THE EXPERIENCE OF PATIENTS AND THERAPISTS IN PSYCHOLOGICAL THERAPY

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Table of Contents

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The Experience of Patients and Therapists in Psychological Therapy

Summary.

Susan Patricia Llewelyn

Patients and therapists are rarely asked to describe their subjective experiences as participants in psychological therapy. In this study 40 therapist/patient pairs were asked to record, after each session of psychological therapy, their subjective views concerning the helpful and unhelpful events which took place, and also to evaluate the helpfulness of those events and the session itself. On completion of therapy, they described their views of the helpful events in retrospect, and provided outcome data.

A total of 1076 events were collected from 399 therapy sessions. These were content-analysed using Elliott's Therapeutic Impact Content Analysis System. Results showed that during therapy, patients found the most helpful aspects of therapy to include reassurance/relief and problem solution events; whereas therapists chose the gaining of cognitive and affective insight. After the conclusion of therapy, both patients and therapists also reported the importance of personal contact. Although decreasing with time, the differences between the two perspectives were highly significant. More differences between the views were found when outcome was poor, although the perspectives could be clearly distinguished even when outcome was good.

It was suggested that different aspects of the therapeutic process have a different degree of salience for therapists and patients, in that patients are most interested in gaining a solution to their problems, whereas therapists are more concerned with the aetiology of the problem and its transformation through patient insight. Despite these differences, however, most therapies seemed to be reasonably helpful. It was therefore speculated that one mechanism of therapeutic intervention may be the alternative way of making sense of the world with which both patients and therapists are confronted in therapy, suggested by the differing types of events which the two groups of participants see as helpful.

LIST OF TABLES

2

LIST OF FIGURES

LIST OF APPENDICES

Chapter One

Introduction.

1.1) Preamble.

Psychological therapy, a process by which one individual endeavours to help another psychologically, usually by a series of regular meetings, occupies the time and energy of countless therapists, patients, and researchers in the U.K., Europe, and the U.S.A.. Beyond this simple statement, there is controversy. Researchers and practitioners have disagreed on what psychological therapy is, or should be, how effective it is, with whom it is or is not effective, why it is effective, or what the term effective means anyway. They also disagree on whether the focus of attention should be on process (what goes on during the therapy), or on outcome (what effect the therapy has on the patient's presenting problem, underlying psychopathology, or personality). The situation is further complicated by the forceful expressions of confidence by members of particular theoretical schools who claim to have found certainty on one or other of the above questions. This certainty is simply not justified, as will be demonstrated below.

It is worth noting at this point that one of the first controversies is related to the language used in the descriptions of the process of psychological therapy; it seems appropriate, therefore, to establish a definition of this term which will be used throughout this thesis. The one chosen is that used by the British Psychological Society's Working Party into the Psychological Therapies, which reported in 1980. The definition they used was taken from Meltzoff and Kornreich, 1970, as follows: "Any informed and planful application of techniques derived from established psychological principles, by persons qualified through training and experience to understand

these principles and to apply these techniques with the intention of assisting individuals to modify such personal characteristics as feelings, values, attitudes and behaviours which are judged by the therapist to be maladaptive or maladjustive." (Meltzoff and Kornreich, 1970, p.6). This definition has the merit of including a wide array of therapeutic activity, (although it still might be seen by some as controversial).

1.2) Organisation of this thesis.

In this introductory section of the thesis, (chapter 1), a number of arguments will be advanced to document the way in which the above controversies have led to a state of confusion and a lack of progress in the advancement of knowledge in the psychological therapies. This will be followed by an analysis of some of the contributory factors to this state of confusion, and a discussion of possible ways out of the present stalemate in research. In subsequent sections of the thesis, a more comprehensive outline of relevant research will be presented (chapters 2 and 3); and this will be followed by a description of the research methods used in the present study, (chapters 4 and 5). These chapters will include a discussion of how the research is related to a) the argument being advanced in this chapter, and b) the research reviewed in chapters 2 and 3. Chapter 5 will also include a presentation of the main questions to be asked by the empirical study. The results will then be given in chapters 6 and 7, and some of the methodological difficulties will be discussed in chapter 8. These results will then be examined in terms of their contribution to our understanding of psychological therapy, (chapter 9), and finally, there will be a discussion of possible future avenues of research, (chapter 10).

1.3) Background and brief overview of research in psychological therapy.

Turning now to the subject matter of this chapter, it is appropriate to start by considering the background to

the present area of concern. Even a brief look at the present academic research literature, or at popular psychological sources such as magazines offering personal therapy services, indicates that there are an extremely large number of psychological therapies all of which may claim theoretically coherent frameworks, training schemes and devoted practitioners. Prochaska and Norcross (1982) pointed out that in 1975 there were over 150 distinguishable therapies available, and using the Delphi method to look at probable developments during the next ten years, considered that it was likely that there would be over 200 by the end of the decade. Further, it now seems as though this was an underestimation, as 250 is the figure currently widely quoted.

One response to this proliferation has been to suggest that there are no real differences in the techniques used by the different therapies, (see section 3.2.3 for a discussion of this view); however there is now growing evidence that these therapies do in fact use different techniques, and that careful examination of the techniques used by therapists of different theoretical persuasions shows that they do differ from each other in systematic and measurable ways.(see for example Stiles, 1983; Russell and Stiles, 1979; Cross, Sheehan and Khan, 1982; Gurman, 1983; and section 3.2). That differences exist in process does not imply, however, either that the outcome from different therapies need be different, or that the helpful factors or active ingredients in different approaches in practice differ, although this is of course hotly disputed by the members of different schools. Both these questions will be dealt with in more detail below, (in sections 2.2 and 2.3 respectively). It is appropriate at this juncture, however, to take note of the more or less accepted state of the research in outcome studies in the psychological therapies, as this is to an extent less hotly disputed.

During the sixties and earlier part of the seventies, most of the effort in psychotherapy outcome research was

spent finding evidence for and against Eysenck's (1952) conclusion that there was no evidence for the effectiveness of psychotherapy, but considerable evidence for the effectiveness of behaviour therapy. Work proceeded on both fronts more or less in ignorance of work on the other, except for scathing comments from each group about the other. Of more serious consequence, the implications of work that was completed tended to be ignored if it did not happen to suit the particular paradigm being investigated. For example, Malan, in an interview with Barnes (1980) said: "I'm becoming convinced that the truth of dynamic psychotherapy is that it is effective, but only in a very small proportion of patients...", (p.5), yet he goes on to say that he believes that it is the only method that offers a radical solution to the majority of neurotic problems. Frank, 1971, cites a young sychotherapist talking about his particular theoretical approach: "Even if the patient doesn't get better, you know you're doing the right thing." (p.60) Equally, Evans and Robinson (1978) in describing the behavioural treatment of a young woman who, by keeping a diary, showed the therapist very clearly that the therapy worked in ways that far exceeded the behavioural, reported: "Generally the diary exposed to us the limitations of therapy and the crudity of our working model, but did not challenge our behavioural assumptions regarding the mechanisms of change" (p.354). These examples of the lack of respect for the worth of research when it challenges private theoretical belief unfortunately seems to be characteristic of psychotherapy outcome research.

A major step forward in our understanding of the effectiveness of the different types of therapy occurred in the second half of the seventies, when a number of major studies were published, throwing new light on the old controversy. In particular, the Temple study carried out by Sloane and co-workers (Sloane, Staples, Cristol, Yorkston and Whipple, 1975), concluded that there was no significant difference in outcome between patients who had received brief psychodynamic psychotherapy, and those who

had received behaviour therapy. The merit of this study was that it met most of the criteria laid down by each theoretical group for acceptable outcome research, and employed a multiplicity of process and outcome measures. Several other studies reported similar findings, for example Green, Gleser, Stone and Seifert, 1975. These studies were followed shortly afterwards by the series of meta-analytic studies which all came to more or less the same conclusion as Luborsky, Singer and Luborsky, (1975), who declared that there were no clear cut winners when therapies were compared with each other; each therapy "offers to provide the patient with a plausible system of explanations for his difficulties, also with principles that might guide his future behaviour..." (p.1005-6); and as such, each one has a right to claim therapeutic success and theoretical coherence; the only generally accepted proviso to this being the evidence that behaviour therapy (notably desensitisation) is slightly more effective with phobias, an psychotherapy with psychosomatic complaints, (Beutler, 1979). The meta-analyses were particularly interesting because they attempted not merely to analyse a large number of very disparate outcome studies, but also to evaluate the studies used according to the quality of the data provided (for example, Smith and Glass, 1977; Smith, Glass and Miller, 1980; Andrews and Harvey, 1981; Shapiro and Shapiro, 1982; Landmen and Dawes, 1982). The results have been disputed, particularly by behavioural therapists who appear to be unwilling to relinquish the notion that behavioural techniques are automatically superior to psychotherapeutic ones (for example, Wilson, 1982, Eysenck, 1978, Giles, 1983); by and large however the results have been accepted. Further, it is now fairly widely accepted that conventional outcome studies have very limited value. A recent text on the subject quoted the following remark by Korchin: "Anyone with the patience of Job and the mind of a bank auditor is cordially invited to look again at the accumulated mass of material and settle the issue for himself." (p.2, in Lambert, 1979). This doesn't mean, however, that we are any clearer about

what it is that actually helps in all these equally effective therapies. The reverse in fact appears to be the case. Thus the current position is nicely summarised by Seay and Alterkruse (1979), who say: "The findings, to date, do not clarify which techniques or combination of techniques produce client change. It would seem, at least from the research literature, that it makes little difference how you say something as long as you do say something." (quoted in Lambert, 1979, p.109) One might add to this that it also appears from the research literature that it hardly matters what you say as long as you do say something. This position seems scarcely credible, and leads to considerable problems for the novice therapist, who is surrounded by theories all claiming to be able to outline what should be said, and how.

It was this problem which was the original starting point for the research reported in this thesis. Many years ago, as an inexperienced therapist, I was interested to learn about the different ways in which psychological therapy could be of help to my patients. I discovered that an enormous variety of techniques were supposed to be able to help them, and moreover, that a good proportion of them, with widely differing assumptions and practices, indeed did help the patients who came to see me. This seemed to me to be of some importance and puzzled me somewhat, and I decided to look further into it. If all the therapies were effective, how could I decide which therapy to learn about? Which therapy or which set of techniques were responsible for change in the patients? Although somewhat reframed, these are the questions that formed the basis for my personal interest in this area. The results of my inquiry are presented in this thesis. It is to be hoped that the results will have some impact on others who are asking similar questions.

1.4) Current questions in psychological therapy research.

Possibly as a result of the acceptance of the

uniformity of outcome by all but the most entrenched theoretical groupings, there has recently been an enormous amount of theoretical confusion, as a new question had to be asked, (which is somewhat similar to the one that I was asking): if all of the therapies with their vastly different theoretical rationales are more or less equally effective, then what exactly is it that is having the therapeutic impact? and on what?

It is therefore this question that is the basis for the work reported in this thesis. In attempting to answer the question, it seem appropriate first to look at what has been done so far in this area, to see whether any answers have as yet been found.

Back in 1963, Carl Rogers commented that there was a need for a good look at the field of psychological therapy res arch, since it was "in a mess". It is arguable that this is a state that has continued to exist until very recently. It appears that there have been a number of reasons for the "mess", including inappropriate research methodologies, inadequate theoretical bases for research, and a lack of courage on the part of practising clinicians and theoretically committed research workers to examine the implicit hypotheses from which much of their work is derived. In particular, the theoretical assumptions, (about the nature of "health", interpersonal influence, etc.,) from which most researchers have been working, have been almost totally inadequate, as is indicated by the failure of thousands of research studies to make any substantial impact on our understanding of what goes on and what is effective in psychological therapy. In a comprehensive review of the psychotherapy literature, carried out in 1977, Orlinsky and Howard concluded that the current state of research is "pre-paradigmatic", and on reviewing all articles published in Psychological Abstracts from 1972 to 1976 report that "one could with little difficulty disqualify any single study as seriously flawed in one way or another, and therefore feel justified in discounting the reported findings." (Orlinsky and

Howard, 1977, p.289). Equally, Russell and Stiles in 1979 quoted Kiesler's comments: "Psychotherapy process research has to rank near the forefront of research disciplines characterised as chaotic, unconnected, prolific, and disjointed, with researchers unaware of much of the work that has preceded, and the individual investigator tending to start anew completely ignorant of closely related previous work", (Kiesler, 1973, p.xvii). This state of affairs demonstrates a lack of theoretical coherence or, worse, a tendency for work to be carried out with little regard for the implic tions of the findings in a wider context than one very limited area of interest to the individual researcher and his or her particular theoretical orientation. To complete this catalogue of woe, Garfield commented in 1980 that "our current knowledge of psychotherapy is far from conclusive, and... many of our present clinical beliefs and procedures have yet to be confirmed by empirical research... to expect certainty in this endeavour would appear inappropriate." (Garfield, 1980 p.103). It is interesting at this point to note that workers such as Goldfried (1980) consider that psychological therapy is approaching a crisis, which some think is characteristically pre-paradigmatic. Goldfried quotes the work of Kuhn, as follows: "Kuhn (1970) has observed that scientific revolutions are typically preceded by a period of "crisis", when well-accepted paradigms simply do not work as well as they did before. Such crises are reflected by the proliferation of competing articulations, the willingness to try anything, the expression of explicit discontent, the recourse to philosophy and to debate over fundamentals," (Goldfried, 1980, p.992). The brief survey of psychological therapy research given above, certainly does seem to indicate that the field demonstrates at least some of these characteristics.

1.5) Possible causes of present problems in therapy research.

Why is this the case? There seem to be two major groups of answers; firstly, the poor level of theoretical

conceptualisation and methodological analysis, and secondly, the lack of good data; the latter problem probably resulting from the former. These two issues will now be examined in more detail.

1.5.1) Conceptualisation and analysis.

In 1966, Kiesler published his critical analysis of psychotherapy research which has subsequently been cited (but too frequently ignored) by numerous researchers; the main thrust of his argument was that research was dogged by a number of "uniformity myths", that is, the notion that it was meaningful to compare different therapies using very disparate methods, with patients who had different com laints. His argument was that we should not assume uniformity, but should instead specify the groups of patients and therapists to which a particular research finding will apply. This position has been widely accepted, although not in all cases has this acceptance been shown in practice. The failure to take note of Kiesler's warning has been further complicated by the discrepancy that often exists between what people say they do and what they actually do do. This was very clearly noted by Klein, Dittman, Parloff and Gill (1969) who observed behaviour therapists at work and noted the occurrence of a v riety of interactions that did not fit into the behavioural model, such as exploration of the inner world of the client, the therapist using his own personality in an unconscious way as though by "second nature", and so on. Equally problematic is the fact that many therapists, especially psychoanalysts, fail to provide any account of their actual interactions with their patients (as noted by Marks, 1978). This naturally enough leads to a lack of honesty in the reporting of research, and an inability to make use of much of the detail that is revealed in any encounter, therapeutic or otherwise, in ways that might make more sense of that encounter. This can then lead either to reductionism or to elaborate structures which owe more to fantasy than any closely observed behaviour.

Perhaps even more serious, however, is the lack of thought given to the underlying philosophical assumptions guiding much therapeutic thinking and practice. As Gurman (1983) has pointed out in his discussion of the problems of family therapy research, one of the main problems is that you can't say everything at once, and this applies as much to research as it does to therapy. One "answer" to this problem has been to ignore the assumptions from which therapy proceeds, with the inevitable result that the theoretical basis of the therapy is equated with that of the wider social and political context within which the therapy takes place. In the case of psychological therapy this means that the assumptions on which research into therapy outcome is based tend to be "medical", which in turn has a number of important implications. One of these is the belief that the patient's own views of his or her "condition" is suspect, as the patient is unable to make any inform d judgements about psychological matters, leaving this to the expert. This point is considered in more d tail in section 3.2. Another implication of the implicit cc tance of the medical model in psychological therapy (po sibly encoded in the very word "therapy" itself), is the notion that there is such an entity as psychological health, or cure, as there is in physical health. As Smail (1982) has pointed out, this "avoids" many moral and ethical questions, in the name of scientific objectivity. In an extremely interesting paper published recently, Stiles (1983) suggests that another consequence of the medical mo el in psychological therapy research is that it contains a notion of outcome that is unitary, so that it supposes (implicitly) that just as there are very limited number of ways to be physically healthy, so there are very restricted meanings to the term psychological health. Hence, he suggests, we tend to assume that there must really only be one way that therapy can be effective; and that the problem is simply that we havn't founa it yet. Stiles' argument then deals with the confusing fact that many divergent forms of therapy seem to be seen by patients, therapists and researchers to be successful, by

proposing that indeed they are equally successful, but in different ways, and over different questions. It may be, therefore, that another uniformity myth can be added to the list provided by Kiesler, that of uniformity of outcome. It may simply be that different therapies have different effects on different aspects of human functioning, and that this is entirely unremarkable given the multiplicity of ways in which human beings choose to give order and meaning to their lives.

One additional conceptual problem that recurs in psychological therapy research which must be mentioned is that of the myth of objectivity. This myth can be seen to operate in two different ways. Firstly, there is a tendency still for research to be judged on a very superficial assessment of how "objective" it seems to be without any regard for the meaning of the resulting work, or for the underlying assumptions that guide the work. As Smail (1978) points out, true objectivity in science is an illusion since the personal activities of scientists inevitably transcend the rules embodied in the rules of the scientific endeavour. If this is true in the relatively impersonal setting of the laboratory, how much more true must it be in the intensely personal setting of the therapeutic relationship? Secondly, there is the myth that the only people qualified to comment "scientifically" on any phenomenon are those not involved in it. This has led to a distrust of the subjective reports of patients in particular as legitimate sources of information; (this will be discussed in greater depth in section 3.2). It may be, however, that at least some psychotherapy researchers are now recognising this; for example, Gurman writes: "objective changes are no more real than are those based on patient reports" and "do not deserve the label of superiority often assigned to them," (Gurman, 1983, p183). Yet it is still possible to find reports of studies particularly in the behavioural journals which ignore all of the above issues and employ a simplistic reductionism that renders their conclusions effectively inapplicable in the real moral and ethical world. These questions are very

ably reviewed by Kazdin, (1979), who considers the numerous theoretical problems in behaviour therapy, as well as some of the consequences for therapeutic practice.

