the most direct phenomenological measure of psychotherapeutic outcome but, as with the therapist's evaluation, warn of the dangers involved in using this as the only measure of outcome.

What is clear, from the above comments, is that no single measure of outcome would be satisfactory and this study has attempted to include as many facets of outcome as possible to ensure that a reliable, overall picture of the result of psychotherapy is obtained. Thus, the client's perception of therapist qualities and situational variables, and the therapist's evaluation of outcome are discussed and measured. The Beck Depression Inventory is used as an attempt to provide more objective, empirical support. Despite the limitations of subjectivity described above, it is recognised that the client is one of the best measures of outcome and by utilising the combined assessments of both the client and the therapist it is possible to obtain a clear, reliable and relatively accurate assessment of outcome (Zax & Klein, 1960; Rogers, 1965; Gottman & Leiblum, 1974; Wolberg, 1977). This study is, thus, based on the client's subjective qualification of the psychotherapeutic experience and the therapist's assessment of outcome.

7.2 Objectives. The objective of this study is to ascertain whether the psychotherapeutic service offered at the Rhodes Psychology Clinic is perceived as adequate by the clients. The aim is not to generalise to other university clinics within South Africa but it is hoped that these clinics might gain some benefit from the research conducted.

7.3 Method.

7.3.1 Population. The population was the 107 clients seen at the Rhodes Psychology Clinic during 1990. A random sample of 50 was drawn by selecting client's file numbers at random from a box. Thirty-five were finally approached to participate in this study; 15 could not be traced. A letter was sent to each subject explaining that an eighteen month follow-up study was being conducted to ascertain whether they had viewed their psychotherapy as successful or not and the reasons for this judgement would benefit the Clinic in planning improved services for the future. Of the 35 people approached, 19 responded in the affirmative and were sent a comprehensive questionnaire (see Appendix A), including a list of 65 symptoms and a Beck Depression Inventory, to complete. Only one subject failed to complete this questionnaire and return it.

7.3.2 Confounding variables. An attempt was made to control as many confounding variables as possible by selecting a random sample. The confounding variable of a wide range in severity in

symptomology was controlled by the Clinic's policy to refer more severely disturbed people to more appropriate places for assistance. Other confounding variables affecting outcome were controlled by questioning the client specifically about any possible influence. These included external factors such as support systems and life changes that may have contributed to changes in the presenting problem during psychotherapy and medication which could have assisted in reducing symptomology.

7.4 Results.

7.4.1 Demographics of sample at time of psychotherapy (1990)/ client variables. The sample consisted of 18 subjects. The mean age was 22 with a standard deviation of 2,34. Of the 9 males (50%) and 9 females (50%), 16 (89%) were white and 2 (11%) non-white. All were single and studying at Rhodes University and currently 13 (72%) are still full-time students whilst 2 are working part-time and studying and 3 are working full-time. Fourteen (78%) were self-referred and 4 (22%) had come for help on the advice of a friend or the Student Advisor. Sixteen (89%) had never been in psychotherapy before, 16 (89%) are currently not in psychotherapy but would become involved again if the need arose. The mean number of psychotherapy sessions was 23 and the standard deviation 21,39. The sessions were extended over an average period of 9 months. Five of the therapists were male (28%) and 13 female (72%). Thirteen (72%) of the subjects were seen by first year clinical masters students and 5 (28%) by the intern psychologist. All the therapists were in

weekly supervision with experienced, qualified therapists. All the subjects were seen in the offices at the Rhodes Psychology Clinic. The average fee charged was R4-00 per session which the clients paid out of their own income.

7.4.2 **Therapist qualities.** Specific qualities which the clients experienced from the therapist or which the therapist was perceived as having were assessed by the subjects on a scale of 0 - 5 with 0 indicating none of the quality present and 5 the highest degree of the quality present.

Table 1: Qualities of Therapist as assessed by Subject

<u>Positive qualities: Mean Score</u>		<u>Negative qualities: Mean Score</u>	
Accepted	4,5	Unaccepted	0,7
Liked	4,2	Criticised	1,3
Unjudged	4,2	Judged	0,4
Listened to	4,5	Unheard	0,7
Warmth	3,8	Cold	1
Care	4,2	Boredom	0,7
Interest	4,1	Withdrawn	0,7
Empathy	4,1	False	0,6
Sensitivity	4,6	Insensitivity	1,1
Genuineness	4,1		
Total Mean of Positive Qualities: 4,2		Total Mean of Negative Qualities: 0,8	

On the question of whether the therapist was perceived to be similar or dissimilar in attitude to the client, 10 (56%) found the therapist to be similar. Of the 8 (44%) who found the therapist to be dissimilar in attitude only one subject perceived the psychotherapy as having failed. Twelve (67%) perceived the therapist as having sufficient experience, 22% felt that the

therapist was not experienced enough and 11% were uncertain. Of those who perceived the therapist as inexperienced (22%), only 2 (11%) perceived the psychotherapy as having failed.

7.4.3 **Situational variables.** On the whole the setting was perceived to be comfortable, private and conducive to disclosure. However, 4 subjects (22%) found the setting to be either uncomfortable or noisy but only one of these deemed the psychotherapy to have been a failure. Sixteen (89%) of the subjects had sessions tape recorded of whom 2 (11%) found this factor to inhibit disclosure. Seven (39%) of the subjects were on medication during psychotherapy which consisted mainly of anti-depressants and tranquillisers.

7.4.4 **Symptomology.** Symptoms covered almost all 65 of those listed in the questionnaire but mood problems were dominant with all the subjects displaying some characteristics of depression. The mean number of symptoms present was 28. Ten (56%) expected psychotherapy to provide both symptom relief and a better understanding of, and insight into, themselves. Twenty-two percent expected purely symptom relief and 22% desired only more insight into and acceptance of the self. Overall, 78% of the sample expected symptom relief and 94% achieved it. Seventy-eight percent expected some insight into and acceptance of the self and 89% viewed psychotherapy as successful in this regard.

The t-test for related groups (scores) was administered to each subject's list of symptoms to assess overall improvement or deterioration as experienced by the subject (Huysamen, 1987). Of the 18 subjects, 17 (94%) had a statistically significant reduction ($p \leq 0,01$) in their symptomology. The only subject not to experience some relief from psychotherapy assessed her symptoms as either not improving or becoming worse. Of the 18 subjects, only 8 (44%) had completed a Beck Depression Inventory (BDI) at the time of psychotherapy.

Table 2: Beck Depression Inventory Scores

Before (1990)	After (1992)	Difference
26	6	20
21	24	-3
30	9	21
24	12	12
10	11	-1
28	0	28
16	8	8
21	5	16
-	6	-
-	7	-
-	0	-
-	13	-
-	14	-
-	4	-
-	15	-
-	2	-
-	9	-
-	1	-

The above before- and after-BDI scores were statistically significant ($p \leq 0,01$) using the t-test for related groups (scores). The result of the BDIs completed by the subjects eighteen months later, at the time of this research, indicates that 28% of

the sample are currently mildly depressed and one is severely depressed.

7.4.5 **General factors.** Ten (56%) of the subjects felt prevented from disclosing freely due to personal, internal factors such as an inability to trust and a difficulty in disclosing certain details to anyone. Of these 10, 6 (33%) found attributes of the therapist or the psychotherapy affected self-disclosure ie. feeling uncomfortable having to fill the therapeutic space, fear of being judged, time factors, gender and cultural differences. Thirteen subjects (72%) found other resources to be a useful support during psychotherapy. These were primarily support systems of friends and family. Of the 10 (56%) subjects who perceived external changes as contributing to the presenting problem, 6 (33%) felt that these were negative changes which adversely impacted on symptoms. Six (33%) subjects terminated before the agreed time due to a range of reasons including the belief that the therapist did not care (5,5%), a sense of disillusionment about the therapist due to the lack of anonymity in a small town (5,5%), an inability to trust the therapist (5,5%), the presenting problem worsening and the subject being assigned to another therapist (5,5%), a lack of money (5,5%) and other commitments interfering (5,5%). Of the 5 (28%) clients seen by the intern psychologist only one did not perceive psychotherapy as successful. Completing the questionnaire resulted in all subjects thinking in some depth about the psychotherapeutic experience and invoked a range of feelings from sadness at the loss

of the psychotherapeutic relationship to a reminder of feelings of anger and deception experienced at the time. For most it was a useful experience allowing some perspective to be gained and current functioning, in relation to the level of functioning at the time of psychotherapy, to be assessed. Two subjects (11%) found the questionnaire to be too open-ended, superficial, frustrating and limiting.

7.4.6 Factors perceived to be related to outcome.

The most important factors leading to change in the presenting problem and successful outcome ranged from the psychotherapeutic situation itself to qualities in the therapist or external factors. The most important were insight gained (33%), attitude change (33%), the experience of a personal 'space' for emotional catharsis (17%) and support from the therapist (33%). Support from friends and family was a contributory factor for 11% of the sample. Only one subject stated that he himself was the most important contributor to any change.

The most important factor which was believed would have most contributed to a greater improvement in outcome was a longer time in psychotherapy (22%). Factors involving therapist qualities included unconditional acceptance from the therapist (11%), some self-disclosure from the therapist (11%), more confrontation from the therapist (6%), guidance from the therapist (6%), a difficulty in disclosing to an opposite-sex therapist (6%) and a focus on

current issues (6%). External factors included better support systems (6%), changed life circumstances (6%) and a more pleasant environment in which psychotherapy could be conducted (6%).

Specific factors were perceived as actually hampering change. Therapist qualities such as silence and non-involvement (11%), no self-disclosure (6%), insufficient feedback (6%) and feelings of being judged and disbelieved were mentioned. Qualities in the client included a fear of being judged and of taking risk (11%), self-destructive behaviour, thought and defences (11%), fear of emotions and pain (11%), a difficulty in self-disclosure (6%) and an intense emotional state (6%). External factors were limited time in psychotherapy to deal with the issues (11%), a lack of external support (6%) and lack of finance (6%).

Overall, 16 (89%) viewed psychotherapy as successful. The main improvement was a substantial decrease in symptomology, increased self-confidence, self-acceptance and self-control, fewer feelings of hopelessness and of being overwhelmed, a sense of being stronger and more certain of their ability, of being more able to integrate experiences and of improved personal and social relationships.