1.5.2) Empirical issues.

The second issue that will be discussed as causing the theoretical and practical confusion now dominating the scene in psychological therapy research is, as was suggested before, possibly a result of theoretical and conceptual failings, and is basically empirical: a lack of a quate data on which to work. This may sound remarkable, given the hundreds of publications annually on the subject of psychotherapy. However, as Stiles said recently: "Virtually nothing is known descriptively of the differential impact of particular types of encounter on clients. If the effects are as diverse ....as the encounters, then this will indeed be a rich vein to mine." (Stiles, 1983, p187).

How has empirical research to date been organised? It seems to have proceeded in a rather haphazard way, often without regard for the need to examine the quality of the empirical data collected. (There are of course exceptions to this generalisation.) Hence researchers seem to have attempted to gather data which supports or fails to support various theories and hypotheses without adequate thought being given to the context (both social and personal) in which that data is gathered, and in ways that forestall rather than stimulate further research. Furthermore, the underlying assumptions have often not been subject to adequate analysis. These points will now be discussed in more detail.

In 1967, Sargent, Coyne, Wallerstein and Holtzman carried out a review of the different approaches that can be taken in the analysis of complex data such as psychotherapy, and indicated that there are a multiplicity of levels at which it is possible to work. They suggested that there are three identifiable levels of study; firstly, naturalistic observation and ordering of data; secondly, a process level search for relationships between

variables, which rests on level one; and thirdly, the testing of certain hypotheses which rests on levels one and two. They stated that it is important not to pursue very detailed and limited hypothesis testing research prematurely, in a way that they label "inappropriate focussed precision". Obviously the testing of carefully formulated hypotheses has a central place in the development of our understanding of any phenomenon; if however there is a lack of observation underlying the formulation of hypotheses, the resultant understanding tends to be theory driven rather than data driven. This does not mean to say that giving primacy to level one type of data, automatically allows the researcher to assume that there are no theoretical formulations underlying his or her observations, as to a considerable degree all observations are theory-driven. However, level one activity possibly permits more freedom of observation than does level three activity, and is of course more appropriate at a different stage of d velopment of the field of inquiry. Yet it does seem as if much psychological therapy research has in the past been characterised by work on the third level identified by Saltzman et al, and it is questionable how appropriate much of this work has been.

It is interesting to note that there is a rich tradition in the p st of eminent researchers in psychology calling for more observational work, despite evidence of a dearth of such work. In 1942, Allport remarked: "Training in concrete psychology should precede training in abstract psychology.... the expert needs repeatedly to return to the concrete... to prevent himself from straying into esoteric and chimerical bypaths," (Allport, 1942, p.172). This call for immersion by the psychologist in his/her data certainly seems to apply to psychological therapy research, but seems not always to have been heeded. Forty one years later, not much seems to have changed. Hill, in a comprehensive review of the philosophical underpinnings of research into counselling, notes the lack of adequate conceptualisation and data in the area, and concludes: "I would postulate, however, that we are at too preliminary a

stage in our scientific development to be testing theories. More appropriately, I would suggest that our research can test our clinical observations and hunches," (Hill, 1983, p.9). This of course, runs counter to much established work in the field, although it does do justice to the remark made by Strupp in 1977: "We are beginning to recognise and take seriously the extraordinary complexity of therapeutic influence" (p.7).

1.6) Some attempts to meet the need for more adequate data gathering.

If it is accepted that a more open-ended less theory driven research strategy is needed, in order to think more clearly about the phenomena of therapeutic interaction, then how do we set about the task of data gathering? One recent answer has been to carry out studies involving a multiplicity of measures with a wide variety of clients. Good examples of this include the work of Greenspan and Sharfstein (1981) who ask: "What happens to a person with a certain syndrome in the context of a certain personality structure where treatment involves a certain technique with a therapist who is capable of certain process steps in that technique?" (p.1208); or the current large scale multi-site outcome and process study of therapy for depression being carried out under the auspices of N.I.M.H. in the U.S.A.. Both these types of study have in common the implicit belief that, with enough data, and the gradual accumulation of detail indicating the conditions under which certain relationships between variables obtain, then we can eventually achieve a comprehensive understanding of the business of psychological therapy. The focus of these studies tends to be on the outcome of the therapy, with the dimension of process being more or less an incidental feature of the research. Other solutions include the attempt to simulate the process of therapy by the use of computers (eg. Colby, Gilbert and Watt, 1966), or to study the detailed analysis of particular features of therapy (eg. Labov and Fanshel, 1977). These studies tend to ignore measures of outcome, or, if

they are included, see them as only incidental to the research. However, another solution, which seems to hold particular promise, is one that falls between the traditional outcome and process distinction by looking in detail at the process of therapeutic interaction from different perspectives, and seeing the minutiae of that interaction in terms of both process and outcome. In other words, these group of studies look at precisely what the therapist and patient did or said, and relate this to impact on the patient. Alternatively, they look at the im act of particularly critical incidents occurring during the therapy, in order to discover how change is brought about during the therapy.

This tradition of research was originally established by Orlinsky and Howard in a series of excellent studies published during the late sixties and seventies (for example, Orlinsky and Howard, 1967, 1968, 1970, 1977), in which they describe their research into the "good therapy hour". This research they see as being less "objective" or "accurate" than film or recordings, but more "real". Their approach was to obtain the judgements of both therapists and patients in each whole hour of therapy, in an attempt to answer the question: what is it that makes a session good? or bad? and does the feeling of goodness or badness relate to outcome and process? Their work was taken up by, among others, Stiles, who looked at the impact of each session, seeing this as a bridge between process and outcome, (for example Stiles, 1980; Stiles and Snow, 1984), and examining each session by means of an evaluation questionnaire; and also by Hill who recommended that process work should be linked to outcome by observing in detail what happens in the therapy session, (Hill, 1983). Of particular interest was the work of Elliott, who looked in detail at the nature of the interactions between participants in order to see which type of intervention led to particularly desired therapeutic results, by focusing on critical interactive incidents, (for example, Elliott, 1983). (The results of this work will be examined in much greater detail in section 4.3.1.) What was particularly

interesting and novel in this work was the importance accorded to the subjective impression gained by the participants, and the impact made on the patient by the therapeutic endeavour; the term "impact" was understood in terms of the patient's own experience, rather than according to any expert observer.

1.7) Philosophical Underpinnings.

Given the points made above (in section 1.5), it now seems appropriate to outline the philosophical underpinings and assumptions of this research. There is in evidence a growing awareness of the importance of understanding the therapeutic interaction as it occurs, not merely trying to find differences between groups of patients, irrespective of the subjective experience of the individuals involved. This awareness has developed coincidentally with the increasing sophistication of thinking in other areas of psychology, and in part may owe some debt to a variety of sources, for example the development of ethogenics by Harre and Secord (1972); the growth of interactive concepts of personality, by researchers such as Carson, (1969), and Hampson, (1982), and the ecological approach taken by writers such as Shotter, (1980). In the particular world of psychological therapy research, theorists such as Kiesler have called for more research in the interactive mode, (Kiesler, 1979), taking up Orlinsky and Howard's plea for an understanding of the fact that most therapists in practice work from interactive, pragmatic constructs, rather than abstract, diagnostic ones, (Orlinsky and Howard, 1977). Research such as the study by Van der Veen (1965) and Schonfield, Stone, Hoehn-Saric, Imber and Pande (1969) showed that the adaptation of each participant to the others' viewpoint regarding appropriate therapeutic behaviour, had a considerable effect on outcome. Work of this nature may also have had an influence on the new approaches.

The research reported in this thesis draws on a number of different sources, some of which have been

indicated above. It seeks to understand the process of psychological therapy from the perspectives of the participants involved in ways that are inevitably subjective. But this is not seen as a difficulty or drawback, rather it is an intention of the research to understand the subjective world of the patient and therapist. Furthermore, it is assumed that the participants will make sense of the same event in different ways, and that no one way is correct in any objective sense. This runs counter to the tradition of empirical, positivist psychology that has been dominant in much psychological therapy research to date, which is generally suspicious of such a perspective, probably because it holds to a view of reality which is absolutist, rather than relative. This empirical tradition has proceeded largely in ignorance of the phenomenological tradition, despite the potential of such an approach to provide another way of understanding many of the confused findings in therapy research. The research reported here draws on this phenomenological research tradition, insofar as it takes account of the different understandings of different participants in the same enterprise. (See Ashworth, 1979, for a comprehensive outline of phenomenological psychology and the idea of constructive alternativism, also the ideas of Kelly, 1955.) Furthermore, it does not presume to judge which view is correct, but assumes that a multiplicity of ways of seeing the same thing probably exist. This is in fact not a new perspective in psychology. The overall view taken in this research is similar to that described by Allport in 1942 when, in discussing the use of personal documents such as letters and diaries in psychological research, he wrote: "It is not therefore the subjectivity in personal documents that leads to conflicting interpretations. It is rather the versatility of the human mind in contemplating its own infinite complexity. The fact that there will probably always be a diversity of maps by the aid of which human conduct can be explored and interpreted will have to be admitted. In the last analysis diverse theories (of equal tenability) are inevitable; probably they are also desirable." (Allport, 1942,

p.172).

This acceptance of the relative nature of truth has not been widely developed at least by psychological therapy researchers (with the possible exception of construct theorists), although it has been recognised of late by a few. Kiesler (1966) pointed out the inadequacy of a monadic perceptual focus, and in 1982, Prochaska and Diclemente traced the history of psychological therapy, and pointed out that most practitioners in effect take a "relativistic intellectual position. Diversity and uncertainty in therapy are not temporary; the very nature of knowledge is that it is contextual and relative", (p.277). Yet as has been noted above the vast majority of researchers have not proceeded on this assumption, possibly because philosophical questions have not been raised. Despite the fact that there are problems with such an approach (cf. Smail, 1984), the research reported in this thesis is based on the assumption of relativity of perspectives in the experience of the therapeutic endeavour. (See the work of Ashworth (1979); Snyder (1982, 1983a and 1983b); and Bullington and Karlsson (1984) for a further discussion of the Perspectivist approach and its roots in phenomenological psychology.)

1.8) Particular approach taken in this thesis.

Looking now at the questions considered in this research, it seems appropriate to outline the specific focus of interest of this study, in the light of these questions, (although each of the points will be dealt with in more detail below). Given the failure of much research to specify successfully the variables leading to positive outcome, and the somewhat embarrassing fact that very different therapies are almost indistinguishable from one another in terms of outcome, the focus of this research is neither on process or outcome, but rather on impact which can be seen as a link between the two. The interactive approaches to personality and social behaviour noted above indicate that it is only meaningful to study an encounter

as personal and complex as psychological therapy by taking account of the fact that it is an interaction that is being considered, not a static collection of characteristics existing in a vacuum. Hence the experiences of both participants will be considered, and the focus of analysis will be interactive. One of the notions to be explored in the discussion will be whether the ways in which each individual learns from, and modifies his/her behaviour and experiences as a part of the interaction, might not be a more fruitful focus of attention if we want to understand how each participant makes sense of the situation that the two of them are in, rather than the more usual strategy of concentrating on individual characteristics.

The philosophical assumption underlying the research is that there are many ways of seeing the same phenomenon, and that no one way is clearly and objectively "correct". Therefore there will be no attempt to discover an objective understanding of what happens in a therapy session other than that provided from the subjective viewpoints of the participants. What will be particularly novel in this is the proposition that it is meaningful and important to ask the patient for his or her understanding of the interaction, as well as asking the therapist. Simply to obtain the therapist's perspective indicates that the most important determinant of the interaction is the therapist; this presumption is assumed in this research to be premature, and runs the risk of seeing the therapist's goals to be of prime importance.

The details of the research carried out will be given in full in later sections; however one or two preliminary remarks seem appropriate at this stage. Much of the psychological therapy research that has been carried out in recent years has of necessity involved selected populations of patients, who are subjected to therapies, which because they are being scrutinised for research purposes, are arguably not typical or representative of the therapeutic consultations that normally occur. Luborsky et al (1975) for example, noted how few research studies concern

patients who are not YAVIS, (that is, young, attractive, verbal, intelligent and successful); and Shapiro and Shapiro (1977) have noted the difference between therapy research and practice. Consequently a priority in this research study has been to study the therapeutic interaction in as non-invasive a fashion as possible. This attempt also results from the considerations mentioned above, that is, the need to obtain more accurate data on what actually happens in therapy. In 1951, Carl Rogers wrote: "Our knowledge of psychotherapy will be more firmly based when it is possible to understand thoroughly, and with sensitive perception the private world of clients undergoing therapy...." (Rogers, 1951, p.129). More than thirty years later, in 1984, Elliott called for a discovery oriented approach to therapy, the goal of which would be to understand the experiences and perceptions of participants in therapy. This thesis attempts to investigate the possibility of developing such an understanding, through an examination of the perceptions of the participants of one particular aspect of therapy, that is, their views of the most helpful (and unhelpful) events of their own experience of therapy.

Chapter Two

The Experience of Participants in Psychological Therapy

2.1) Introduction.

As indicated in chapter 1, an approach that seems likely to provide some interesting insights into the process of therapy is to ask the participants in that therapy to describe and evaluate their experiences. This chapter reviews the work that has been carried out using this approach, and draws out some of the unresolved problems raised by it. It must be noted that the focus of interest throughout will be on the experience of therapy, rather than on the experience of any particular mental illness or neurotic disorder. There are a large number of published accounts of personal experience of psychiatric disturbance which focus mainly on the symptoms and course of the breakdown, but which do not provide much detailed information about treatment received. Examples of such accounts are Bowers, (1965), Sutherland (1976), and Macleod, (1981). These accounts will not be considered in this thesis.

In this chapter, then, there will be, firstly, (in sections 2.2 and 2.3) a consideration of the experience of patients, and some indication of the drawbacks and advantages of taking this perspective. Secondly, in section 2.4, findings from research which takes the patients' view will be described. This will be followed in section 2.5 with an outline of the views of therapists. In section 2.6, there will be a discussion of the contrast between these two viewpoints, and a discussion of the implication of the differences. Lastly, in section 2.7, there will be a discussion of some of the outstanding questions that remain unanswered in this area. It must be noted at this point that this chapter is somewhat lengthy, because it not only reviews past research in the area, but also

provides the evidence which justifies the research strategy to be used in this thesis.

2.2) Objections to the use of the patients' viewpoint.

Many thousands of articles and papers have been published that consider the business of psychological therapy from the point of view of theory, practice, technique, process and outcome. The vast majority take the stance of the detached observer, whose investigations are presented in as objective a way as possible. In addition, case histories may be told to illustrate certain theoretical points. Only rarely do the subjects of those case studies have a chance to comment. Why is this so? As has been discussed above, this thesis takes the view that the patient is uniquely well placed to offer some particularly interesting insights into psychological therapy process. But before even considering the possibility that the experience of participants can tell us anything of interest, there are a number of objections to this strategy that need to be considered. Four of these will now be noted below in some detail, and possible ways of responding to these objections will also be given.

Firstly, there are often thought to be particular problems if one of the participants of interest is, or has recently been, seeking psychological help. Although the mental health professional is normally quite willing to accept the patient's opinion that he or she is not well and is in need of treatment, there is usually a reluctance to accept at face value anything else that the patient may say about the treatment. In particular the patient is not assumed to be competent to judge how the therapy is or is not working. There are several possible causes for this, some of which seem to go beyond the straightforward positivistic suspiciousness of non-objective data, (see section 2.6.2). Sonn (1977) has outlined some of these objections. She considers that the main reason for this neglect of the patient's view is the prevalence of the

medical model of mental illness, and suggests that patients are seen as objects, suitable only for objective study. Further, she suggests that the medical model engenders a suspiciousness of accepting all things at face value, and that psychotic patients, in particular, are seen as being unable to articulate anything sensible about themselves, because of their illness.

Secondly, there is the view that patients are inherently ungrateful and critical, and will have nothing good to say about the therapy received. An example of this view is given by Sutherland (1976) who reports Kavka, a psychiatrist, as saying: "post-therapeutic confessionals, written under intense abreactive pressure and unneutralis d exhibitionism, often betray their underlying motives of subtle revenge towards the disappointing treatment." (quoted in Sutherland, 1976). The implication of this view seems to be that if asked, most patients would be highly critical of their therapy, either out of malice, or outraged sensibility and frustration.

In fact the vast majority of reports provided by ex-patients are actually highly complimentary to their therapists, (there are of course some well publicised exceptions to this rule, interestingly enough often provided by pseudo-patients, for example Caudill, Redlich, Gilmore and Brody, 1952). Reviews by Weinstein in 1979 and 1981 suggest that between 67% and 78% of patients feel favourably towards their treatment when opinions are surveyed after the conclusion of treatment. The problem is in fact to interpret this finding, and to consider ways of obtaining more critical views.

The third objection to the use of the patient's viewpoint is the assumption that can be loosely labelled psychoanalytic. This is the view that the patient is unable to see the therapy or the therapist with any degree of clarity, because of transference phenomena. In other words, the patient would not be capable of describing his or her therapy in any realistic way due to the

overwhelming nature of fantasies about his or her therapist. Langs (1973) considered that patients are unable to judge treatment adequately, because of "transference dissonance".

This objection was considered (and to a degree at least, rejected) by no less a figure in the psychoanalytic world than Anna Freud, when she wrote: "Moreover, analysts and patients are two real people of equal adult status, in a real personal relationship to each other. I wonder whether our, at times, complete neglect of this side of the matter is not responsible for some of the hostile reactions which we get from our patients, and which we are apt to ascribe to transference." (quoted in Kamin and Caughlan, 1963, p.667). However, the majority of analysts seem not to share Anna Freud's view. For example, when I discussed with psychoanalysts the research to be carried out for this thesis, the reaction I gained tended to be incredulity that anything of any value could be gained; the reason given for this was the probability of my obtaining only unresolved transference reactions, (even after the conclusion of therapy).