Of the 2 (11%) who viewed psychotherapy as a failure, one had felt there was not enough time to deal with issues and the other had found it a totally negative experience. Nine (50%) gained a good understanding into the dynamics of the presenting problem, 8 (44%)

perceived this understanding to be fair and one found she had gained no understanding at all from psychotherapy. These findings were compared with the therapist's rated degree of success, as noted in the termination summaries, in order to establish the degree of congruence between the client and therapist's perceived assessment of successful outcome. Generally there was consensus (72%). However, in 5 (28%) cases there was lack of agreement with 4 (22%) subjects feeling that outcome was successful where the therapist had viewed it as doubtful.

CHAPTER 8

DISCUSSION AND CONCLUSION

The results indicate that 89% of the subjects assessed psychotherapy as having been successful. Based on this figure, the contributory variables of the client, therapist and situation will be discussed.

8.1 Client variables.

8.1.1 Initial level of adjustment. The initial level of adjustment is deemed to be one of the strongest indicators for successful psychotherapy (Luborksy et al, 1971). Taking into account the Clinic's policy to take clients who are not severely disturbed, a higher success rate would be expected. This is supported by the finding that 94% of the sample had a statistically significant reduction in symptomology and 89% rated psychotherapy as successful.

8.1.2 Motivation and expectancy. Sifneos (1981) and Malan (1963) stressed the importance of motivation as a powerful factor in outcome. The more egodystonic the symptoms, the more motivated the client is likely to be (Rosenthal & Frank, 1956; Frank, 1959 in Bergin & Garfield, 1971). Indicative of a high level of motivation is the number of self-referrals made (78%). It is important to point out that the other 22% had approached friends or the Student



Advisor which indicates that they too were motivated to seek assistance. Bergin's findings (Bergin, 1971 in Wolberg, 1977), in reviewing Eysenck's results, that there was a 91% improvement rate for those who stayed in psychotherapy suggests that motivation is a key factor in success. The 89% success rate in this sample supports this conjecture.

There was a high correlation between client expectancy and outcome with 78% expecting symptom relief and 94% ($p < 0,01$) of the sample achieving this. Fourteen (78%) subjects also desired an increase in self-understanding and insight and, of these, 89% viewed psychotherapy as successful in achieving these aims. Thus, more success was gained than was expected with more clients achieving symptom relief and gaining more insight despite not specifically expecting to gain this from psychotherapy.

8.1.3 **Age and sex.** Despite conflicting results, the literature indicates that generally younger, female subjects are more likely to view psychotherapy as successful (Casner, 1950; Cartwright, 1955). The mean age of the sample was 22 with an equal number of males and females. Whilst this finding supports the belief that younger people achieve more, it does not support the theory that females achieve better results in psychotherapy. In fact, the only subject who found psychotherapy to be a resounding failure was female and 100% of the male subjects found statistically significant symptom relief despite one male believing that overall

psychotherapy had not been successful.

8.1.4 **Level of intelligence, education and occupation.** On the whole, research supports a higher level of intelligence and education as a positive indicator for successful psychotherapy (Casner, 1950). If, as Cartwright (1955) and Casner (1950) suggest, students tend to be rated as more successful, then a very positive outcome would be expected in this study as the entire sample consisted of students with a minimum of 12 years education. The result of an 89% success rate supports this.

8.1.5 **Socioeconomic status.** Research indicates that middle- to upper-class individuals stay longer in, and gain more from, psychotherapy (Rosenbaum et al, 1956; Bergin & Garfield, 1971). This factor was unable to be clearly assessed and thus cannot be considered a factor for critical discussion here.

8.1.6 **Perceived similarity between client and therapist.** Similarity of attitude, culture and class is seen as facilitating both process and outcome (Lesser, 1961; Rosenbaum et al, 1956). Despite 44% of the sample finding the therapist to be dissimilar in attitude, only one subject perceived psychotherapy as a failure. This suggests that, despite perceived dissimilarities, psychotherapy can and does have successful results if other critical variables are present.

8.1.7 **Client/therapist congruence on success.** Clients who feel satisfied with psychotherapy are usually viewed as having been successful by the therapist (Cartwright, 1955). This was, however, not totally supported by these findings. There was congruence in 72% of the sample but 28% of the subjects viewed psychotherapy as successful whilst the therapists viewed the outcome as either doubtful or unsuccessful because of only partial or moderate improvement. This indicates that the expectancy of the client and therapist differed and, for some clients, a reduction in symptomology was sufficient. This emphasises the point that goals in psychotherapy may differ from client to client and client to therapist and that ultimately the goal is client regulated (Wolberg, 1977).

8.1.8 **Client characteristics.** With 56% of the clients perceiving their own characteristics as hampering the process and outcome of psychotherapy, it is clear that the client himself is a critical factor in the psychotherapeutic equation. A difficulty in self-disclosure (6%), a fear of their own emotional reaction (11%), of taking risk or of being judged (11%) and of their own self-destructive behaviour and thoughts (11%) were perceived as being the most important client factors hampering the process and outcome of psychotherapy.

8.1.9 **Conclusion.** Bearing in mind that the client's report is a subjective assessment and that results may be inaccurately assessed if they do not conform to the client's own value system or desire (Wolberg, 1977), it is clear that highly motivated, younger, well-educated clients with an initially reasonable level of adjustment are likely to achieve considerable success in psychotherapy. It is also clear that despite perceived dissimilarity between the client and therapist, psychotherapy can and does have successful results. The client is, without doubt, critically important in the psychotherapeutic alliance and process and his own characteristics can attribute to or hamper psychotherapy.

8.2 **Therapist variables.**

8.2.1 **Therapist characteristics.** The most important of these appear to be empathy, non-possessive warmth, and genuineness and, if these qualities are present, significant improvement is expected (Bergin & Garfield, 1971). If not, deterioration in the client's psychological state is often experienced (Truax & Carkhuff, 1964 in Malan, 1973). Thus one would expect therapist qualities of boredom, lack of sensitivity or criticism to further detrimentally affect psychotherapeutic outcome. The mean score of 4,2 (out of a possible 5) on positive qualities in the therapist as assessed by the client, clearly indicates that the therapists provided a climate where the client felt heard, liked, accepted, unjudged and cared for. The therapists themselves were generally perceived as

interested, empathic, genuine and sensitive.

Factors which were perceived of as leading to improvement in outcome were mainly qualities of the therapist which created a therapeutic space, insight, attitude change and a belief in the self for the client. However, some negative qualities were perceived to be present in some therapists with criticism, coldness and insensitivity scoring the highest (mean of 1,1 out of a possible 5). One subject, who deemed psychotherapy to be a total failure, perceived the therapist as critical, unaccepting and judgemental (mean of 3) and as being mildly cold, bored, withdrawn, insensitive and false (mean of 1). Overall, a mean of 0,8 was scored for negative qualities. However, despite this psychotherapy was viewed as successful (89%) for all bar 2 (11%) which suggests that the presence of negative qualities, on a minor level, is insufficient to hamper change and growth if other positive factors are present.

Self-disclosure was inhibited, to some degree, for 33% of the subjects by the therapist or the psychotherapeutic space. For example, the therapist's silence, non-involvement, lack of challenging, lack of focus on present issues and a lack of self-disclosure and the client's sense of needing to fill the space inhibited the client's self-disclosure. These reasons were seen as factors which hampered psychotherapy and it was felt that their presence would have facilitated progress. Langs (1989) states that

self-disclosure by the therapist is a negative factor in psychotherapy and can be perceived as destructive by the client's unconscious. The training in the Masters Clinical Psychology Course at Rhodes emphasises no self-disclosure from the therapist. Thus, despite this being perceived as a negative quality by the 33% of the clients, it is a healthy sign that there was very little self-disclosure from any of the therapists.

Certain qualities perceived to be present in the therapist also resulted in 16% of the sample terminating early. Bergin and Garfield (1971) found that those who terminate early rarely seek psychotherapy elsewhere, and the findings that none of the subjects in this sample who terminated early have been in psychotherapy since, supports this finding.

8.2.2 **Sex of therapist.** Conflicting results suggest that a satisfactory psychotherapeutic alliance is more important than any sex difference. In only one instance, in this study, was the sex of the therapist viewed as negatively affecting disclosure but the final outcome was still viewed as a success and there was a statistically significant reduction in the client's symptomology ($p < 0,01$). This indicates that, although at times it is difficult for a client to disclose freely with an opposite-sex therapist, the overall result can be positive.

8.2.3 **Degree of therapist experience.** Overall the literature supports the theory that the more experienced the therapist is, the better the psychotherapy will be and the more successful the outcome (Joslin, 1965 in Carkhuff, 1966; Truax & Carkhuff, 1964). This does not, however, mean that neophyte therapists are unable to provide a sufficiently effective environment for healing, change and growth (Malan, 1963; Strupp, 1971). Although only 67% of the sample perceived the therapist as having sufficient experience, of the 22% who did not, only one subject perceived psychotherapy as having totally failed. Despite not being perceived as having sufficient experience 2 (11%) found the therapist to be very high on positive qualities ($M = 4$) and psychotherapy to be a success. The other 2 (11%) found the therapist critical, unaccepting, bored, withdrawn and insensitive ($M = 1.9$). Notwithstanding this, one of these subjects still found a statistically significant level of symptom relief but did not view psychotherapy as successful overall. A factor which may strengthen the therapist's ability and counteract inexperience slightly is that all the therapists were given weekly supervision. These results suggest that, even if the therapist is relatively inexperienced, if he is able to provide an atmosphere of empathy, warmth, genuineness and sensitivity, the client can benefit substantially from the experience.

8.2.4 **General therapist variables.** As the basis of this study was the client's self-report and the therapists' views of success of psychotherapy, many of the therapist variables have not been

explored in depth. Therefore, little information can be ascertained as to the presence and effect of such factors as personality, attitudes and the ability to provide insight to a client. This may be considered to be a weakness in this study.

8.2.5 Conclusion. On the whole, successful outcome was largely attributed to therapist qualities. Clearly, therefore, the personality characteristics and skills of the therapist are critically important and can positively or negatively affect outcome. If, however, negative qualities are present in a mild form and all the other variables in the equation have been successfully fulfilled, psychotherapy can have very positive results.

8.3 Situational variables.

8.3.1 Length of psychotherapy. It is clear that short-term, in-depth psychotherapy (10 - 50 sessions) is extremely effective (Malan, 1973; Malan, 1975, Mann, 1981 & Sifneos, 1981 (in Ursano & Hales, 1986)). The mean number of therapy sessions for this sample was 23 and the 89% successful outcome supports this statement. The one subject who did not find psychotherapy successful did nevertheless have some symptom relief in 20 sessions. The subject who viewed psychotherapy as a complete failure only attended 3 sessions. The suggestion by Cartwright (1955) and Kirtner and Cartwright (1958) that there is a 'failure-zone' falling between 13 - 20 sessions is not supported by these findings. Of the 33% of the sample falling into this zone, only one subject perceived

psychotherapy as a failure despite gaining some symptom relief.