Fourthly, the objection is sometimes made that patients will not be able to pick out important aspects of therapeutic process, precisely because they are patients and are thus too badly educated, unintelligent, unreliable, emotional or befuddled to be able to make judgements about therapy. Consequently it is suggested that their responses will be invalid. The reason why these points are made seems to be that there are usually found to be differences in the views expressed by the two viewpoints; it is assumed that an explanation has to be found for this, and the explanation proffered is that the patients' viewpoint is "at fault"; (see section 2.6). Hansen, Moore and Carkhuff (1968) felt that clients are unable to make effective interpersonal discriminations, and Kaul, Kaul and Bednar (1973) suggested that clients are unable to make sophisticated judgements about therapy, but simply rely on "gut feelings".

Without entering a debate about the usefulness or otherwise of "gut feelings", the question of the quality of patients' responses does merit some attention, particularly the notion that patients will not be able to pick out what was really useful about therapy. It is unlikely, for example, that patients will be able to use the same technical language as therapists. But does this mean that they are unable to pick out the crucial aspects of the process? One very interesting way of examining the validity of this argument is to consider the responses of patients who really ought to be able to make judgements which are fairly sophisticated, that is, patients who know theoretically and practically about psychological change procedures. If the responses of these subjects are not substantially different from the responses of ordinary patients, then it may be possible to argue that there is some validity to the patients' viewpoint.

Both these questions have been considered fairly recently, and the results are illuminating. Firstly the responses of "sophisticated" patients have been examined in a study by Buckley, Karasu and Charles (1981), who asked therapists to evaluate their own experience of therapy. The responses obtained were almost indistinguishable from other patients' responses (see ection 2.3.1). In particular, these therapist/patients saw non-specific factors to have been the most crucial. (The issue of non-specific factors will be discussed in detail in section 3.3.) The researchers concluded that the "role of interpretation and insight as psychotherapeutic agents of change remains controversial, and these factors have been questioned as key curative factors in psychotherapy," (Buckley, Karasu and Charles, 1981, p.303). Similar findings have been obtained in a number of descriptive studies of the experiences of therapists in therapy (see section 2.4.1).

It might of course be objected that therapists/patients themselves are an unrepresentative

group, because of their age and social class. However, this seems unlikely to have any significant effect on the validity of the point being made above, which is that therapists as patients do not see as crucial factors which are more "technical" than mere patients. Further, studies by Robiner and Storandt (1983) and Frank, Eisenthal and Lazare (1978) have in fact suggested that age and social class do not have any major effects on perceptions of the therapist.

The responses of uninvolved "patients" have also been examined in a number of studies, in order to consider whether emotional involvement invalidates the patient's viewpoint. Although there are a number of problems in the use of this particular method, (precisely because the uninvolved "patients" are uninvolved), the results again support th contention that the patients' perspective has some validity. Caracena and Vicory used college students to compare viewpoints on therapist "conditions", and concluded that "the assumption that low and insignificant relationships (between patient rated and judge rated conditions) reported in the literature have been due to the initial perceptual distortion of the troubled respondents does not hold if the same lack of relationship holds using a group of non-client college freshmen and sophomores," (which indeed it does). (Caracena and Vicory, 1969, p.513). This study was extended and replicated by McWhirter, (1973), who found that "normal" clients had the same responses on a variety of measures as more disturbed clients.

One last way of considering the validity of the patients' perspective is to consider its constancy over time, as it might be objected that patients are unreliable and inconsistent in their responses, which might therefore be seen as invalidating their comments. This question was considered by Small, Small and Estevez (1969), who found that if a variety of measures were repeated during a patient's stay in hospital, a remarkable degree of consistency was in fact obtained.

In concluding this fourth point regarding objections to the use of patient reports, it is hoped that the point has been established that there is little or no support for the notion that the patient's viewpoint is invalid and unreliable. One of the clearest justifications for examining the viewpoint of the patient was provided by Bordin, as follows: "It should be clear that the lack of correspondence between a patient process report and the report of either the therapist or an independent observer does not in itself undermine faith in the veridicality of the patient's report. It is possible that the patient is giving us realistic views of the process not accessible from other positions. It would take much more subtle and searching evidence to demonstrate that the patient's report is a superimposition of some other set of psychic process rather than a description of therapeutic interactions." (Bordin, 1974, p.58).

Other objections to the use of patient reports undoubtedly exist, and some of these objections are of considerable weight, for example the argument that no accounts are ever given without some purpose, the view that people are almost inevitably self-deceptive even when trying to be cooperative and honest, and the point that distortions in memory prevent an accurate picture being obtained. These points are serious, and are considered in greater detail in chapter 8 below. What will be considered now, however, will be some of the advantages of this particular research strategy, while admitting that there are indeed some limitations to it.

2.3) Advantages to the use of the patient's viewpoint.

There are a variety of different benefits to be gained from adding the patient's viewpoint to those of other interested parties in the therapeutic endeavour, and five of these will be discussed in some detail. It must be stressed, however, that it is not being suggested that the patient's view should replace other viewpoints; merely

that this perspective should be added to others.

2.3.1) Insight into the therapeutic relationship.

The first and possibly major benefit to be gained is the insight that this additional source of information can give us into the relationship between the participants, especially if the patients' views are different from the therapists'. One of the first empirical studies which examined the patients' viewpoint was that by Heine (1953) who compar d the attitudes of patients to three types of therapy; psychoanalytic, Adlerian, and non-directive. Subsequ nt studi s by Feifel and Eells, (1963); Board, (1959); B rrett-L nnard, (1962); Strupp, allach and Wogan, (1964); Orlinsky, Howard and Hill, (1975); Ryan and Gizynski, (1971); and Sonn, (1977) all used questionnaire metho s to elicit from patients their views of their therapy experience in retrospect. What was particularly interesting about these studies was the consistent finding that patients were particularly impressed with the relational aspects of the therapy, over and above the technical aspects. Ryan and Gizynski, for example, found that behaviour therapy patients thought that their feelings about their therapists were central to the outcome of therapy; and Strupp et al. found that the feelings of having the therapist's respect held by psychotherapy patients, were of greater importance to the outcome than the therapist's technical skill. Sonn found that patients "feel good and grateful when they are understood and when they are treated with respect", (Sonn, 1977, p.257). These questions were examined in more depth by the Sloane et al (1975) study referred to in chapter 1. The finding here was that behaviour therapy patients and psychotherapy patients were almost indistinguishable from one another in terms of their opinions about the helpful aspects of their treatment. Similar findings were reported by LLewelyn and Hume, (1979), and Cross and Sheehan, (1982).

The point of interest about all of these studies was that they drew attention to an aspect of the therapeutic

interaction, namely the quality of the human relationship between patient and therapist, which is often given little attention by theoreticians. This raises another fundamental point concerning the use of patient reports; namely the fact that there are indeed often substantial differences in the features highlighted as helpful by therapists and patients; this will be considered in more detail in section 2.7. For the present it will be enough to note that, as Orlinsky, Howard and Hill pointed out, the patients' perspective allowed a new way of thinking about therapy sessions. They commented that therapists were more likely than patients to see theoretically derived themes as having been of importance in therapy sessions, and were "more inclined than patients to view patients' concerns from the professional vantage points of pathology and genetic concern." (Howard, Orlinsky and Hill, 1970, p.106). Further, patients were more likely than therapists to highlight existential concerns. Much of this work has been revised and extended by Stiles (1980), who used Session Evaluation questionnaires given out at the end of every session in order to look at the experience of participants. He found, for example, that patients' feelings were more positive after sessions that he labelled (from measures taken from the semantic differential) "smooth and easy". These sessions seemed to account for approximately 70% of sessions and can be contrasted with 11% of "heavy going" sessions, 10% of "coasting" sessions, and 4% of "floundering" sessions. The point about this type of analysis is that the issues it addresses are probably best described in such non-technical, metaphorical terms, precisely because the experience of them by the patient is not a technical one.

Various other approaches have been taken to consider the different insights that the patients' viewpoint can give us. Pohlman and Robinson (1960) for example, studied the likes and dislikes of clients about their counselor's behaviour, (they found that clients particularly dislike insincerity, and the counselor being in a hurry; and particularly like not being interrupted, and the counselor

having a sense of humour as well as being polite). Hartlage and Spurr (1980) found that patients preferred therapists being frank and honest, and self-respecting. From a slightly different perspective, researchers such as Young (1980) have looked at the relationship between clients' perceptions of therapists and various verbal and non-verbal cues. Of more interest, however, has been the recent work on response modes and patient recall of significant aspects of therapeutic interaction. What has been particularly novel in this approach was that it looks at the interaction between participants in close detail, in an attempt to avoid some of the more "global" judgements made necessary by other research techniques, as well as avoiding some of the grosser memory distortions.

This approach was spearheaded by Goodman and Dooley (1976) who devised a categorisation system for ordering the responses made by participants in therapy. (This will be discussed in greater detail in chapter 4 below.) The idea was taken up and expanded by a number of researchers, such as Dole, DiTomasso and Young, (1982) who looked at therapist recall of their intentions in the therapeutic interaction, and Hill, Carter and O'Farrell (1983) who examined therapist and patient retrospections in a single-case study. (This study will be referred to in more detail in chapter 9.) However the most fruitful exploration of this approach has been made by Elliott and co-workers in Toledo, Ohio. As some of this work is central to this thesis, it will now be considered in more detail.

Elliott's idea was to ask both the therapist and the patient to listen to tape recordings of their normal therapy sessions immediately after each session, together with a research worker, and to indicate when an incident of particular importance occurred. He noticed that there were considerable differences between the events noted by therapists and patients in the type of event selected. He then examined these events, and asked judges to place them into to a number of categories, namely, event type, therapist intention, client intention and client state.

(Elliott, 1979; Elliott, J mes, Shulman and Cline, 1981; Elliott, Barker, Caskey and Pistrang, 1982; Elliott and James, 1982.) This method is known as Interpersonal Process Recall, (I.P.R.), (Elliott, 1983), and is based on the work of Kagan, which has been summarised in a recent publication (Kagan, 1983). The importance of the development of this method was that it allow d close scrutiny of the patient's experience of specific events in therapy. Elliott's (and my) view of the use of this method is that it is enormously fruitful in providing insight into the process of psychological therapy; he comments as follows: "(I.P.R. research) suggests an image of clients as highly perce tive yet forgiving observers of the therapeutic process, particularly of the impact of significant events." (Elliott, 1984). The findings from this method will be discuss d in section 2.4.5.

2.3.2) Responsiveness to the patient's needs.

A second advantage of taking the patient's viewpoint seriously is that it encourages the therapist to take the needs and values expressed by the patient, more seriously. This point of view has been most vociferously expressed by "consumer" groups of psychiatric patients, (see Brandon, 1981) and is in line with various "political" developments in attitudes towards the consumer. Hence there have been calls for "consumer oriented research" for instance, by Morrison (1979), and within the psychological therapy research literature, there has been an increasing number of papers which recommend paying attention to the needs and wishes expressed by clients. For example, Hornstra, Lubin, and Lewis (1972), and Polak (1970) have pointed out that patients often have very different goals in treatment from those expressed by staff; in particular patients say they want symptom relief whereas staff tend to stress personality growth or change. Lazare, Eisenthal and Wasserman pointed out that "patients do not want to be different human beings. They want to feel better" (Lazare et al, 1975, p.557). This doesn't automatically mean that the therapist has to take the patient's perception of the

problem as the only valid way of seeing it; but the idea that it is a somewhat important one seems to have been rather under-developed in the past, by at least some therapists. Corrick (1980) also pointed out that patients will have expectations about therapy which may have considerable impact on the process and outcome of therapy; simply to dismiss these ideas as "wrong" or irrelevant may lead to considerable therapeutic difficulties.

2.3.3) Negative and positive aspects of therapy.

A third reason why taking account of the patients' view of therapy can be useful is that it can give both an indication of the way in which therapy may be helpful, and some indication of where things sometimes go wrong. The negative experiences of therapy will be looked at first.

Although patients are by and large not very wiling to be critical of their therapists, as noted in section 2.2, some studies of the patients' viewpoint have been completed which do provide some insight into therapeutic failure. Kline, Adrian and Spevak (1974), for example, found that dissatisfaction was linked with a lack of interest or direction from the therapist; and Mayer and Timms (1970) found that dissatisfaction was related to a lack of parallel expectations. In addition, Lorr (1965) reported that the patient seeing the therapist as critically hostile, was related to negative outcome, and Sonn (1977) reported in her study of patients' experiences in treatment that "patients return again and again to the issue of how much or how little the doctors and others understand their plight, their feelings and their needs. Closely connected to the issue of understanding is that of the degree and kind of distance staff put between themselves and patients" (p. 245). Rozsnafszky (1979) in an account of psychonoxious therapy showed clearly how overstrong allegiance to particular theoretical schools, to the neglect of wishes expressed by the patient, can lead to serious problems for the patient. Similar conclusions, with particular reference to the "growth movement"

therapies, were reached by Rosen (1970); Schurr (1976); Spitzer (1980); and Back (1972), All of these studies show how the patients' perspective can illuminate the harmful or unhelpful aspects of proces.s.

Turning now to the way in which the patient's views can give an indication of the way in which helpful therapy sometimes proceeds, there seem to be two major aavantages of this approach. Firstly, the patient may paradoxically be able to see the interaction more clearly than his trained therapist, simply because the patient has not had the benefit of instruction in any particular theoretical orientation. Hence he or she has no particular axe to grind regarding the mechanisms of therapeutic change. This was found by a previous study which I carried out (Llewelyn and Hume, 1979) where "encouragement and reassurance" was seen by patients as having been the most helpful aspect of treatment; similar findings have also been reported in a recent study by Murphy, Cramer and Lillie (1984). Further, "non-specific" aspects of treatment were more highly rated by patients than either psychotherapeutic or behavioural aspects. Other studies have reached similar conclusions. Gidro-Frank, Peretz, Spitzer and Winikus (1967), for example, found in a 5 year follow-up of hospitalised patients that very few patients reported improvement to have been because of the formal aspects of their treatment, but rather saw the sense of acce tance and mutuality between themselves and the staff to have been central. They also mentioned the relief from intolerable family situations to have been important. Other studies have also shown that patients are more likely to see non-specific and "relationship" aspects of treatment to have been of importance; the study by Ryan and Gizynski mentioned above showed that behavioural techniques did not seem to be salient to patients, who "hardly stopped talking about issues in the relationship between themselves and their therapists." (Ryan and Gizynski, 1971, p.6). Similar findings were obtained by Chastko, Glick, Gould and Hargreaves (1971) in their study of nursing interactions, where the personal contact with

nurses was valued far more than "technical" and skilled interventions.

The second way in which the patients' perspective can be informative about the positive aspects of therapy, concerns the relationship between process and outcome. Some studies have looked at this in a very straightforward way; for example Martin, Sterne and Hunter (1976) found that patient perception of the therapist's understanding was positively correlated with outcome, although this conclusion was not supported by a study by Stanley (1967), where no such relationship was found between the patients' perception of the relationship and a variety of change criteria. However, the whole question was reviewed by Gurman in 1977, and he concluded that of 22 patient-based studies, only one failed to show a relationship between patients' perceptions of the therapist, and outcome.

However, we might not expect it to be as straightforward as this in all cases. It might be that there are systematic variations in the attitude of the patient to the therapist which are enormously important in the attainment of therapeutic gain. It might be argued, for example, that an overwhelmingly positive attitude towards the therapist is not in fact very helpful in the long run as the patient has to learn critical independence from the therapist. Hence a study of the attitudes towards the therapist over the course of a series of sessions might give an interesting view of the patient's progress, as might an examination of the relationship between the two viewpoints.

A number of studies, for example that by Saltzman, Luetgert, Roth, Creaser and Howard (1976) have examined some of these questions. Saltzman et al. looked at patients' experiences of therapy using the Therapy Session Report devised by Orlinsky and Howard (1977), and noted that dropouts could be predicted by the third session according to their responses on fifteen different dimensions. Similarly, Bottari and Rappaport (1983) related the

patient's perception of their therapist's level of functioning during the first meeting, to subsequent symptom change and length of treatment. Taking this further, B rnard, Schwartz, Oclatis and Stiner (1980) related the patient's view of process to outcome by taking measures of the patient's perception of the therapist at different points in the therapy. Basing their research on the theory of brief psychotherapy of Mann (1973), they predicted that patients' and therapists'—views should not necessarily correlate throughout the period of therapy, although a rapprochement might be expected tovards the end. In fact they found that therapists and patients had differing vi ws at the end of therapy as well, (this study will be considered in more detail in section 2.6). Cooley and Lajoy (198) by contrast found some support for the hy othesis that when the two participants perceive the therapy in a similar way, then this is related to positive outcome. (It is of course interesting to ask here whether some of these findings are dependent on the type of outcome measures used.) Deitzel and Abeles (1975) also found evidence of different levels of complementarity at ifferent stages of treatment.

It is hoped that the above section has demonstrated that the patients' viewpoint can contribute towards our understanding of the therapeutic process, and that this is true of both positive and negative aspects.

2.3.4) Conceptual analysis.

The fourth advantage of including the patient's perspective in any account of therapy, is conceptual. To include only the therapist's view implies that the individual most responsible for the therapy is the therapist, which in turn implies that the therapist is the most important determinant of the therapeutic interaction, or rather act, since the interactive nature of the process is not really considered to be of relevance. This approach sees the patient as a largely passive recipient of therapeutic "medicine" dispensed by the therapist, and implies

that the therapist's intentions and goals have primacy. Further, it suggests that the patient does not have much influence on the therapist. These are dubious assumptions, from both a conceptual and a practical point of view. There is evidence (for example, Van der Veen, 1965, Carson, 1969, Will, 1977) that patients do influence their therapists, and also that most patients do adopt an active as well as a collaborative role in their therapy, (Martin, Friedmeyer, Moore and Claveaux, 1977). Given the nature of interpersonal interaction it would be remarkable if the therapist were to be unaffected by the patient, (this question is considered in more detail in chapters 8 and 9 below). It may also be recalled (from the material presente in chapter 1) that the non-interactive paradigm has not b en particularly successful in advancing our understanding of psychotherapeutic change. Thus it can be argued that work which does take into account the patients' perspective may be more fruitful.

There has indeed been some work developed from within an interactive framework, which has been productive. For example, Saltzman et al. concluded from their study (reported in 2.3.4) that: "these findings tend to be in keeping with a well-established line of research that has examined therapeutic process as a function of interaction and mutual influence... and contrasts with the findings of other research that seems to locate the necessary and sufficient conditions for therapeutic change within the behaviour or characteristics of the therapist" (p.553). It can be argued that an approach which includes both therapist and patient perceptions is more likely to provide an accurate understanding of the interaction, than an approach that pres nts one viewpoint alone.

2.3.5) Educational benefits.

The last a vantage of adding the patients' viewpoint to our observation of the therapeutic encounter is the benefits that such an approach could provide educationally. Rippere (1978) and Pearson (1980) have both

produced anthologies of p tients' accounts of a variety of psychiatric disorders and psychological treatments which make interesting reading for the novice therapist, and are specifically intended for educational use. A number of "novels" have also been written which portray very vividly what it is like "on the receiving end". Examples of these are the novels by Green, (1964), and Plath (1963). *Novel*-like personal accounts have been written by a number of ex-patients, for ex mple,— Gordon, (1980), and Smith, (1977). In addition, ex-patients have written of their x riences in a variety of "popular" publications such as special issues of Mind Out in 1974 and 1981.

More detailed and specific use could also be made in tr ining of patients' perception of therapists. Luchins (1951) used questionnaires completed by patients to train novice therapists in various aspects of their therapeutic work, and Lazarus (1971) reported that he asks patients to complete therapy evaluation forms as a standard teaching measure in his clinics. Barker (personal communication) is developing a d vice which will allow patients to give feedback to their therapists concerning whether or not the therapist is behaving empathically during each therapy session, and although this is principally for research use, there seems to be no reason why it should not also be of use in training. As yet, almost no work seems to have been done which allows the patient to give direct feedback to the therapist concerning the helpful aspects of the therapeutic interaction, immediately after it has happened. Exceptions to this include the work of Elliott (as described above) and Lietaer, (1983).

The five points documented above give details of the reasons why the inclusion of the patient perspective can allow for a fuller understanding of therapeutic interaction, and how such an understanding can have implications for outcome, theoretical thinking and training. I shall now examine the work that has been done so far using this approach.

2.4) Research into the patient's perception of psychological therapy.

It is possible to select out five different strands of work that have been carried out using the patient's viewpoint, which can be distinguished according to the method used a d the main focus of interest; all however accept the validity of the approach, for the reasons given above in section 2.3. They can be seen as ranging from the very general and descriptive to the very particular and detailed. The first concerns retrospective accounts; the second, diary accounts (both of which are of course impressionistic and general); the third concerns surveys of patients' experience (which are also general but often much less impressionistic); the fourth, retrospective questionnaire studies; and the last, immediate recall of specific events in specific sessions, (both of which are less general and more detailed). Following an examination of these five strands, there will be a brief discussion of the similarities and differences between the findings from each of them.

2.4.1) Retrospective Accounts.

The first method to be documented is the collection of personal accounts of psychological therapy. Some of the first such accounts were provided by psychologists who had undergone psychoanalysis. Boring (the historian of psychology) wrote an account of his analysis entitled: "Was this Analysis a Success?", and concluded that it wasn't really, although "what the analysis did was to sanction these (troubling) needs". (Boring, 1940, p.8). He also expressed praise for his therapist, whom he liked. Landis, another psychologist, found that his analysis helped, although he found "transference vastly over-rated" (Landis, 1940, p.20). In addition, he also became very fed up with the process of childhood recall, reporting that he found that the "week after week of trying to talk with nothing to say became a veritable nightmare" (p.22). He did however have some praise for the procedure of

psychoanalysis and thought this was of more value than the underlying theory of personality structure. Some different impressions were provided by the joint account of Kindwall and Kinder who reported a very fruitful therapeutic interaction, with a considerable "sense of collaboration between physician and patient as a person" (Kindwall and Kinder, 1940, p.532). They concluded that "a personal relationship between patient and physician seemed infinitely more important than all of the supposedly detailed and coldly scientific machinery of psychiatric observation" (p.529).

More recent work has come to very similar conclusions. A number of other eminent psychological thinkers have written about their experiences of treatment. Guntrip provided a description of his analyses with both Fairbairn and Winnicott, and ma e it fairly clear that he felt much more warmly towards the latter, despite his claim that the work done with Fairbairn although more "intellectual", was equally important. His view of psychoanalytic therapy at the hands of these two is, however, quite instructive. He wrote: "What is psychoanalytic psychotherapy? It is, as I see it, the provision of a reliable and understanding human relationship... not a technique... it is a process of interaction, a function of two variables, the personalities of two people working together" (Guntrip, 1975, p.155). It may be recalled from section 2.2 that the study by Buckley, Karasu and Charles (1981) also found that therapists, when patients themselves, valued the non-specific, relationship aspects of treatment. Various other professional writers have recorded their experiences of psychological treatment, for example Killian and Bloomberg (1975), one of whom was a social worker; Worth (1969), who was a trained psychiatric nurse; "Sue" (1981), a psychology undergraduate and trained biochemist; and Jones (1980), a social worker. The comments by Worth are particularly revealing; she wrote: "The nurse who possesses warmth, sensitivity, and an attitude of respect for others, and who is able to communicate these characteristics to the patient... really teaches the patient how

to relate to the world around him." (Worth, 1969, p.74-75).

What is interesting about all of these accounts is the stress placed upon the "human" qualities of the relationship between therapist and patient. The fact that they are all professionals with varying degrees of knowledge of the theories of psychological change, make this finding all the more intriguing. Even the trained psychoanalysts do not seem to highlight typically psychodynamic features of the interaction. Incidentally, descriptive reports by patients who are not professionally trained reach very similar conclusions, for example Blaine and McCarthur, (1958); Barlow, (1975); Gordon, (1980); and Ford and Hollick, (1979). There are some accounts which are very hostile to the treatment experienced, for example Yorkshire Girl (1983) and the series published in Mind Out (special issues), in 1974 and 1981. These are very much in the minority, however. The problems highlighted by such reports are usu lly related to the patient being made to feel "like a guine -pig", or the treatment being excessively drug-oriented, in other words, the "non-human" aspects of treatm nt. Some of the accounts provided by pseudo-patients, for example, C udill, Redlich, Gilmore and Brody, 1952, are also very critical of the experience of therapy, largely because it seemed to be "endless one-way talk" (p.324).

2.4.2) Diary accounts.

A very small number of studies have looked at the experience of patients on a regular, ordered basis, using a diary format. One of the most interesting was that provided serendipitously by Evans and Robinson (1978), (as was briefly described in chapter 1). The therapy was behavioural, and was directed towards the patient's sexual difficulties, diffuse anxiety problems, and loneliness. Unknown to the therapist, the patient kept a diary of her feelings about the therapy and her therapist, and presented it to the therapist at the conclusion of

therapy. The diary is an immensely rich document including f elings of anger and resentment towards the therapist, as well as the expression of numerous sexual fantasies, most of which are never acknowledged by the therapist.

Another "diary" of particular interest was the one provided in a fascinating book written jointly by Yalom and one of his patients, Ginny Elkin, (Yalom and Elkin, 1974). The book was written after Yalom had agreed that the patient should "pay" for her therapy by writing an account of each session after it ended; he then did likewise. The therapeutic relationship was clearly a good one, but was perceived very differently by the two. Towards the end of therapy, Ginny wrote of her feelings about the helpful aspects of therapy as follows: "All the time I was not really seeking for change but for a man whom I could talk to as I did to you, who would question and understand me, have your patience, and yet be separate from me..." (p.242). On another occasion she wrote: "I never really gave in to therapy... but I think I achieved something personal with you..." (p.242).

The diaries were not written in any systematic way; in fact Yalom said that he had not intended to publish the accounts and only decided to do so long after the conclusion of therapy. The book therefore provides a vivid and interesting picture of the experience of therapy from the inside; it is not however able to answer any specific or direct questions about the perceptions of the two, concerning the therapeutic aspects of the interaction. It raises a number of interesting possibilities, but was not carried out in such a way that specific conclusions can be drawn.

A third diary account is that provided by Hill, Carter and O'Farrell (1983) in which a single case study is published, including the subjective accounts of both therapist and patient. However, the amount of space dedicated to the content of the patient's diary is very small,

so th t few conclusions or even impressions can be drawn from it. Nevertheless it is interesting to see that Hill et al. considered it worth a mention as a part of the case study.

2.4.3) Surveys of patient satisfaction.

The third (and probably most common) approach to the patients' experience of psychological therapy has been to carry out large scale surveys of p tients' attitudes, usually concerning satisfaction. On the whole, the subjects of these surveys have been hospitalised psychiatric p tients, and the studies have concerned all aspects of their hospital stay. Consequently they are only of marginal relevance to the main focus of this thesis, and will only b mentioned in passing, and insofar as they have relevance to the central point of interest.

A number of studies have asked patients to rate the most helpful aspects of their hospital stay. An example of this approach is yer and Rosenblatt (1974), who asked patients in a state hospital what they most valued about treatment. Responses indicated that they most valued "having three good meals a day", rather than any psychological aspects of the therapeutic regime! Other studies have been carried out by Linn, (1968); Kotin and Schur, (1969); Raphael and Peers (1972); Raphael (1974); Chastko, Glick, Gould and Hargreaves, (1971); Gould and Glick, (1976); Keith-Speigel, Grayson and Speigel, (1970); Leonard, (1973); and Lee, (1979). Results were mixed, but v rious points emerged from most of these studies. Interaction with nurses was usually more highly valued than interactions with doctors, especially when nurses were pleasant, encouraging, caring and humane. Individual psychotherapy was seen as very beneficial whereas community meetings were not seen as being particularly helpful.

As has already been indicated (in section 2.2), the question of patient satisfaction has been ably reviewed by Weinstein (1979 and 1981), who found that the vast

majority of patients find their stay to be beneficial. He contrasted this with the findings of Goffman (1961) and Rosenhan (1973) who, as sociologically skilled observers, described the experience of hospitalised patients, from the outside. Goffman and Rosehnan have both been highly critical of hospital provision for psychiatric patients, claiming it to be degrading, stigmatising and destructive of the individual. They have also pointed to widespread inmate discontent. They would also claim (along with writers such as Brandon (1981) that patients are too frightened, degraded or coerced to respond critically to patient evaluation studies. Weinstein suggested that the findings of such riters has resulted from the fact that th y were not in the desperately unhappy position of sychiatric patients, and made unwarranted assumptions about the needs and values of such patients. He suggests that while there is discontent in some areas, and there may be abuse, such problems are unrepresentative of the experience of the majority of patients. Certainly, an analysis of Goffman's hypotheses by Linn (1969) found that the patient group studied was highly heterogeneous in its com osition, such that some were very positive and others negative in their attitudes. This gives some support to Weinstein's view. However, it might also be argued that the researchers reviewed by Weinstein were equally unaware of the true experience of patients, and that their views and those of the patients they studied, merely tended to reflect the views held in the institution in which they exist (Caine and Smail, 1969).

This controversy suggests that the method used in such approaches needs some consideration here, especially as it does relate to the choice of methodology employed in this thesis. The question of patient satisfaction is clearly a vexed one and has been reviewed recently by Lebow (1982), who suggested that the whole area has been complicated by a number of methodological problems. These he sees as firstly, the uniformity myth about patients and their needs, feelings and problems; secondly, oversimplified measures of satisfaction leading to simplistic

affirmation of existing treatment modes; thirdly, semantic problems in the construction of questionnaires so that patients are forced to make global judgements; and fourthly, a lack of reliability in the measures used and consequently in the resulting findings. Such limitations clearly limit the value of much existing research in this area. However, I believe that these criticisms do not touch perhaps an even more fundamental problem in the surv y approach to patient_experience. This is the question of whether such large scale studies can ever in fact grasp the fundamental experience of patients in a way that c n inform us about the helpful or unhelpful aspects of psychologic l or psychiatric treatment. As Allport once remark d: "Psychological causation is always personal and never actuarial" (Allport, 1942, p.187).

The problem with surveys is that they don't give us much insight into psychological processes, and yet this is the approach that has been most widely used in the area of patient experience. The descriptive approaches taken by Goffman and Rosenhan are perhaps closer to achieving this, yet they are marred by a lack of input from "real" patients, and the imposition of certain presumptions which are ideological in nature. More recent work by Baruch and Treacher (1978) has examined the experience of psychiatric patients from a more phenomenologically sound perspective, by using in-depth interviews. In many ways this approach, examining in detail the psychiatric patient's phenomenal world, in one particular British city, is more revealing than any number of more "representative" surveys, and has fewer drawbacks than the earlier work of Goffman and Rosenhan. Baruch and Treacher found that patients were subjected to a rather wooly, badly organised form of treatment; that consultants rarely "knew" their patients in any personal sense; that there was a paucity of discussion and decision implementation; and that relationships between teams of health workers were very poor. They concluded from this that the patients were confused and poorly served by the services, and were on the whole not satisfied, although they didn't often complain.

In some ways this study provides an excellent description of the patient's experience of psychiatric care, and can indicate something about the patient's inner world, and the sense that he or she makes of psychological or psychiatric treatment. However, the questions asked by Baruch and Treacher concerned the whole experience of psychiatric care, so that the study did not concentrate on the smaller and more precise question of the experience of psychological therapy. Nor did it contain any attempt to categorise responses which would allow conclusions about the efficacy of certain procedures to be drawn, however tentatively. This clearly limits the usefulness of this particular study, to the questions raised in this thesis, although it does demonstrate the benefits of paying close attention to the patients' experience.

2.4.4) Studies of patients' retrospective opinions about treatment.

As has been indicated in section 2.3.1 and 2.3.3, a number of studies have examined the patient's experience of therapy in retrospect, by asking the patient to complete questionnaires at the end of therapy. These studies will not be listed again here; the reader is referred back to the appropriate sections. As has already been stated, the results of the studies are remarkably consistent; they suggest that the patient is particularly impressed by the human aspects of the relationship, over and above the "technical" aspects. Further, this seems to be the case whether the patient is receiving behavioural or psychotherapeutic therapy. Consequently, these aspects of therapy have often been called "non-specific". As will be suggested in section 3.3, this term is not without problems. This is particularly so when using patient retrospections, as it could be argued that the finding that non-specifics are seen as most helpful might simply reflect the inability of the patient to remember the crucial events of therapy. The patient might therefore indicate very general and undifferentiated factors simply

because they are easier to recall and write down on a questionnaire. In my own previous research, for example, patients were asked to complete questionnaires up to one year after conclusion of therapy, (Llewelyn and Hume 1979). It could be that these results were obtained largely a result of the particular methodology used.

This argument would of course hold less weight if the responses of patients studied immediately after the end of therapy sessions were seen not to differ substantially from those studied well after the termination of therapy. There is in fact some evidence that this is indeed the case, for example the study by Saccuzo (1975), who used Orlinsky and Howard's Therapy Session Report after each session, and found that patients valued the most: catharsis, encouragement, and having someone to talk to on a person-to-person basis. Similar results were obtained in the study by Saltzman, Luetgert, Roth, Creaser and Howard (1976), who found a positive relationship between outcome and the patient's perception (on a sessional basis) of the therapist's manner as understanding and committed to helping.

These studies therefore suggest that the patients' perspective consistently accentuates the "human" aspects of the interaction, when the patients are asked to evaluate the sessions after they have ended. But what are the actual activities, either of the therapist or of the patient, that give rise to these positive helpful experiences? Some work has been done on this question, and this will now be considered.

2.4.5) Patients' perceptions of helpful events in therapy.

The fifth strand of research looking at the patients' perspective on psychological therapy, is the most precise. This is the examination of the patients' perception of the detailed events of the therapy session. The first systematic study of patients' perceptions of helpful factors occurring in therapy sessions was not carried out in

individual therapy but rather in group psychotherapy. The seminal work by Yalom (1975) on the therapeutic factors occurring in group therapy allowed researchers to examine the contribution of different helpful factors from a variety of theoretical perspectives. A number of different studies (for example Sherry and Hurley, 1976; Rohrbaugh and Bartels, 1975; Feeney and Dranger, 1976; Butler and Fuhriman, 1980; and Kansas and Barr, 1982) asked group members in a variety of group settings to indicate how helpful they had found various therapeutic activities, such as "the group teaching me about the type of impression I make upon others", or "learning to express my feelings". The results allowed group therapy researchers to establish "league tables" for the helpful aspects of group therapy. However, the materials used in this particular research format were usually limited to the stimulus statements provided by Yalom.

A considerable advance was then made in this country by Bloch, Rabstein, Crouch, Holroyd and Themen (1979), who suggested that the wording and format of the helpful factors noted by Yalom might limit the responses from patients. They therefore developed a method of eliciting from group therapy patients, what they had themselves seen as the most important events that had occurred in previous therapy sessions, and then categorising these events into an adaptation of Yalom's categories. This allowed comparison between different aspects of the therapy process, as well as permitting comparison between the types of events seen as helpful by patients and therapists. What was particularly novel about this approach was that it allowed subjects to provide an account of their experience in their own words, as well as introducing a categorisation system which was a method of analysing these responses in a systematic way.

Working in the field of individual therapy, various researchers had been developing schemes of categorising therapeutic factors (see chapters 3 and 4 below), although no scheme achieved the almost total acceptance as had

Yalom's, in group therapy. Hence it was not immediately apparent how a systematic analysis of patients' personal accounts might be carried out in individual therapy. However, some category systems did exist, and began to be used in this way. Hawton, Reibstein, Fieldsend and Whalley (1982) for example, developed a method of categorising responses from suicidal patients which they then used in a study considering the different perceptions of therapy provided by self-poisoners at different stages of their treatment. This study suggested that "exploration" was the most frequently occurring therapeutic activity, whereas "confrontation" occurred only very rarely.

However, the most important advance was made by Elliott and co-workers (referred to in section 2.3.1). They devised a categorisation system for patients' responses which was based not upon a theoretical notion of likely helpfulness or importance thought up by the researchers, but rather, was based on a cluster analysis of responses provided by patients, reporting on their experiences in therapy. This cluster analysis (Elliott and Feinstein 1981) was developed and adapted until it consisted of a total of thirteen different types of events occurring in therapy, eight of which are helpful and five of which are unhelpful, (Elliott 1983). (Further details of this system will be given below in chapter 4.) Elliott and a number of his co-workers also developed an analysis of the response modes used by helpers, (such as "questioning" and "advisement"), and tried to relate specific helpful events to response modes. In addition, they used the system to consider the aspects of therapy seen as helpful on a session by session basis, and suggested that some therapeutic activities, such as "interpretations" and "advisements" are seen as having been of more use than the asking of questions, (Elliott, Barker, Caskey and Pistrang, 1982).