However, 28% of the subjects stated that they would have preferred more time in psychotherapy and felt that issues could have been explored in greater depth, more effectively, given a longer time span. Thus, it appears that terminating merely because it is the end of the year can leave clients feeling that issues have not been resolved as successfully as they might have.

One advantage of shorter-term psychotherapy is that dependence is not as easily fostered which could interfere with the client's self-actualisation (Wolberg, 1977). Eighty-nine percent of the subjects seeking growth and insight felt they had achieved these aims.

8.3.2 **Tape recorded sessions.** Although there is very little literature to be found on the effects of this factor, it would seem that being taped does affect self-disclosure to some degree (Benzaglia, 1965 in Carkhuff, 1966). Of the 89% who had sessions tape recorded 11% found this to inhibit self-disclosure which supports the above conjecture. However, it would appear that it is insufficient to prevent psychotherapy from being successful as all these subjects, bar one, experienced psychotherapy as successful despite the effects of being tape recorded.

8.3.3 **Physical and cultural setting.** Little research deals with any specific results about the physical setting except to state that it does affect the process of psychotherapy (Goldstein, 1971). Discomfort and noise factors were viewed as problems by 22% of the subjects but only one found this to adversely affect outcome. This indicates that, despite less than ideal conditions, psychotherapy can be therapeutic.

The cultural setting to which the client returns is of importance. Seventy-two percent found friends and family to have been supportive throughout psychotherapy and all these subjects assessed outcome as successful. This indicates that a supportive milieu enhances the likelihood of psychotherapy achieving its aims. The importance of the societal/familial milieu is further borne out by 33% feeling that external factors and changes negatively impacted on symptoms. For example, the lack of external support was perceived as either hampering psychotherapeutic outcome (6%) or as being a factor which would have improved outcome if present (6%).

8.3.4 **Payment of fees.** This is linked to motivation and the research reveals that a significantly high proportion of paying clients experience psychotherapy as successful (Rosenbaum et al, 1956). All the subjects paid for their own psychotherapy which indicates a high level of motivation.

8.3.5 **Conclusion.** It is clear that situational variables do affect how the client perceives the whole psychotherapeutic equation. A comfortable, quiet and private setting in which the client feels able to self-disclose is important. But equally important is the motivation and responsibility implied by clients paying their own fees and whether the length of psychotherapy is sufficient to effectively deal with the client's problems.

8.4 **Symptomology.** Less-disturbed clients, with neurotic symptoms, tend to respond more positively to psychotherapy (Bergin & Garfield, 1971). With all 65 symptoms present to some degree across the entire sample, it is significant that 94% found statistically significant reduction in symptomology. Wolberg (1977) states that most clients regard symptomatic relief as the best measure of gain and the results clearly support this statement. Luborsky et al (1971) and Malan (1980) state that depression is a good prognostic indicator. With depression being the most common symptom in this sample (present in 100% of the sample), good results would be expected and have been gained. Although Lambert et al (1986) state that no widely accepted single measure of depression exists, Hatzenbuehler et al (1983) suggest testing depression with the Beck Depression Inventory (BDI) as it is the most frequently used self-report depression inventory. The statistically significant difference in BDI scores indicated that depressive symptoms had improved significantly. Although 2 subjects (11%) had a slight increase in BDI scores, both had viewed psychotherapy as successful

and had gained insight into both the problem, the self and had a significant reduction in symptoms. Although 39% of the sample were on medication, of the 44% who completed a BDI at the time of psychotherapy, only 11% were on medication indicating that, although medication may assist in reducing depressive symptoms, psychotherapy was sufficient in the majority of these cases. However, despite 94% of the sample finding a significant reduction in symptoms, according to Beck's categorisation of depression (Hatzenbuehler et al, 1983), 28% are currently suffering from mild depression and one is severely depressed. This suggests that, in the long-term, the reduction in depressive symptoms has not been successful for 34% of the sample.

8.5 General.

8.5.1 **Confounding variables.** An important point to consider in assessing results is why certain subjects did not respond. Goldman (1976) reports that response rates of 30 - 50% are considered to be good but he believes that results need to be interpreted very tentatively if the response rate is less than 70% as those clients who failed to respond may have completely altered the picture of the findings. It is difficult, if not impossible, to ascertain what motivated some people to reply and others not to. The response rate, in this study, was 54% which is a good response rate but the results must be interpreted cautiously.

Rudolph and Cumming, 1962 (in Bergin & Garfield, 1971) point out that the more sophisticated an agency's psychotherapy method is, the more highly selected is the population that it serves. Furthermore, it is more likely to label clients as unsuitable or unmotivated. Lief, Lief, Warren and Heath, 1961 (Bergin & Garfield, 1971 p.278) emphasise the need to select middle class clients "if we consider the needs of university clinics to train residents in insight therapy". Bearing in mind that the Rhodes Psychology Clinic is a training institution, the assessment for psychotherapy does tend to be more selective in order to ensure that the client's needs can be more adequately met by the therapists-in-training. These factors of selection for the Clinic in general and self-selection for the study limits generalising the findings to the population in question only. However, as the aim of this study is to be of benefit to the Rhodes Psychology Clinic, good use can be made of the findings.

8.5.2 **Spontaneous remission.** Rogers and Dymond (1954) state that spontaneous remission is so commonly observed that its existence can hardly be doubted. It is, of course, impossible to measure how much of any improvement is due to spontaneous remission. Fiske et al (1970) stated that its effects can be considerable. However, Bergin and Garfield (1971) state that studies show that there is something unique about psychotherapy which causes improvement beyond the effects of spontaneous remission. The result of the 'deterioration effect' in

psychotherapy should also be considered in finally analysing whether the outcome is successful or not. However, in the light of the considerable, statistically significant improvement experienced by the subjects in this sample, it is clear that spontaneous remission was not the only factor at work and that psychotherapy played a major role in assisting these clients to function more adequately in their daily lives. It is also apparent that the 'deterioration effect' did not play much of a role in these specific cases.

8.5.3 **Failure.** Further supporting the finding of 89% successful outcome is that all these subjects would return to psychotherapy for help if the need arose. However, 11% of the sample viewed psychotherapy as a failure despite one subject experiencing some symptom relief. The failure was attributed mainly to qualities in the therapist. According to Wolberg (1977) what is regarded as success and the goals of psychotherapy are more or less client regulated. He warns that the client's estimate of failure in psychotherapy should not be accepted at face value as this may be based on a false premise. If the client has an ideal which he is striving for in psychotherapy, the failure to achieve this may cloud any success which has been attained. Personality damage or neurotic fears may prevent the client from disclosing and even beginning the psychotherapeutic process. Clients' perceptions of the therapist and situation are often largely based upon their own fantasies and, with the psychodynamic approach emphasising little

self-disclosure from the therapist, the client has little concrete fact to base his assumptions on. In many cases where the therapist is viewed as cold, distant, bored or critical, unresolved negative transference is involved. A resistance to change could also be a reason that the client chooses to terminate early or views psychotherapy as a negative experience (Gottman and Leiblum, 1974). Thus, although it is important to look critically at the reasons given for failure in psychotherapy, these reasons are not always related to a failing in the therapist or in the service provided by the Clinic.

8.6 Conclusion. Bergin and Garfield (1971) state that it is impossible to conclude very much from gross studies of psychotherapeutic effects and an attempt has been made, in this study, to break the psychotherapeutic equation down into more meaningful segments for evaluation. The basis of this study was the clients' perceptions of psychotherapeutic success according to their evaluation of the therapist, the situation and their own qualities, and the therapists' evaluation of outcome. Wolberg (1977) stresses that the client's evaluation may be limiting because of the subjectivity and possible distortion of the self-report. It is important to stress that the objective of this pilot study is to ascertain whether the clients at the Rhodes Psychology Clinic perceive the services rendered as beneficial or not.

Bergin, 1971 (in Malan, 1973) came to the conclusion that psychotherapy has a positive effect under the right conditions and that not all clients are suitable for psychotherapy. What is clear from the above findings is that all the conditions for an ideal psychotherapeutic milieu do not have to be present for psychotherapy to be successful. Although clients reported that certain qualities of the therapist, the situation or themselves, as clients, was inadequate or missing in the overall, ideal psychotherapeutic equation, 89% perceived psychotherapy as successful and 94% achieved a significant reduction in symptoms.

If we are defining success purely on the level of symptom relief, this sample has a success rate of 94%. However, as Wolberg (1977) points out, if behaviour change is the goal, positive results are usually reduced. Many clients can't be relieved beyond symptom reduction and attitude change and Wolberg (1977) believes that many sicker clients can't cope with their defences being stripped away. However, as only less disturbed individuals are seen at the Clinic this is less of a confounding variable. More important is the time factor and possibly the shorter-term psychotherapy provided by the Clinic accounts for symptom relief being the dominant success. It is perhaps unrealistic to expect personality change to result in under 30 sessions.

In the final analysis, a more realistic aim for successful psychotherapy should be that the client experiences symptom relief,

gains the capacity to function reasonably well and is able to experience some measure of happiness (Wolberg, 1977). It is clear that most of the subjects in this study achieved this end.

With Bergin and Garfield (1971) and Wolberg (1977) coming to the conclusion that a person suffering from a psychological problem is better off with no treatment than to have an emotionally inadequate psychotherapeutic relationship, it is heartening to have found that 89% of this sample experienced psychotherapy as successful. A note of caution has to be introduced here though. It is impossible to assess why 46% of the original sample requested to participate were unwilling to. With the possibility that their input could have altered the results to provide a more negative picture, these results may be optimistically positive.

It is also important to take heed of the negative aspects discovered in this study in order for the Clinic to provide a better service in the future. These would include stressing that therapists be warm, sensitive and non-judgemental in order to facilitate self-disclosure and improve the psychotherapeutic alliance. As the Rhodes Psychology Clinic is a training institution factors such as a limited length of psychotherapy and therapist inexperience cannot be radically altered. However, the effects of these two factors can be lessened by stressing the length of psychotherapy at the initial assessment-feedback session, dealing with termination issues effectively and ensuring that the

training therapists continue to be given adequate supervision. Care can also be taken to ensure that the physical aspects of the psychotherapeutic space are enhanced by ensuring privacy, comfort and quietness.