Subsequent work by Elliott concentrated on the precise details of certain therapeutic events. Using the method of Interpersonal Process Recall described in

ection 2.3.1, Elliott suggested that emphasis should be plac d on the most critical aspects of therapy, and that much previous process work had been wasted, because it paid as much attention to relatively unimportant aspects of therapy process as to the critical parts. He pointed out that "since significant events are both infrequent and highly complex, they should be studied closely when they are encountered", (Elliott, 1981, p.4). Hence his most recent work has been to study significant events, such as achieving insight, in considerable detail, in order to try an understand how and why such an event occurs, (Elliott 19 3).

Very recently, another study which used only interview data with a small number of patients, has been published in the U.K., concerning the views of patients regarding helpfulness, (Murphy, Cramer and Lillie, 1984). It was exploratory in nature, and was unfortunately rather poorly constructed; nevertheless, some interesting results were suggested, namely that the aspects most highly valued by patients were talking to someone who understands, and receiving advice. These results will be discussed further in chapter 9. The views of therapists were not obtained in this particular study.

From the above review, it can be seen that only a very small number of researchers have as yet turned to the study of significant therapeutic events in individual therapy as seen from the patients' viewpoint. As far as I am aware, there is very little ongoing work of this nature in the U.K., and only the work of Elliott and his colleagues in the U.S.A.. In Belgium, Lietaer (1983) has very recently devised another categorisation system for helpful events seen by the patient and the therapist, and has been studying the results obtained with patients receiving client-centered therapy. His preliminary results suggest that patients indicate that the relational aspects of therapy are more helpful than do therapists, who tend to stress process and cathartic factors. The research reported in this thesis uses the methods devised by

Elliott to examine the perceptions of therapists and patients of helpful factors in a variety of forms of psychological therapy, in order to investigate a number of questions about the nature of therapeutic processes. The details of the questions raised will be given in sections 2.7 and 5.2.

2.4.6) Summary of the patients' perspective.

The five sections above have reviewed evidence from studies of the patients' perspective on psychological treatment. Although there are exceptions, the findings from whichever methodology is employed, seem remarkably consistent. The first and probably most remarkable finding is that patients value the relational aspects of treatment ov r and above the technical aspects; even professionally train d therapists, when in therapy, report likewise. The second is that the m thodological approach taken does not appear to make much difference to the findings, although participant observation studies (e.g. Goffman) do appear to be an exception to this. The third is that patients do tend to recall aspects of therapy in very favourable terms, so that it is sometimes rather difficult to tease out exactly how the good effect was achieved. These findings therefore suggest that some future work is needed which investigates the precise details of therap utic effectiveness, more accurately, and in less "global" terms.

Before this, however, it seems appropriate to consider the vi ws of therapists on the issue of successful and effective methods of therapeutic intervention. The next section will consider this question.

2.5) The therapists' perspective on psychological therapy.

If therapists are considered as a group, ignoring for the moment the particular theoretical orientation favoured, it is probably true to say that their views on helpfulness in therapy are encapsulated in the theories

they use. Proshaska and Norcross in their most recent survey of clinicians in the U.S.A., reported in 1983 that although many clinicians may claim that their pr ctice is eclectic, they nevertheless do draw upon specific theoretical formulations in attempting to understand their patients' problems. Further, these formulations do have an impact on therapist behaviour. Sundland, in a review of the effects of theoretical orientation on the practice of therapists concluded that "at least on self-report data, therapists are consistent in what they say they do and what we woul exp ct from their chosen "school" of therapy...." (undland, 1977, p.206). Note that this does not necessarily mean that the specific distinctions are in fact the effective parts of treatment, or that the theories used actually have an enormous amount of effect on the ex erience of the patient; in fact some studies suggest that this is indeed not the case, (Howard, Orlinsky and Trattner, 1970). H wever, therapist behaviours do differ. A number of studies based on careful observation, reported by Russell nd Stiles (1979) and Stiles (1983), further support the notion that therapists do really behave in consistently different ways, and that these can be traced to different theoretical and philosophical assumptions. As Frank (1971) has suggested, therapists appear to gain confidence and the ability to structure their interactions, as well as to cope with failure, when possessing some theoretical orientation. If we are to understand their thoughts about how therapy works, it seems sensible, as suggested above, to assume that the views of therapists (concerning the experience of helpfulness) are encapsulated in their theoretical views, although this has never really been examined in practice. This question will be examined in more detail in chapter 3 below.

Despite the importance of theoretical orientation at least in determining the actions and beliefs of therapists, there is an increasing amount of evidence that the personality, feelings and values of the therapist also have an enormous impact upon the outcome and process of

therapy, (for example Howard, Orlinsky and Hill (1969); Bent, Putman, Kiesler and Nowicki, 1976; and Frank, 1979). Swenson concluded from a review of a large number of studies "that the therapist is successful with the patients in whom he is interested and involved", (Swenson, 1971, p.32); and Strupp and Wallach found that the therapist's attitudes and feelings "too ubiquitous and subtle to be covered by the term countertransference" had an enormous influence not only on the diagnosis and formulation of treatment plans, but also, "and this is of greater consequence, in terms of the course and outcome of the interaction between the two" (Strupp and Wallach, 1965, p.131). Further, Sundland concludes from his thorough study of the effects of theoretical orientation that it is a much over-rated variable, in terms of effect on outcome.

There seem to be two sets of findings, therefore, which at least superficially contradict each other. These are that therapists appear to be consistent in their reports of their theoretical orientation and what they say they do, and yet also that personality factors have a considerable influence on outcome. So what is happening? We also know that outcome is not closely related to theoretical orientation of treatment. Possibly the answer is that although therapists may indeed try to do what they say they do, this is not what comes across to patients and/or is not what has the major therapeutic impact. The next section will therefore consider the differences between patient and therapist views of therapeutic effectiveness; and Chapter 3 will consider theories concerning the factors responsible for therapeutic improvement.

2.6) Relationship between patients' and therapists' perspectives.

As outlined in sections 2.3 and 2.4, the overwhelming conclusion from patients' accounts of therapeutic process is that personal relational aspects of therapy are paramount. Section 2.5 suggests that therapists, on the

other hand, are likely to see theoretically derived factors to be of the greatest importance. A number of studies have considered the difference between these two viewpoints, and these will now be reviewed.

2.6.1) Research comparing the perspectives of patients and therapists.

As has been suggested in section 2.4.1, retrospective accounts such as the one by Boring and his therapist Sachs (1940), an diary accounts such as the ones reported by Yalom and Elkin (1974) and Evans and Robinson (1978), direct our attention to differing perspectives on the therapeutic factors involved in treatment. Typically the responses of patients are based on relationships, rather than on techniques. F r example, Yalom's reports emphasise his "therapeutic clarifications", whereas Elkin seems to gain most benefit from his "simple human acts". Questionnaire studies such as the one by Feifel and Eells (1963) show similar discrepancies; patients gave highest ratings to "non-specific factors", whereas therapists gave highest ratings to "therapeutic skill and technique". Studies of group therapy also show differences in perspective between leaders and group members as was shown for example in a study by Bloch and Reibstein (1980), and also the study by Zastowny, Janosik, Trimborn and Milanese (1982).

The first really systematic investigation of the effects of differing perspectives was provided by Cartwright, Kirtner and Fiske, in their "method factors" study which was reported in 1963. The conclusion from this study was that significant differences can be observed if a comparison is drawn between the judgements about outcome and process made by a variety of groups of observers and participants. They reported: "No one measure and no one score based on a single method appears to provide by itself an adequate index of therapeutic change." (Cartwright, Kirtner and Fiske, 1963). This view confirmed the results of questionnaire studies such as the one by Zaslove, Ungerleider and Fuller (1966), which found that

differences existed between different staff groups (such as doctors and nurses), and between staff and patients, regarding the helpful aspects of treatment and the relative importance of groups of staff. This point was gradually accepted by therapy researchers, although a number of other researchers have reached different conclusions; Strupp, Wallach and Wogan (1964), for example, found that there was substantial consensus between the therapist and patient concerning the essential features of the therapy experienc . Studies comparing the views of judges with the vi ws of participants fared no better however; for example a study by Bozarth nd Grace (1970) showed that "objective" measures of the quality of the therapeutic rel ti nship (the opinions of judges) did not correl te at ll well with p tients' measures; an a study by Hansen, oor nd Carkhuff (1968) found no significant relationship b tween p ti nts' and judges' views of the therapists' facilitating skills. Further, a comprehensive review by Parloff, askow and Wolfe (1978) found no support for the notion that judges can adequately represent the patients' viewpoint, and disconfirmed the hypothesis that judges' ratings are better predictors of outcome than patients' ratings.

The question was further examined (and the notion of differences in perspective confirmed) by intz, Auerb ch, Luborsky and Johnson (1973) who carefully investigated twelve therapy sessions experienced by four patients, from three different perspectives: the therapists', the patients', and trained observers'. Their conclusion was that therapy could only be understood by appreciating this variety of perspectives. They drew an analogy between their research and a well known Japanese film "Rashomon", in which the same event (a murder) is retold from three different viewpoints, to stunning theatrical effect. (Incidentally, a similar effect is obtained by reading "The Alexandria Quartet" by Lawrence Durrell.) Hence this distinction between viewpoints is sometimes known as the "Rashomon" phenomenon. This finding has since been confirmed, for example by Luft, Smith and Kace (1978), who

found that therapists, supervisors and patients concurred on only one in ten measures of therapeutic efficacy, and by Gurman (1977) who concluded that "there is very little agreement between therapists' and patients' perceptions of the therapeutic relationship". In a review of the patients' experience of psychological therapy in 1977, Howard and Orlinsky concluded that the question of the differing perspectives opened up "a methodological Pandora's box.... whose contents might prove a considerable plague to behavioural science *as we have known it.*" (Howard and Orlinsky, 1977, p.587). Possible consequences of the opening of this Pandora's box will be considered in the next section.

2.6.2) Possible factors involved in the "Rashomon" phenomenon.

It is interesting to note that the idea that different individuals might see things differently is seen as such a threat to "science". Yet an acceptance of the complexity of human interaction is crucial if we are to understand "scientifically", if by "science" we mean more than the insistence that events be predicted and controlled, in a way that even modern physical science has rejected, (Claxton 1979; Will 1980). The comment by Howard and Orlinsky reflects the poverty of the positivist approach to human behaviour, which sees the idea of complexity as a "threat". Accepting the possibility of different "truths" (as advocated for example by Kelly, 1955; Harre and Secord, 1972, Ashworth, 1981; and Snyder 1983b), allows a definition of "science" that is not tied to positivism and respects the diversity and relativity of perspective. Such an idea of science is closer to that advocated by McCleod (quoted by Van Kaam, 1959), that "to be scientific is to be curious in a disciplined way, ie., to try and understand" (p.66). To accept this is to see precisely where we might gain further insight into the therapeutic process, because in encouraging us to consider the idea that the therapist may not have the only valid viewpoint on the interaction, it also prompts us to look

more closely at precisely what it is that is happening. This is not an astonishingly new view, although it may prove to be somewhat threatening to a positivist outlook. It suggests that "reality" is not merely to be accepted at face value, but rather, that people create meaning and order, instead of having it imposed upon them; and furthermore, that no two ways of creating meaning are necessarily alike. Some psychologists have recognised this, for example, noting the prolific nature of therapies, Prochaska and Norcross pointed out that in fact psychological therapists do take "a relativistic intellectual position. Diversity and uncertainty in therapy are not temporary; the very nature of knowledge is that it is contextual and relative" (Prochaska and Norcross, 1982, p.277). However, from my reading of most theoretical writers in the area of psychological therapy, it does not seem to me that they do very often accept such a difficult position, although it is my belief that they should.

Caskey, Barker and Elliott seem to be researchers who have accepted this relativism of perspective, as well as accepting the need to explore it further, in a study which attempted to investigate the nature of the differences in perspective. They remarked that once Pandora's box is opened, "Hope remained behind"! (Caskey, Barker and Elliott, 1984, p.2). Their study indicated that there may be reasonable agreement between participants on therapist intention, but that the agreement was lower on measures of impact. Stiles (1980) found that agreement can be found on some sessions, but not on others, and that disagreement seemed to centre on measures of impact, rather than on measures of the value or depth of the session. This result confirmed earlier observations by Howard, Orlinsky and Hill (1970), that judgements about the affective tone and mutuality of a session seen to be shared by participants. Further, Mintz, Luborsky and Christoph (1979) suggested that although distinct viewpoints do exist, nevertheless "the similarities are much more striking than the differences" (p.32). All of these studies therefore seem to imply that the crucial areas of disagreement concern the

aspects of the session that were seen by the participants as having had particularly therapeutic effect, whereas the therapeutic intentions and the overall quality of the session seem to be relatively unambiguous.

It seems as if the original conclusion that there is no agreement between the perspectives, was actually premature, and may have resulted from a over-simplified methodology, which fail d to differentiate between different aspects of process. Four possible factors affecting this "Rashomon" phenomenon will now be discussed. Firstly, there is the possibility that specific therapeutic interactions may have different impacts on *patients simply* because some patients see some of their problems in particular or even idiosyncratic ways. If therapists are not aware of the difference between their goals and those of their patients, they are hardly in a position to recognise the importance of some or their therapeutic activities to their patients. Chesney, Larson, Brown and Bune (1981), for example, found that patients saw themselves as more seriously disturbed than did therapists, possibly because their conception of "normal" is more constricted than the conception held by therapists; and Hornstra, Lubin, Lewis and Lewis (1972) have pointed out that therapists are often not in touch with either the changes or treatments desired by patients. This could have enormous implications for the ways in which patients evaluate therapeutic process, although not always in a clearly defined direction. A study by Kahn, Obstenfeld and Heiman (1979) for example showed that mental hospital staff saw psychological treatment in more positive terms than did patients (although not as negatively as the staff had predicted). Likewise, Dimsdale, Klerman and Shershaw (1979) found that there was a discrepancy in treatment goals between therapists and patients, which they labelled "ideological".

A second factor affecting the "Rashomon" phenomenon may simply be that therapists and patients have different views only at particular stages of therapy. As was mentioned above (in section 2.3.3), a study by Bernard et al

(1980) suggested that the views of patients and therapists should not necessarily correlate throughout therapy, and that disagreement should be predictable in the middle sessions of therapy. Schwartz and Bernard reported that "patients and therapists had consensual views of what the beginning phase of therapy should be like. Patients' increasingly positive and decreasingly consistent evaluations of the middle phase of treatment can be understood as reflecting the patients' needs to view the process as succeeding, even as their actual experience is punctuated by unexp cted stress, frustration and turmoil. As a result, patients' and therapists' evaluations correlate less strongly in the middle phase, and their levels of evaluation become more discrepant." (Schwartz and Bernard, 1981, p.107). Work by Ditzel and Abeles (1975) similarly suggests that there are different levels of complementarity at different stag s of therapy.

Other recent studies suggest that a third factor affecting the discrepancy in the views of participants may be the nature of the therapy, that is, its length and its quality. The idea that the discrepancy may depend on the type of therapy, that is, whether it is short-term or long-term, was examined by Horn-George and Anchor (1982), who compared the phenomenological view of the relationship and therapy sessions held by both therapists and patients in long-term therapy (more than 20 sessions) and short-term therapy (less than 15 sessions). Using the Therapy Session Peport, they found that there was more congruence in long-term cases than short-term. Another factor which may affect the degree of congruence between the two accounts is the quality of the relationship. Schonfield et al. (1969) suggested that there was a correlation between the increasing congruence of the two accounts and patient improvement. A similar conclusion was reached by Weaver, (1975).

One last attempt to account for the difference in perspective should be mentioned, which was that by Gibb, Best and Lambirth (1983). They used the distinction made

by attribution theorists, that we tend to ascribe causes of behaviour in line with our particular viewpoint, according to a typical pattern of attribution, in combination with our particular attribution style, (Antaki and Brewin, 1982). Attribution theorists believe that actors tend to see their own behaviour as being caused by external factors, whereas observers tend to see their behaviour as being caused by internal causes. Gibb et al tested this hy othesis by examining the attributions made about the causes of psychological distress, by a number of psychiatric patients and therapists. Contrary to prediction, no diff rences were found. However, this seems to be a promising line of research for the future.

It may be evident from the above that there are a number of possible factors affecting the degree of discrepancy b tween patient and therapist in accounting for the efficacy of therapy sessions. This review of the literature has raised a number of interesting questions concerning the reasons for the discrepancy, which merit further investig tion. These will be presented in the next section.

2.7) Questions concerning the "Rashomon" phenomenon.

The first question which still needs to be asked is whether the clash in perspective results from an inevitable methodological quirk, in that no two participants can ever see the same event in precisely the same way, or whether the participants have very different "interests" in the same event and therefore perceive its salient features differently. It might be argued, for example, that the therapist has a vested interest (both economic and personal) in seeing his or her particular belief system validated, and consequently ignores evidence that does not validate it, or even sidesteps it. Equally, it might be hypothesised that the patient is unwilling or unable to use some of the therapeutic tools made available to him or her by the therapist because of fear, resistance

or stupidity, or because he or she is unable to "make sense" of the interventions of the therapist. Very few studies have looked in any detail at the actual events seen as helpful by the therapist and the patient occurring in the same therapy session in order to see what seems to be going on in the experience of the two participants, and the way in which the participants make sense of the experience that they are sharing. The work of Elliott and his co-workers in individual therapy, and the work of Toch and his co-workers in group therapy, have made a start in this direction. However, it is clear that more research is indicated which looks not only into the detail of therapy experience, but also at the differences between the two perspectives in terms of the helpful factors thought to have been of importance, from the two viewpoints.

The second question which arises from this review of the "Rashomon" phenomenon concerns the development of the therapeutic relationship over time. The research reported by Bernard et al. suggests that there may be some systematic changes in the relationship which could well be picked up through an examination of the different perspectives. If participants are encouraged to describe their views of their therapy experience, do they report the "frustrations" suggested by Bernard et al.? Do the participants draw together in their accounts, or do the differences increase?

The third question that could be asked concerns the quality of the therapeutic relationship. Is there more likely to be concordance between the participants if the relationship is a good one? Is there any relationship between concordance and outcome?