Although the majority of people coming to the Clinic are students, the Clinic is open to the community at large. It was impossible to ascertain how the services of the Clinic were viewed by any of the community as the random sample drawn included only students. Thus the results of this study can only truly be generalised to the student population of Rhodes University.

Overall, although only a fairly rough index of measurement and despite the methodological limitations of this study, it would appear that the Clinic is fulfilling a useful service to the student body by alleviating symptoms, changing attitudes, providing insight and putting the client firmly on the road to further psychological health. The combination of a good psychotherapeutic relationship, emotional catharsis, insight, a higher level of functioning and an alleviation of anxiety due to symptom relief provides clients with the ability and motivation to improve further.

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APPENDIX A

GENERAL:

AGE (DATE OF BIRTH) :

MARITAL STATUS (AT TIME OF THERAPY):

LEVEL OF EDUCATION (AT TIME OF THERAPY) :
(CURRENTLY) :

OCCUPATION (AT TIME OF THERAPY):
(CURRENTLY) :

WHO REFERRED YOU TO THE CLINIC ?:

SELF-REFERRAL

FRIEND
.....

FAMILY MEMBER
.....

STUDENT ADVISOR

OTHER (if so, please specify)

FOR HOW LONG DID YOU UNDERGO THERAPY ?

IN WHAT YEAR WAS THIS ?

HAD YOU BEEN IN THERAPY BEFORE ? YES / NO
If so, when ? For how long ?

WOULD YOU UNDERGO THERAPY AGAIN ? YES / NO

Comment

ARE YOU CURRENTLY IN THERAPY ? YES / NO
If so, for how long ?

QUALITIES OF THE THERAPIST:

PLEASE RATE THE FOLLOWING QUALITIES AS YOU EXPERIENCED THEM FROM YOUR THERAPIST BY CIRCLING THE NUMBER WHICH MOST CLEARLY INDICATES THE DEGREE TO WHICH THE QUALITY WAS PRESENT. (SCALE OF 0 - 5 WITH 0 INDICATING THAT NONE OF THE QUALITY WAS PRESENT AND 5 INDICATING THE MOST).

EG. 0 1 2 3 4 5
 (unaccepted) (totally accepted)

DID YOUR THERAPIST MAKE YOU FEEL:

ACCEPTED 0 1 2 3 4 5

LIKED 0 1 2 3 4 5

UNJUDGED	0	1	2	3	4	5
----------	---	---	---	---	---	---

LISTENED TO	0	1	2	3	4	5
CRITICISED	0	1	2	3	4	5
UNACCEPTABLE	0	1	2	3	4	5
JUDGED	0	1	2	3	4	5
UNHEARD	0	1	2	3	4	5

WAS THE THERAPIST:

WARM	0	1	2	3	4	5
CARING	0	1	2	3	4	5
INTERESTED	0	1	2	3	4	5
EMPATHIC	0	1	2	3	4	5
GENUINE	0	1	2	3	4	5
SENSITIVE	0	1	2	3	4	5
COLD	0	1	2	3	4	5
BORED	0	1	2	3	4	5
WITHDRAWN	0	1	2	3	4	5
INSENSITIVE	0	1	2	3	4	5
FALSE	0	1	2	3	4	5

DID YOU VIEW THE THERAPIST AS:

SIMILAR IN ATTITUDE TO YOU ?	0	1	2	3	4	5
DISSIMILAR IN ATTITUDE ?	0	1	2	3	4	5

DID YOU FEEL THAT YOUR THERAPIST WAS SUFFICIENTLY
EXPERIENCED/QUALIFIED ? YES / NO

COMMENT

.....

.....

SITUATIONAL QUALITIES:

PLEASE CIRCLE THE QUALITIES YOU FEEL ARE MOST APPROPRIATE AND
CORRECT - MORE THAN ONE QUALITY IS ACCEPTABLE.

DID YOU FIND THE SETTING IN WHICH THERAPY WAS CONDUCTED:
COMFORTABLE / PRIVATE / CONDUCIVE TO DISCLOSING FREELY / NOISY /
DISTRACTING / UNCOMFORTABLE

WERE THE SESSIONS TAPED ? YES / NO

IF YES, DID THIS HAMPER OR INHIBIT YOU FROM DISCLOSING FREELY ?
YES / NO

CLIENT INFORMATION:

WHY DID YOU SEEK HELP AT THE CLINIC ? (eg. depression, anxiety,
social relationships, etc.)

.....

.....

HOW DID YOU FEEL ABOUT THIS PROBLEM ? (Briefly describe)

.....
.....
.....

WHAT WERE YOU HOPING TO ACHIEVE BY THERAPY ?

.....
.....
.....