These and a number of other related issues are presented in greater detail in chapter 5, together with the precise questions to be examined in this study. However, we shall now turn to chapter 3, which will review some of the theories of therapeutic effectiveness, and

will also consider whether the notion of therap utic factors could be an effectıve way of examining the therapy exp rı nce with nore accuracy and understandıng.

Chapter Three

Therapeutic Factors in Psychological Therapy.

3.1) Introduction.

In the previous chapter, there was a discussion of the factors seen as therapeutic or helpful by the two main participants in psychological therapy. In this chapter there will be a review of some of the existing literature concerning the theories of therapists about the processes involved in the achievement of psychological change. In the first section (3.1), there will be a very short outline of the controversy between behaviour therapists and psychotherapists (already referred to briefly in the first chapter), and in section 3.2, recent moves towards integration and eclecticism will be discussed. This will be followed in section 3.3 by a discussion of the concept of "non-specific" factors which some have seen as providing the way out of the controversy, even if it does not lead to integration. This will include a presentation of some research into the therapeutic relationship and the personality of the therapist which have also been seen as having a crucial impact on the experience of psychological therapy of no matter which theoretical persuasion. In section 3.4 there will be a discussion of therapeutic factors, which may offer a more fruitful way forward, and lastly, in section 3.5, there will be a discussion of the possibility of using therapeutic factors particularly as seen by the therapy participants, as an indication of which therapeutic factors do seem to be effective under which circumstances.

3.1.1) The perennial controversy: behaviour therapy versus psychotherapy.

As was noted in the introductory chapter, most well researched text books and papers reach the conclusion that there is no longer any substantial evidence that there are significant differences between behaviour therapy and

psychotherapy in terms of outcome (for example Goldfried, 1982; Garfiel , 1980). N vertheless arguments still persist about which theory is more able to account for therapeutic chang . For example, psychoanalytically oriented therapists such as Strupp (1977) point out that the therapist's personality is a crucial aspect of treatment, and pres nt some extremely interesting research evidence to support this claim (Strupp and Hadl y, 1979); nevertheless psychoanalytic writers still insist that the kindling of transference is central to the therapy. Malan comments wryly that "the rewards for our efforts are pretty small", (Malan, 19 0, quoted by Barnes, p.5); yet he continu s to vocate psychoanalytic psychotherapy. Fun m ntalists such s Jacoby (1975) bemoan the "watering down" or taming of psychoanalysis to incorporate more "superficial" and social considerations. Equally, some behaviour therapists still persist in seeing all aspects of the therapy relationship in behavioural terms; for exampl , Wilson et al. define the relationship as "social reinforcement" and suggest that the presence of this "stimulus" serves as "safety signals exciting the reduction of con itioned nxiety." (Wilson, Hannen and Evan , 1968, p.105). The idea that tub-thumping behaviourism is dead and buried is disconfirmed by writers such as Wilson (1982), who insists on the superiority of this approach over all others and against all the evidence.

3.2) The search for integration.

However, it is probably true to say that most therapists recognise that the task may now be to seek an integration of approaches rather than to persist in seeking for differences. This has been the major theme of two recent international conferences of the Society for Psychotherapy Research, for example. A need for integration has been noted on a numb r of fronts, and the development of two of these fronts will be considered here in brief: that is, the relationship between the theory and practice, and the details of therapeutic inter ctio . The approach taken in this short discussion will be

hist rical, in that the development of the debat concerning the n ed for integration will be traced, tog ther with an a sessment of the problems encountered during the debate.

3.2.1) The need for theoretical an practical integration.

Firstly, it w s noted by both behaviour therapists and psychotherapists that theoretical notions distinguishing one f rm of therapy from another were not always perationally accurate or coherent, so that theory bore only scant relatio ship to practice. The well-known paper by Breger and Mcgough (1965) pointed out the limitations of behavioural theory in explaining the practice of behaviour therapy, as well as highlighting some of the inad qu cies of the theoretical underpinings of the a proach. The observational study by Klein, Dittman, Parloff and Gill (1969) confirmed this split between theory and practice in the interactions between well established behaviour therapists and their clients. Other writers also started to voice their doubts. In 1971, Locke pointed out the impossibility of carrying out behaviour therapy in the terms in which it was originally described, because of the recurrent social relationship which could not easily be described in terms of stimulus and response; and a study of desensitisation and flooding which was reported in 1973 by Gelder et al concluded that "the results suggest that current theories about the mechanisms underlying behavioural treatments are inadequate and in need of revision." (G lder, Bancroft, G th, Johnston, M thews and Shaw, 1973, p.459).

It was also becoming evident that patients themselves were not impressed by the theories of behaviour therapists (see the research reviewed in chapter 2). Hence this need for theoretical development was gradually recognised by behaviourists at least in some quarters; for example, a recent review paper by two behaviour therapists, which looked at the current status of behaviour therapy,

described it as "a thing of the past", (Kazdin and Hersen, 1980, p.284). Kazdin also pointed out elsewhere that a number of behavioural techniques are not as obviously behavioural as they were once claimed to be: "the current theoretical basis of desensitisation is very unclear and no particular v riatıon of the many views that have emerged seem to have captured the field." (Kazdin, 1979, p.631). Other behaviour therapists now claim that behavioural approaches are more "profound" than had been originally thought, and can deal just as effectively wıth emotions, art, values and other "private events" as can any other approach (Cullen 1980).

Turning to psychotherapy, it has also become clear that many psych th rapists now accept the value of some of the theoretical notions provided by behaviour therapy in accountıng for effectıve therapeutic practice. Egan (1975) for example, who works from a counselling perspective, recommended the addition of "concreteness" as a way of encouraging clients to change, (which can be seen as a very behavioural notion), to the list of necessary and sufficient conditıons for personality change advocated by Pogers; and in a recent study of phobic patients, Klein et al tried to include some behavioural aspects in their description of the effectiveness of psychotherapy: "there is specificity to psychotherapy over and bove simply making a hope-engendering, anti-demoralising relationship with a therapist, in that the therapy leads to the correct in-vivo beneficial activity." (Klein, Zitrin, Woerner and Poss, 1983, p.144). Lik wise, Ryle (1983) calls for a model of psychological therapy which involves very complex learning in a human relationship. All of these examples demonstrate that at least some psychotherapists have been becoming more conscious of the merits of behavioural intervention, even if only as an addition to their normal therapeutic approach.

3.2.2) The need for a fresh look at the therapeutic relationship.

What was being suggested in the above section (and by the r search reviewed in chapter 2) is that some of the theoretical notions of both behavioural therapy and psychotherapy were gradually being exposed as inadequate, and in need of some revision. Secondly, and in parallel with theoretical changes, some changes could be noted in the development of the therapeutic relationship, in terms of both techniques used and the emphasis placed upon them. Nickelson and Stevic (1972) for example, reported that behavioural counselors who were hig ly rated on scores of warmth, empathy and genuineness, were more effective in modifying behavi ur than those with low ratings, and Fischer, Pavenza, Kickertz, Hubbard d Grayston (1975) found that there was no difference in ratings of warmth, mpathy and genuineness between therapists of either theoretical orientation. Similarly, O'Leary, Turkewitz and Taffel (1973) noted that 96% of parents whose children were rec iving behavioural treatment, liked their behaviour therapists; the researchers noted (almost, it seems, with surprise), the presence of qualities such as warmth, under.tanding, and sincere interest in these behaviour therapists. In short, behaviour therapists were starting to pay attention to the "relationship" aspects of treatment; ilson and Evans (1977) claimed that there was a "misconception of behaviour therapy as impersonal", (p.548), and that both "interpretations" and "social reinforcement" were important.

It seems, however, as if this could not be accepted without further experimental evidence. Morris and Suckerman (1974) used automated tape recordings in order to try and deliver desensitisation without the personal element; they also varied the tone of voice on the tapes so that the voice was either warm (soft, melodic and pleasant) or cold (harsh, impersonal and business-like. Better results were obtained by the former. Other studies reached similar conclusions, for example researchers looking at a behavioural therapy group (Abramson, Garg and Meghreblian, 1980), which was aimed at reducing obesity, discovered that vacations taken by the therapists and changes in

lea ership had an effect on the amount of weight lost. It was also recalled that in a study reported in 1963, Feinberg and Zaslove had found that all of the patients receiving behaviour therapy from unresponsive therapists, (who had deliberately tried to eliminate aspects of helpful concern from their behaviour), attempted to make better relationships with their therapists. Although these reports may now seem obvious, it is important to note that they were far from obvious to behaviour therapists at the time, and were not reflected in the training of novice therapists.

In similar fashion, changes could be noted in the practice of at least some psychotherapists. In 1966, Kanfer remarked "the problem in the area of psychotherapy today is not to decide whether conditioning techniques will replace interview methods, but to understand how the best elements of each can be combined for maximum usefulness". (Kanfer, 1966, p.172). Kanfer also commented that: "recent developments in the field of psychotherapy suggest that in addition to warmth, understanding and compassion we should also train the clinician so that he possesses the technical skills to do something about the patient's misery." (p.176). A series of studies in the sixties and seventies (for example Woody, 1968; Leventhal, 1968; Rhoads and Feather, 1974), considered the possibility of including some behavioural element (such as desensitisation) concurrently with the psychotherapy. Psychotherapists such as D'Alessio (1968) suggested that the concurrent use of behavioural techniques could highlight the transference, although he saw it as very much a secondary factor.

3.2.3) One possible solution: eclecticism.

This recognition of the possible contribution of both psychotherapeutic and behavioural approaches was given increasing prominence, and labelled the eclectic approach. In 1967, Carkhuff wrote that eclecticism means "being shaped by what is effective for those we serve"; and thus

"in employing the term eclectic, we are not describing a particular approach or absence of approach, rather we are underscoring the recognition that no one theoretical orientation or series of techniques is adequate to deal with the complexities of multiple persons in potentially constructive interactions." (Carkhuff, 1967, quoted in Corrick, 1980, p.6). Although there were several meanings given to the term "eclectic", it was generally taken to imply that the therapist would use a multiplicity of techniques depending on the needs of the particular patient, (for example, Lazarus 1971). There was no real discussion at this stage of the *possibility that the* techniques themselves were not central. Researchers such as Marmor (1971) suggested that behaviour therapy and psychotherapy were actually complimentary techniques, and in 1974, Oliver called for "super-theory", which would provide "transformation formulae for translation of data collected and integrated under one sub-theory into the langu ge of any other sub-theory", (Oliver, 1974 p.3). In 1977, Wachtel (a psychoanalytically oriented therapist) presented his attempt to reconcile the two approaches; an attempt that was highly acclaimed, (although it must be noted that this approach to eclecticism was not entirely new; in 1950 Dollard and Miller had published an attempt to reinterpret psychoanalysis in learning theory terms). In the early eighties there were further attempts to integrate the approaches, for example, Llewelyn (1980); Cohen and Pope (1980), and Goldfried (1982); and in 1983, Beutler suggested that the task facing therapy researchers was now to develop a language system which would permit the incorporation of all therapeutic ideas within a broad social context. This increase in eclecticism has been noted in the labels that therapists use to describe their work; in 1983, for example, Prochaska and Norcross noted that 4% of American therapists saw themselves as "atheoretical" eclectics; 31% saw themselves as "technical" eclectics, and 65% saw themselves as "synthetic" eclectics, (note that the latter percentages include those in the former categories).

3.2.4) Limitations to integration.

However, there have been a number of problems that have become apparent in this growing rapprochement. Because this is not the most central issue in this thesis, only two of these objections will be mentioned here, and these will only be discussed briefly. Firstly, there are considerable philosophical objections to an unsystematic or unconsidered eclecticism. Messer and Winokur (1980), for example, suggest that there are limits to integration because the two approaches have contrasting views of reality, and possess different "cosmic visions" presupposing different understandings of the world. They believe that psychotherapists possess essentially introspective, romantic and tragic constructions of reality, whereas behavioural therapists' constructions are extraspective, ironic, and comic. In other words, the underlying assumptions of behavioural therapists are that with sufficient manipulation of the environment, problems can be solved and people can be made happy; whereas the underlying belief of psychotherapists is that people are basically conflict-ridden, and that these conflicts are an essential part of life itself; furthermore, they can never really be resolved. The implications of this are that at a fundamental level the theories are incompatible. Similar criticisms are made by Pilgrim (1977) and Smail (1980) who both point out that the philosophical underpinings of behaviourism are incompatible with many (but not all) psychotherapeutic approaches.

The second objection to eclecticism to be discussed here is that it can lead to muddled thinking and confused practice. As Robertson (1981) describes it, "eclecticism is the last refuge for mediocrity, the seal of incompetency". Although this doesn't necessarily follow, there is always a risk in eclectic practice that the techniques used will be applied in an incoherent and ad hoc fashion. Corrick (1980) pointed out that there is no guidance in eclectic practice concerning which technique should be

used when, nd there is a tendency to try to be "a therapist for all seasons", unless n extremely complex and involved programme of eclectic intervention is worked out. When this has been tried (for ex mple, Gilmore, 1980), the result is unwieldy and unuseable, largely because the underlying rationale is empirical rather than theoretical.

3.3) The non-specific factors hypothesis.

S far, I have d scribed the growing recognition of a need to account for the positive outcome of both behaviour therapy and psychotherapy, and the limitations of n eclectic approach to resolve the questions raised by these outcom findings. An alternative approach has been to look for factors in therapies that occur in all types of ther py and are specific to none, and this will now be outlined. As was noted in section 2.3, it was speculated, increasingly frequently, that the factors responsible for positive outcome were not the technical features of treatment, but were rather th non-technical features that were an inevitable part of any helping relationship. These factors were lab lled "non-specific", although there has never been a very satisfactory definition of exactly what is meant by this term, (Wilkins 1983). Some researchers included the therapeutic relationship itself within this term; others restricted it to more general features as might be included in a "placebo" treatment, such as having a regular appointment, expectancy of receiving help, and so on. It was thought that these non-specific factors might provide the clue that explained why both behaviour therapy and psychotherapy were equally effective.

3.3.1) Development of the non-specific hypothesis.

The oldest recorded discussion of "in common" or non-specific factors was published by Rosenzweig (1936), who suggested that there might be unrecognised factors operating which differed from the factors alleged to be operating. Since then, this has been a weak but persistent trend in psychological therapy research. One

particularly important study of non-specific factors took place in 1960, when Fiedler compared the therapeutic relationship in three different types of therapy, and concluded that the "ability to understand the patient is the most important of our criteria of expertness as a therapist." (Fie ler, 1960, p.442). In 1964, Strupp, Wallach and Wog n confirmed that the patient's experience of having the therapist's respect, understanding and warm conc rn was more important than ny technical skill. This finding wa replicated by numerous studies with different types of therapy and different types of patients, for example Ryan and Gizynski, 1971, Mathews, Johnston, Lancashir , Munby, Shav a d Gelder, 1976, (behaviour therapy patients); John on, 1976, Thompson and Anderson, 1981 (medical inp tients); Chastko et al, 1971, Leonard, 1973, Tovian, 1977, (psychiatric inpatients); Kay, 1969; Hunt, 1984; (c unselling clients); Lubor ky, Singer and Luborsky, 1975, Sloane et al, 1975, Llewelyn and Hume, 1979, (psychotherapy and behaviour therapy outpatients); Zeiss, Lewinsohn and Munoz, 1979 (cognitive therapy patients). Most of these studies took as their central problem the fact that there was little evidence for the effectiveness of particular and specific factors in therapy, which the researchers understood to imply that the non-specific factors were central. For example, McCordel and Murray (1974), in a study of group therapies, concluded that "the burden of proof would seem to lie with the researcher who claims a specific effect for a specific technique", (p.343); and in 1979, Lee stated from an overview of studies examining the patients' view of therapy that: "one may venture, based on these findings, that whatever helps in psychotherapy is mostly through the positive patient-therapist relationship, without which any skillful therapeutic technique alone may prove effectless." (p.51). In 1976, Kazdin and Wilcoxon reluctantly concluded that "on purely methodological grounds... non-specific treatment effects... cannot be ruled out in accounting for the effects of desensitisation" (p.751). Furthermore, in 1981, Rounsaville, Weissman and Prusoff concluded that

"the f ilure of the process variables to be significantly related to treatment outcome can be seen as supporting the view that psychotherapy is effective through non-specific aspects of treatment, such as the provision of support and the installation of hope." (p.73).

3.3.2) Non-specific factors.

There were three main consequences of these and other studies. The first was that more attention started to be paid to the non-specific factors as important in themselves. Lists of these factors were postulated, for example by Gelder, B ncroft, Gath, Johnston, Mathews and Shaw (1973) who included the following: encouragement, hope, warmth, faith, trust, empathy, suggestion and rapport. Urban nd Ford (1971) and Murray and Jacobson (1971) did likewi e. Factors such as the positive attitude of the therapist (Orne, 19); credibility (Shapiro, 1979); expectation (Goldstein, 1960); and catharsis (Bergin, 1980) were added to the list. Discussing the importance of the therapist's attitude, Orne wrote that "it is ntirely possible that the absence f a strong positive attitude towards the psychotherapeutic technique on the part of the therapist will prevent any significant thera- utic ch nges, whereas the presence of such attitudes will lead to ignificant changes without even an effe tive specific therapeutic manip lation." (Orne, 1968, p.409). It became difficult to know what (if anything) was to be left out. The place of non-specifics was hotly debated; th Journal of Consulting and Clinical Psychology in 1979 published a short series on the issue of non-specifics, concentrating particularly on the role of expectancy. Wilkins (1979) as a part of this four-part controversy objected that the term "non-specific" had no conceptual or operational clarity or definition, and suggested that we should eliminate the term completely. He commented that expectancy, for example, could not be seen as a "non-specific" because the term was a negative one, which implied that there was "a class of events ccording to a property that is presumably absent from members of that

class", (Wilkins, 1979, p.840). However, Kazdin (1979) refuted this, saying that this was not necessarily so, as non-specifics did not necessarily have to be independent of specific factors. In addition, he claimed that the task of researchers was to go beyond these ubiquitous non-specifics to specify exactly what they were, pointing out that what was seen as non-specific in one therapy might be seen as specific by another. Also as part of this controversy, Bootzin and Lick (1979) cited a study which showed that a placebo treatment was just as credible as a more specific treatment, suggesting that non-specific factors raise crucial questions about mechanisms, not effectiveness. ence questions raised by the non- pecific factors were seen as the mo t promising avenue for research for a number of years; Strupp, for example, wrote that "it appears that significant advances in psychotherapy r search will emerge from better conceptual analyses operating in all forms of therapy rather than premature comparisons of techniques and systems." (Strupp, 1973, p.7).