PLEASE TICK WHICHEVER OF THE FOLLOWING APPLIED TO YOU AT THE TIME
YOU PRESENTED AT THE RHODES PSYCHOLOGY CLINIC IN THE LEFT HAND
COLUMN:

MOOD PROBLEMS

1. Depressed
2. Tension
3. Easily upset
4. Irritable
5. Lonely
6. Easily hurt, too sensitive
7. Constantly worried
8. Crying more frequently
9. Losing interest in things in general
10. Hopeless
11. Thinking about ending my life
12. Wishing I were dead
13. Bitter
14. Sad or blue
15. Guilty
16. Discontented
17. Easily bored

ANXIETY PROBLEMS

18. Anxious
19. Increased muscle tension
20. Physical reactions like: headaches/gastrointestinal
problems/sweating/hyperventilation
21. Panicky
22. Nervous or highly strung

COGNITIVE PROBLEMS

23. Having difficulty remembering recent events
24. Having difficulty remembering things in the past
25. Confused

- 26. Having difficulty concentrating
- 27. Inefficient in work or study
- 28. Daydreaming
- 29. Having difficulty thinking clearly
- 30. Hearing voices
- 31. Seeing visions
- 32. Having strange or unreal feelings

STUDY/WORK AND FINANCIAL CONCERNS

- 33. Unable to make a vocational choice
- 34. Dissatisfied with vocational choice
- 35. Working too hard
- 36. Not interested or challenged by work/study
- 37. Financial difficulties

SOCIAL AND FAMILY CONCERNS

- 38. Having difficulty making friends
- 39. Feeling uncomfortable with other people
- 40. Having too few dates
- 41. Not finding a suitable life partner
- 42. Having difficulty trying to decide whether to get married or make a long-term commitment
- 43. Having to break up a love affair/relationship
- 44. Frequent arguments in love relationship
- 45. Feeling rejected by family/friends/loved one (circle appropriate answers)
- 46. Poor relationship with father/mother (circle one or both)
- 47. Unhappy where I am living
- 48. Withdrawing from other people

FEELINGS ABOUT ONESELF

- 49. Lacking leadership ability
- 50. Not being smart enough
- 51. Timid or shy (non-assertive)
- 52. Taking things too seriously
- 53. Physically unattractive
- 54. Lacking ambition
- 55. Too easily influenced by others
- 56. Not able to do anything well
- 57. Feeling worthless
- 58. Feeling misunderstood
- 59. Feeling helpless
- 60. Feeling ashamed of something
- 61. Unable to make decisions
- 62. Feel things are out of control

VALUE AND RELIGIOUS CONCERNS

- 63. Needing a philosophy in life
- 64. Not knowing what kind of person I want to be
- 65. Confused about religious beliefs

OTHER PROBLEMS (please specify)

66.
67.
68.

PLEASE LOOK BACK OVER THE SYMPTOMS MARKED AND, IN THE RIGHT HAND COLUMN, RATE THE IMPROVEMENT SINCE ATTENDING THE CLINIC ON A SCALE OF 0 - 5.

EG. 0 = SYMPTOM GOT WORSE

1 = NO IMPROVEMENT

2 = MINOR IMPROVEMENT

3 = MODERATE IMPROVEMENT

4 = SIGNIFICANT IMPROVEMENT

5 = SYMPTOM IN COMPLETE
REMISSION

GENERAL

DID YOU COMPLETE A BECK DEPRESSION INVENTORY AT ANY STAGE ?

YES / NO

(Please assist us by completing the attached Beck Depression Inventory as you are feeling now. Please ensure that you answer all 21 items).

DID YOU FEEL YOU WERE ABLE TO FREELY DISCUSS ALL OF YOUR PROBLEMS ? YES / NO

DID YOU FEEL PREVENTED, BY ANY CIRCUMSTANCE, FROM REVEALING CERTAIN INFORMATION ? YES / NO

If yes, please specify what circumstance

.....
WERE YOU ON ANY MEDICATION WHILST IN THERAPY ? YES / NO

If yes, please specify type and dosage

.....

WERE THERE ANY OTHER RESOURCES YOU FOUND USEFUL AT THE TIME ?
(eg. friends, family, church, etc.)

.....
.....

WERE THERE ANY OTHER CHANGES IN YOUR LIFE, AT THAT TIME, WHICH MAY HAVE CONTRIBUTED TO CHANGES IN YOUR PRESENTING PROBLEM ? YES / NO

If yes, please specify

.....

.....

HOW MUCH UNDERSTANDING DID YOU GAIN INTO YOUR PROBLEMS ?

.....
.....

WHAT FACTORS DO YOU BELIEVE WERE THE MOST IMPORTANT IN LEADING TO CHANGE ?

.....
.....
.....

WHAT FACTORS DO YOU BELIEVE WOULD HAVE LEAD TO GREATER IMPROVEMENT THAT THOSE WHICH YOU EXPERIENCED ?

.....
.....
.....
.....

WHAT FACTORS DO YOU BELIEVE **HAMPERED** OR PREVENTED CHANGE ?

.....
.....
.....
.....

IF YOU TERMINATED BEFORE THE AGREED TIME, WHAT FACTORS WERE INVOLVED IN MAKING THIS DECISION ?

.....
.....
.....

IN GENERAL, WOULD YOU SAY THAT THERAPY WAS SUCCESSFUL AND THAT YOU
FELT AN IMPROVEMENT IN YOUR SYMPTOMS ?

YES / NO

(Please qualify if you wish to)

.....

.....

HOW DID YOU EXPERIENCE COMPLETING THIS QUESTIONNAIRE ?

.....

.....

THANK YOU FOR THE TIME AND EFFORT YOU HAVE SPENT IN COMPLETING THIS
QUESTIONNAIRE. YOUR HONESTY AND SELF-DISCLOSURE IS GREATLY
APPRECIATED.