3.3.3) Training and expertise

The second consequence of the debate about the importance of non-specific factors was to question the role of training and the necessity for technical expertise in the therapist. A number of studies suggested that extensive training did not produce any better results than minimal training (for example, Berenson and Carkhuff 1967; Durlak 1979), although these findings have subsequently been subject to considerable criticism (Lambert 1979). It was argued that if non-specific factors were in fact the part of treatment which was effective, then there seemed little point in insisting on either extensive or technically very sophisticated training for therapists. It was further pointed out, following Frank (1971), that the skills used by therapists were not that dissimilar to those used by witch doctors (Torrey 1972); and a review of the role of faith in healing carried out by Calestro in 1972 showed that many features of primitive healing were also

characteristic of contemporary therapy. In a study comparing groups of inexperienced therapists with professionals of varying orientation, Gomes-Schwartz showed that training had an influence on process and not on outcome, and concluded that "the fact that the patient's willingness to ally himself with the therapist and work at changing was not influenced by the theoretical orientation and professional status of the therapist, may be of particular importance for understanding why there were no differences among the groups." (Gomes-Schwartz, 1978, p.1031-2). Although there were some exceptions, results concerning the relevance of expert training were fairly consistent; in a substantial review carried out in 1977, Gurman concluded that what the therapist did was more important in determining outcome, than his or her purported level of expertness.

Similar conclusions were reached in the fascinating comparison carried out by Strupp and Hadley, also in 1979. They randomly assigned mildly disturbed (student) patients to professionally trained therapists or to untrained, volunteer college professors who acted as "benign, interested father figures". They found that there was little difference in outcome between the groups, although transcripts showed enormous differences in content of the therapies. For example, in contrast with the professionals, the professors gave advice, talked anecdotally about themselves and so on. They concluded that "the techniques of professional therapists did not seem to give rise to measurably superior treatment effects; these skills appeared to potentiate the natural healing processes inherent in a good human relationship", (Strupp and Hadley, 1979, p.1135). Nevertheless they also pointed out that the pseudo-therapists "experienced difficulty in discharging their assignment, for example, they would run out of relevant material to discuss, they were unable to work towards specific goals, and very few would have been willing or able to treat patients over more extended periods of time." (p.1139).

3.3.4) The therapeutic relationship.

The third consequence of the debate about the role of non-specific factors was that the therapeutic relationship itself was given increasing prominence. Working from a psychodynamic stance, Strupp et al. concluded that "mutual trust is a sine-qua-non for successful psychotherapy", (Strupp, Fox and Lessler, 1969, p.80); and from a behavioural background, Andrews wrote that the relationship with the therapist was "a new interpersonal learning experience"; so that a central feature of therapy was "the therapist establishing himself in a direct nurturing role, using the relationship as a leverag to encourage the patient to confront fear arousing situations", (Andrews, 1966, p.477). It was agreed that the qualities of the therapist, such as his or her personal values, beliefs, prejudices, and interactive skills, all had impact on the outcome of therapy, as did the quality of the relationship between the therapist and patient. Strupp (1981) for example, wrote "the major determinants of the formation of a good working alliance are not only the patient's characterological distortions and maladaptive defenses but, at least equally as important, the therapist's personal reactions".

The personal qualities of the therapist will be considered very briefly, as this question has already been considered in section 2.5. A number of studies (for example Ford, 1978; Orlinsky and Howard, 1967; Howard, Orlinsky and Perlstein, 1976; Shapiro 1976) showed that personal feelings were important; Shapiro for example, showed that when the therapist disliked the patient, improvement ratings dropped rapidly. Further, a study by Kline, Adrian and Spevac (1974) showed that the main focus of complaint from dissatisfied patients was the lack of interest from the therapist.

Turning to the effects of the interaction between therapist and patient, the findings are even more marked. Mintz, Auerbach and Luborsky (1971) concluded that a good

therapy entails both an involved understanding between therapist and patient; and an active, co-operative patient. The work of Howard and Orlinsky on the Good Therapy Hour attracted much attention, with conclusions such as the following being drawn: "Who the therapist was and who the patient was... was comparatively less influential than what they did together as different situations arose in treatment" (Howard, Orlinsky and Perilstein, 1976, p.525) This does not mean however that the assumed importance of non-specific factors went unchallenged; Bandura for example saw the therapy relationship as artificial, providing "substitute gratifications for those lacking in the client's natural relationships, instead of serving as a major vehicle for personality change", (Bandura, 1969, p79).

3.3.5) Limitations of the non-specific hypothesis.

All of the points noted above (that is, the three sets of consequences of the development of thinking and research concerning the role of non-specifics) led to the conclusion that non-specific factors were extremely important, although no-one could really agree on what they were, nor whether the term "non-specific" was a particularly helpful one. It was also agreed that it would be very difficult to draw up a therapy consisting entirely of non-specifics, for as Frank said, a myth or rationale was actually a very important aspect of the process; "after all, the patient and therapist have to do something together, they cannot simply sit and stare at each other." (Frank, 1971, p.356). The non-specific hypothesis reached its logical conclusion when, in 1981, Hynan suggested that we no longer need to teach students any particular theoretical formulations about helping clients, on the basis that techniques are ineffective.

It may have become evident from the research reviewed in this section, that there are a considerable number of problems with the non-specific hypothesis. Firstly, it is difficult to see how the further investigation of non-

specifics, as unspecified, will lead our understanding of psychological therapy anywhere in particular. In a sense, to label an effective factor as non-specific says little more than that we do not as yet kno what it is. Rather than simply leave it at that, perhaps our task is to see what is going on that has therapeutic impact. Cross and Sheehan (1981) note that many factors (such as expectancy), now being seen as central to therapy, were originally seen as artifacts; indeed it may be recalled that transf rence itself was originally seen by psychoanalysts as a by-product of, or even obstacle to, treatment rather than its central focus. The question therefore becomes how to translate these factors into something specific that can be used in re earch and practice. Bandura for instance suggested that we should see these non-specific factors as simply so far unspecified. He claimed that it is reasonably straightforward to specify social influence factors for example, as being quite specific, in that "a liked person can function as an incentive and raise general drive level in the individual who responds with liking", (Bandura, 1969, p.112). Others writers, for example Mann (1973), have stressed the importance of technique, and decry the "anti-intellectualism" which they feel results from an emphasis on non-specific, humanistic and spontaneous factors to the exclusion of all else. The implication of this viewpoint might be, therefore, that the non-specific hypothesis is a result of intellectual laziness rather than anything more profound, and that the real task ahead is to uncover what exactly these non-specifics are. Such a viewpoint would propose that only the "null hypothesis" has been accepted, which does not "prove" that specific factors are ineffective.

Secondly, the non-specific hypothesis does not clarify what mechanisms or interactions are occurring, which may give rise to the experiences described as "non-specific" factors; nor does it provide any guidance as to whether what is going on is the most effective way of proceeding. We may accept that the therapeutic relationship is important, but how is it important? Horn-George

and Anchor (1982) found that there was substantial agreement amongst therapy researchers that the relationship was the crucial factor within which other factors were operative, although no consensus existed about what these factors were, nor how they related to the therapeutic relationship. Further, the non-specific hypothesis does not really clarify what the therapist should actually do in any given situation. Orne has pointed out that a p rticular technique may indeed work because the therapist believes in it, but this does not mean that "given an equal conviction and a different course of action, it might not work better" (Orne, 1968, p.409). It is clearly not enough to sit and stare at the patient, so what should the therapist actually do? Greist, Klein, Eischens, Faris, Gurman and Morgan, (1978) suggested that a well planned programm of jogging produced as much improvement as a course of psychotherapy, and Murgatroyd (1982) provided an xample of the ultimate non-specific counselor, who recently vertised a therapy "to facilitate the release of inner tensions" in a well-known popular magazine; the counselor in question was to be a nude Soho model!

A third drawback of the non-specific hypothesis is that it is not clear how specific factors are related to non-specific factors and how they are in turn both related to positive outcome. Rickels (1977) points out that non-specific factors can be either additive or interactive, and there is no way, with a definition such as "non-specific" that this relationship can be teased out. For example, Klein, Zitrin, Woerner and Ross (1983) found support for the importance of non-specific factors, but also for specific factors, in this case the patient facing the phobic object. Similar findings were obt ined by Buckley, Karasu and Charles (1981) who looked at the importance of interpretation and insight alongside other non-specific factors. If they remain unspecified, it is difficult to discover what exactly is going on. It is also difficult to deal with criticisms from writers such as Malan who, in describing nine intensive case histories, reached the unlikely conclusion that: "There were

apparently no cases of powerful non-specific factors at work", (Malan, 1976, p.268).

A last limitation of the non-specific hypothesis is that there is an increasing amount of evidence that therapists do act in very specific ways, which can in fact be distinguished as springing from different types of theoretical orientation. For example, DeRubeis, Hollon, Evans and Bemis (1982) showed that behaviour therapists and psychotherapists used procedures that were consistent with their theoretical orientation as recommended by the originators of the theoretical schools; similar results were obtained by Russell and Stiles (1979) who looked in detail at the intersubjective communication strategies used by participants (both therapists and patients) and found them to be clearly related to theoretical orientation. Stiles has subsequently concluded (1983) that therapy is effective in many different ways, and that past research has been mistaken in looking for non-specific effects, largely because we have erroneously presumed that only uniformity of therapeutic action can explain uniformity of outcome. Stiles on the other hand feels that we do not need to look for non-specifics if we are prepared firstly, to accept that there are many ways of achieving a positive outcome, (which can itself be defined in a variety of ways); and secondly, if we are prepared to be more specific in our examination of what actually goes on in therapy.

All of this seems to suggest, therefore, that the non-specific hypothesis is at its strongest when it is vague and unspecified; when it is examined in detail there are a considerable number of problems with it. The hypothesis has called attention to processes which were not noted by theories of psychological change in the past, and has thus been beneficial. But to progress further with our understanding of change processes, a clearer and more specific approach is needed, which avoids some of the problems inherent in the non-specific hypothesis.

3.4) Therapeutic factors.

One way forward has been to investigate the possibility that there are particular processes, (normally actions or interventions made by the therapist) which are particularly effective, in all types of therapy, but which may depend on circumstances for their effectiveness. These actions (therapeutic factors) were discussed briefly in chapter 2. They should be distinguished from non-specific factors, which are thought to be unconnected with technique and to be present even in "placebo" conditions, although in pr ctice some of the labels given to the factors are identical. They should al o be distinguished from conditions necessary for the therapy to occur at all, such s the presence of the patient. These therapeutic factors will now be examined in more detail.

3.4.1) Systems of therapeutic factors.

As was pointed out earlier (in section 2.4.5), the first systematic presentation of a list of therapeutic factors was in group therapy, by Corsini and Rosenburg (1955). Their list consisted of nine factors, and their aim was to provide a taxonomy of therapeutic events that would cover a variety of different theoretical persuasions. A similar taxonomy was proposed by Berzon, Pious and Parson, (1963). The subject was advanced considerably by the work of Yalom (1975) who proposed twelve curative factors, such as interpersonal learning, installation of hope, and catharsis. His work was criticised by Rohrbaugh and Bartels (1975) who made the point that some of these curative factors were in fact mechanisms or conditions for change, a theoretical distinction that was also made by Bloch and Reibstein (1980). Numerou studies have been published in the years since the publication of Yalom's system of analysing group therapy effectiveness, for example Maxmen, 1973; Steinfeld and Mabli, 1974; Sherry and Hurley, 1975; Feeney and Dranger, 1976; Kansas and Barr, 1982; Macaskill, 1982; Butler and Fuhriman, 1983; and Marcovitz and Smith, 1983. Almost all of these studies

found some evidence for the validity of Y lom's syste , although they proposed that the distribution of factors varıe with the type of group, and they pointed out a number of weakne s s in th theoretical formulation. They did not however enter the controversy concerning specific and non-specifıc factors; the acceptance of Yalom's system appeared to have circumvented this.

Turni g to the field of in ividual therapy, n uch uniformity could be found. F r example, in 1954, Bibring h d propos d a list of five basic techniques of psych therapy, (sugg sti n, abreaction, manipul tion, clarification, and interpretation); and a number of basic texts were being published detailing the therapeutic principles involved ın behavi ur therapy, for example Skinner, 1953, and W lpe, 1969. Yet the need for a unifying system had long been recognised. Marmor summarised the conclusion of a symposium held at the American Psychological Association in 1955 as follows "(we must find) the common denominations that underly the varying data and therapeutic successes of these different schools of thought", (cited in Strupp, 1957, p.295).

A number of writers have tried to propose systems of therapeutic factors, and some of these have received some degree of acceptance. For example, Frank (1971) listed six basic features of any therapeutic relationship which he suggested were responsible for therapeutic change. These features were as follows: firstly, an intense, emotionally confiding relationship; secondly, a rationale or "myth"; thirdly, provision of new information concerning the nature and sources of the problem; fourthly, the expectation of help engendered by the presence of a socially sanctioned healer; fifthly, the provision of some experiences of success; and lastly, the facilitation of emotional arousal. Similar groupings of therapeutic factors were provided by Marmor, (1971); Calestro (1972); Strupp (1957, 1973); Luborsky (1977); and Garfield (1980). Strupp, for example, suggested that there were three basic elements or ingredients in therapy; firstly, a

relationship of respect, interest, understanding and helpfulness; secon ly, one or more of a variety of techniques such as persuasion, encouragement of openness, or interpretations of self-defeating behaviour; and thirdly, a willingness on the part of the patient to participate in and profit from therapy. Psychoanalytically oriented writers such as Malan (1976) claimed that the cornerstone of any therapeutic relationship must be the transference/parent link, although he also listed six other factors, such as the patient achieving insight of a non-transference kind, and the patient taking responsibility for his or her own life. Miller (1981) looked in detail at the role of faith in psychoanalysis, and explored its position in relation to other techniques. It was clear that some of these factors were specific to particular approaches and others were simply concomitants of any therapeutic approach, but the distinction was not always made by the authors. Further, there was often confusion between factors affecting change (such as the attitude of the patient), and factors effecting change (such as the provision of homework tasks).

The field was becoming so overwhelmed by different systems that in 1977, Orlinsky and Howard concluded their substantial review of the therapeutic relationship as follows: "What is needed is a comprehensive list of input, process and output factors that makes sense and is subscribed to by most of the people working in the field - no matter what their theoretical predilections might be - so that their efforts may become mutually intelligible and their results comparable and cumulative. The sooner someone arranges this little matter, the better off we shall all be..." (Orlinsky and Howard, 1977, p.319).

3.4.2) Developments of thinking about therapeutic factors.

No-one has as yet "arranged this little matter". However, besides going on to propose yet more category systems for therapeutic factors (for example, Garfield

19 0; Prochastka and Diclemente 1982;), some writers have chosen t investigate some factors in more depth. For example, Curtis (1982) and Stiles (1983) both see self-disclosure as a c ntral factor, and have examined it in some detail, and Elliott (1983) has, as described in section 2.4.5, studied insight as a therapeutic factor occurring in the context of a numb r of other factors. This is of course not a new development; Davis and Skinner (1974) and Dies (1973) have studied self-disclosure; Orlinsky, Howard and Hill (1970) looked at c tharsis; Milne and Dowd (1 83) and W llerstein (1983) have look d at interpretation; and Johnson (1971) has studied empathy. What may be new however is the notion that these factors operate in a relationship in very specific ways, although the relationship itself may be the "n n-specific" f ctor that must underly the specific factors.

Further, some recent work implies that, far from supporting the "non-sp cific" hypothesis that therapy m rely consists of befriending the patient, the evidence is that what the therapist does is highly specific, although what the pati nt makes of it all may be less so. The work of Cross and Sheehan (1981, 1982), for example, suggests that therapeutic actions may operate differently within different theoretical orientations. Further, they suggest that an important aspect of therapy is what they call the "secondary" as opposed to the "primary" variables in therapy. These secondary variables are seen as a variety of major aspects of therapeutic change which occur only indirectly as a result of therapy. They postulate that the way in which secondary variables operate, depends on the nature of the therapy. For example, they found in a study in 1981 that all the patients in their study, receiving either behaviour therapy or psychotherapy, also obtained "alternative counsel" outside the therapy hours; that is, they talked more than previously to their friends and relations about themselves. However, what was particularly interesting was that the pati nts did this differently, according to the type of therapy

received. ehaviour therapy patients talked more to friends during the months of treatment, whereas psychotherapy patients talked more after the conclusion of treatment. This suggests that the therapies are having very specific effects, and that therapeutic factors exist which operate in specific ways, but that the overall result may be similar in the long run. This was also the implication of the study by Mintz, Luborsky and Auerbach (1971) who found that clusters of process factors were effective in some types of therapy and not in others. Usually therapies emphasised either directiveness or the empathic relationship, and either (but not both) mode was effective.

One implication of this view is that therapeutic factors may not only be differently effective in different t erapies, but also that the way in which they operate may differ over time. Trower and Dryden (1981) for example, reviewed the research into self disclosure and warmth, and suggested that timing was crucial; at times warmth, for instance, may actually become counter productive. Crowder (1972) suggested that successful outcomes were reached when early sessions were characterised by behaviours which were "hostile/competitive"; middle sessions by behaviours which were "passive/resistant"; and later sessions by behaviours which were "support seeking/interpretive". Mann (1973) also suggested that therapists should use different therapeutic skills at different stages in therapy, such that the patient should be increasingly offered "reality" in contrast to nurturance of the transference. Other writers have suggested that sensitivity to the needs of patients at particular times is crucial; for instance Prochaska and Diclemente (1982) report that many therapists are not effective precisely because they ignore the effects on the client of many of their previous change interventions; so that the therapist proceeds according to previously successful strategies ignoring the present state of the patient.

In a recent paper by Greenspan and Sharfstein (1981), there is a call for more specific attention to be paid to

the processes occurring in the experience of psychological therapy, by breaking processes down into stages, or steps. Each step has its own justification in particular theoretical approaches. For instance, one crucial step is the formation of processes wherein the relationship will tolerate the potential of discomfort; another is the occurrence of causal interaction or feedback. Only in some orientations is higher level causal, symbolic or representational communication appropriate or possible. As can be s en, this approach (and that of Cros and Sheehan) to the problem of ennumerating effective therapeutic factors, allows for a far more sophisticated analysis than merely listing likely "non-specific" factor which are all presumed to operate in all cases.

Yet another approach to the question about the utility of therapeutic factors as a way of approaching the therapy relationship has been introduced by Goldfried (198) who talks about therapeutic strategies. These he s es as operating at an intermediate level of abstraction between technique and theory "although the specific techniques that are used to implement each of these strategies may vary from orientation to orientation." (p.586). His strategies include induced expectation that the therapy will work; participation in a therapeutic relationship; and repeated testing of reality. Similarly, Davis (1983) talks of underlying components of therapy, such as mutuality of goals, consensus regarding responsibilities in the therapeutic setting, and good affective bonds.

However, the problem still remains of understanding the mechanisms of effective therapeutic interaction from the receiving end, a question that has not been ddressed in detail by the researchers who have produced the lists of factors, strategies, or components. Nor do many of these systems progress beyond rather global evaluations of "good" versus "bad", (Stiles and Sultan 1979), and thus they still say little about the specifics of therapeutic interaction. As Kiesler (1979) pointed out, we may accept that the therapeutic relationship is important, but how is

it? Perhaps we should look at the minutiae of the therapeutic interaction, to see how some of the most important aspects of interpersonal interaction are negotiated, such as the tone of the affective core, or issues of dominance. We could also try to understand how interpersonal influence occurs in, and is moderated by the therapy relationship. Kiesler suggests that such an approach would be possible if we develop our understanding of the therapeutic relationship along the lines advocated by Sullivan, so that we see it as obeying a "reciprocal-circular model of causality, rather than a unidirectional-linear model", (Kiesler, 1979, p.309). Smail (1982) has also suggested that we should see the therapy relationship as a process of negotiation, rather than as the application of a set of techniques. Issues of concern therefore become responsibility, influence and encouragement, so that the level of analysis extends beyond present paradigms of therapy research, and moves towards a consideration of whether there are processes going on beyond the roles of the two people involved, and which are best understood interpersonally.

So how do we develop such an understanding of this complexity? Possibly some accurate description is a necessary starting point. Elliott pointed out that a therapeutic "interaction has multiple meanings or interpretations, all of which are needed in order to describe it properly." (Elliott, 1979, p.292). Chapter 2 demonstrated the lack of adequate and detailed empirical evidence concerning the experience of therapy from the participants' viewpoint, and this chapter has demonstrated the limitations of some of the lists of specific and non-specific factors, as well as indicating some of the advantages of looking at therapeutic factors. The remainder of this chapter will consider how an analysis of therapeutic factors might be carried out which draws on the experience of participants, and avoids some of the drawbacks of the analyses outlined above.

3.5) Usefulness of considering therapeutic factors from the participants' viewpoint.

S ctions 3.2 and 3.3 suggest that an uncritical emphasis on the importance of non-specific factors, or an adherence to an unexamined eclectic viewpoint, does not progress our unaerstanding of the process of therapy very far. It was suggested by section 3.4 that the mere production of a list of therapeutic factors does not either. However, such a list may be a prerequisite for the development of an accurate view of what is occurring in the therapy session. Chapter 4 will review and evaluate a number of such lists. At this point, however, it seems appropriate to consider the possible usefulness of such li ts to an und rstanding of therapy, particularly if we are interested in the views of the participants in therapy, as sugg sted in chapter 2.

Given that we are trying to understand the experience of psychological therapy, and that theories of therapy seem to be inadequately formulated to account for therapeutic outcome in terms of the specific techniques outlined, it may be that therapeutic factors could be the means by which we may advance our comprehension of the therapeutic encounter. The accounts provided by patients and therapists as described in chapter 2, make very interesting reading, and permit a closer understanding of therapy process than most experimental accounts. However, they are not (and by and large do not pretend to be) systematic. One of the drawbacks to this is that it is not unambiguously obvious what implications there may be for therapeutic theory or practice. Frequently reports are too general for any conclusion about future action to be drawn. However, patients' reports in particular draw attention to aspects of process which perhaps should be more readily available to therapists, and which perhaps should have implications for practising therapists. Yet the devices that are available for translating the experiences into application, namely, the theories advanced by therapists, often do not focus on the factors that have

bee described by patients when they have b en asked retro pectively about treatment. Thus we need a way of fınding out about patients' and therapists' experiences of therapy which are not circumscribed by particular theor t-ical formulations. With such a methodology, it might also be possible to compare the accounts provided by patients and therapists in a systenatic way, ana which could therefore have implications for practice.

The questions that remain unanswered in the area of the participants' experience of psychological therapy re numerous, in part b c use w do not yet h ve a method for analysing these experiences. Some que tions that might be asked include the foll wıng: Do patı nts' views change over time? Are sone specific actions more lıkely to lead to positive outcome within sessions, than others? What ex ctly occurs when a patıent reports that he or she has g ıned in ight? o patients value problem solution more than insight? Th research reviewed in the chapters abov , suggested some tentative answers to some of these questions, but there has as y t been no systematic attempt to study them in detail, over extended periods of time, uɔing the experiences of participants. This has proɒably been partly due to the fact that there have been few acc ptable ways of making systematic sense of the factors seen as therapeutic by patients and therapists whe they report directly on their experiences, and partly due to over-reliance on either very specific theory, or non-specific factors to describe these experiences.

These are some of the questions considered in the research reported in this thesis. As will be described in detail in the next chapter, the research methodology developed by Elliott and hıs colleagues, concerning therapeutic factors, has been adapted so that it permits the quantification of the qualitative responses provided by the participants in therapy. This will permit sone answers to be given to the above questions, in a way that does not depart too far from the direct experience of participants.

TABLE 1: Elliott and James (1982) and Elliott (1982) 4-part Content Analysis System for Psychological Therapy.

1. Event Type	1	Personal Insight	
	2	Clarification of Problem	
	3	Awareness	
	4	Problem Solution	Helpful Events
	5	Involvement	
	6	Understanding	
	7	Reassurance	
	8	Personal Contact	
	9	Misdirection	
	10	Mis-perception	
	11	Disappointment	Unhelpful Events
	12	Negative Therapist Reaction	
	13	Unhelpful Confrontation	
2. Therapist Intention	1	Gathering Information	
	2	Giving Information	
	3	Communicating Understanding of Client's Message	
	4	Explaining Client to Client	
	5	Advising Client	
	6	Guiding Client in Session	
	7	Reassuring Client	
	8	Disagreeing with Client	
	9	Sharing	
	10	Other	
3. Client Intention	1	Disclosure	
	2	Self-exploration	
	3	Request for Help	
	4	Avoidance	
	5	Agreement	
	6	Other	
4. Client State (Adapted from Hill et al, 1980)	1	Calm - Relaxed	
	2	Happy - Joyful	
	3	Vigorous - Active	
	4	Competent - Powerful	
	5	Concerned - Caring	
	6	Respectful - Loving	
	7	Tense - Anxious	
	8	Sad - Depressed	
	9	Angry - Hostile	
	10	Tired - Apathetic	
	11	Confused - Bewildered	
	12	Criticised - Shamed	
	13	Inadequate - Weak	

Chapter Four

Empirical Investigation: Categorisation, Questions and Method.

4.1) Introduction.

As was indicated at the conclusion of chapters 2 and 3, many questions remain concerning the experience of therapy from the viewpoint of the participants, which require further investigation. It was suggested in chapter 3 that some answer to some of these questions might be most effectively found by a close study of the experience of participants, which was neither so limited that the responses of participants were restricted by the method used, (for example, the work of Sloane et al, 1975, or indeed my own earlier work, Llewelyn and Hume, 1979), nor so unstructured and global (for example, the work of Goffman, 1961), that no conclusions could reliably be drawn from the responses. It was also suggested that, in the past, the development of categorisation systems for structuring the responses of subjects had proved to be a particularly fruitful way of avoiding either of these drawbacks (for example, the work of Bloch et al, 1980, in group psychotherapy). Hence it was felt that in this study concerning the helpful and unhelpful events occurring in individual therapy, some form of categorisation of the experience was needed, which would allow conclusions to be drawn concerning the relative efficacy of various aspects of therapeutic intervention, but which remained as closely tied as possible to the experience of participants. For this to be achieved, it was felt advisable to review all the existing systems available for the description of therapeutic process, and to select one for the study of therapeutic interactions to be carried out in this thesis. The first part of this chapter (section 4.2) concerns the selection of a category system. The second part of the chapter (section 4.3) discusses the characteristics of this system, and its particular method of

administration, as well as outlining its content. The third part of this chapter (section 4.4) concerns the methodology involved in the use of the system.

4.2) Category systems in psychological therapy.

As was stated above in chapter 3, a number of category systems have been devised which aim to describe the major therapeutic factors involved in psychological therapy. Before looking at any particular system in detail, however, a number of points concerning the use of category systems need to be made.

4.2.1) The need for a category system in the analysis of psychological therapy research data.

In 1951, Rogers wrote that "our knowledge of psychotherapy will be more firmly based when it is possible to understand thoroughly and with sensitive perception the private world of many clients undergoing psychotherapy" (p.129). Yet there have been very few studies which have tried to uncover this private world. The diaries published by Yalom and Elkin referred to in previous chapters, were, according to Yalom, very nearly not published when a psychoanalytic colleague of Yalom's described them as "chaotic situations", in which the therapist appeared to be saying whatever happened to spring to mind. There is clearly a feeling of unease concerning the use of direct experience, possibly because direct experience is not easily absorbed into reproducible or prescriptive form, hence appearing "chaotic".

The most common response to this has of course been to shun such data, and to concentrate on simpler questions which have already been categorised and classified by the researcher; in other words, to test previously formulated hypotheses in an attempt to demonstrate understanding through the ability to predict and control. Research carried out in this way has the obvious advantage of being (at least if it is well done) immediately open to unambiguous interpretation, and can in some cases imply

causality. However, it can also prematurely limit our understanding by pre-judging the salience of certain issues; it was argued in chapters 2 and 3 that this is the case in much psychological therapy research. Furthermore, it can under certain circumstances obscure rather than clarify our perception of events by ignoring the particular in favour of the general.

The importance of alternative methods of data collection has long been recognised by a number of writers. Orlinsky and Howard (1967) stressed the importance of approaching data which is less "accurate" or "objective" on the grounds that it is in many ways more "real". Lorr and McNair (1966) pointed out that if psychological therapy is to be accurately appraised then certain basic conditions need to be satisfied, including description of the basic processes involved. Greenspan and Sharfstein (1981) emphasised the importance of asking the right questions; they suggested that we should attempt to reconceptualise the complex process of the therapeutic relationship, so that an adequate understanding of process can lead to adequate outcome research, and they point out that accurate description is a necessary prerequisite for this.

What all these writers appear to be suggesting is that understanding a complex interactive process is a difficult and challenging task, for which simplistic hypothesis testing is frequently inadequate. This does not mean, however, that we have to abandon any attempt to be "scientific", if by "science" we mean something more profound than the testing of limited hypotheses. The discussion in section 1.5.1 concerning the nature of science suggests that an approach to phenomena, which is one of disciplined curiosity, is in itself scientific. Further, as Strupp, Chassan and Ewing (1966) suggest: "Accurate description is the first requirement in any science, without it, measurement and prediction are an impossibility", (p.361). But if we do accept that adequate data gathering is a basis for good science, then we need in addition to take account of the step after observation,

which is also characteristic of the scientific enquiry, that is, the ordering of phenomena.

What all of the above considerations seem to me to point to is that, despite the attractiveness of "chaotic" data, (which in this research refers to the personal accounts produced by therapy participants), if we are serious in any attempt to understand the inner world of patients and therapists, we will need to be able to describe their experiences in a comprehensible and applicable form. In other words, we will need to make sense of the data in a way that also makes sense to others, and in a form that allows for some generalisations and conclusions to be drawn. What I am proposing, in effect, is that we need to have some form of theorising which organises our perceptions of the data. This is not the same as testing well formulated hypotheses derived from a particular theory, but it recognises that in making sense of events we need to have some form of categorisation of these events. This is especially so if we wish either to communicate our findings to others, or to decide what are the implications of our data, that is, what should we do differently in future? Of course, this is one of the traditional functions of theory, but as has been argued above, in the field of psychological therapy research, there has been a surfeit of theory and a paucity of data. Hence some less theory-bound way of making sense of the data is needed, although it must be accepted that even an apparently theory free taxonomy will have assumptions and values enmeshed within it. As Vine (1980) pointed out, all psychological theories or taxonomies are inescapably reductionist, in that they seek to organise their subject matter in a reasonably parsimonious manner in order to make data comprehensible. What we need is a way of making sense of our "chaotic" data in a way that respects as far as possible the experience of those providing the data, and which is as non-reductionist as is feasible.

To summarise the above points, the research carried out in this thesis consists of the personal accounts of

therapists and patients which may be of interest in their own right, but for any implications to be drawn concerning them, some way of organising them must be found. The next step must therefore be the establishment of some taxonomy of experience which will allow us to make sense of all the data. This exercise is undoubtedly not without problems, because various assumptions will be either explicitly or implicitly present in the categorisation systems we choose to employ. Furthermore, the categorisation process is by its very nature reductionist, which mitigates against any attempt not to distort the data. Nevertheless, some way of ordering the data has to be found. The next section discusses possible ways of carrying out this ordering of the data.

4.2.2) Content Analysis and Category Systems.

The most appropriate form of classification for the questions raised in this particular research study, that is, what are the most helpful aspects of psychological therapy process as indicated by the subjective reports of therapy participants, is a content analysis of these reports. Content analysis has been defined as "a research technique for the systematic ordering of the content of communication processes." (Marsden, 1971, p.345), and is a process whereby events are placed into category systems, or taxonomies. Category systems have been employed in the content analysis of psychological therapy for many years; the numerous systems used and the ways in which they have been used is outside the scope of this thesis, and have been reviewed by Marsden (1971) and Russell and Stiles (1979). Briefly, systems have been used to categorise (amongst others) the words, non-verbal behaviour, length of utterance, grammatical structure, emotional content, linguistic features and intention structure of the participants in therapy; typically each researcher designs his or her own system which is used for a few studies only and then abandoned (Lorr and McNair, 1966), probably because of its inadequacies. Three different types of category system can be isolated: content based; intersubjective

and extralinguistic. A content based system is concerned with information relevant to the subject's underlying processes such as his or her personality or psychodynamic structure; an intersubjective system is concerned with information relevant to the quality of the subject's relationship to the other; and an extralinguistic system in concerned with the subject's transient state, usually emotional. (Russell and Stiles, 1979).

A number of content analysis strategies can be employed to place events into categories; these are known as the classical, the pragmatic and the nonquantitative. Firstly, the classical strategy assumes that the frequency of occurrence of any given category of event is an indication of its importance, and classifies events according to their manifest content. In other words, the observable semantic and syntactic aspects of the event or communication rather than its implied content, are the basis for the categorisation. Secondly, the pragmatic model challenges this view, and suggests instead that classification of an event should rely on inferences made about the meaning of the communication, thus permitting complex contextual judgements to be made. (This distinction relates to the distinction that can be made between statistical versus clinical prediction.) The pragmatic model "attempts to realise psychological meaningfulness by working directly with complex clinical constructs", (Marsden, 1971, p.347). Thirdly, unlike the classical or pragmatic models, there is no very clear underlying method in the nonquantitative model, which uses a network of concepts for analysis. A distinctive feature of it, however, is that it suggests that the frequency of occurrence of any given event is not necessarily an index of its importance. Hence some measure of intensity is normally included in the content analysis process.

These different classification strategies rely on different underlying assumptions about the way in which variables in therapy may have impact; they also differ in terms of what they omit. As has been pointed out: "content

analysis systems are inevitably criticised for what they leave out. The practising clinician often feels that the measured part of the therapeutic transaction is pitifully small alongside the complex of stimuli that he senses as a participant..." (Auld and Murray, 1955, p.391). One way of avoiding the charge of oversimplifying a complex interaction is to carry out as detailed an examination as possible of therapeutic interaction, as has been done for example by Labov and Fanshel, 1977. Another solution is to accept the limitations of any given system, attempt to make the system as conceptually robust as possible, and resist the temptation to overextend the implications of any conclusions that may be drawn from its usage, (Hill, 1983).

Despite these limitations, most category systems offer interesting possibilities for highlighting at least some aspects of therapy process. What all of them have in common is an attempt to allow inferences to be drawn concerning the importance of some events over others. Russell and Stiles suggest that a number of criteria must be used in the establishment of category systems: firstly all the categories should be mutually exclusive; secondly they should be exhaustive, and thirdly they should derive from the same classification strategy; in other words, conceptually different levels of analysis should be kept separate. However, very few existing category systems meet all of these criteria. Hill (1983) in a recent review points out in addition that no one measure is perfect for capturing the whole gestalt of therapy process; either the measure used is reliable, observable, quantifiable and devoid of clinical significance, or else it is messy, confused, operating simultaneously on different levels, but somehow clinically meaningful. She points out that the researcher is caught in Kiesler's dilemma: "If you can't count it, it doesn't count; if you can count it, that ain't it". (Kiesler, 1973, quoted by Hill, 1983, p.14). Nevertheless, content analysis does offer at least some way of making order from what may on first glance appear to be chaos; hence content analysis of responses of

therapy participants into category systems is frequently the method chosen for use in analysis of complex interactive data.

Two additional points need to be made regarding the use of content analysis, which concern the method of administration. Firstly, the material to be content analysed has to be sorted in some way; that is, it has to be broken down into units for categorising. These units are inevitably arbitrary, and usually exist for the convenience of the researcher only. Examples of the type of unit used in content analysis are a sentence spoken by either of the participants, or a five minute segment of conversation. The task of the coder performing the content analysis is to decide into which category of the system used to place a given unit. Units may be presented in isolation, or in varying amounts of context. Kiesler (1973) has drawn up a list of considerations which should be borne in mind when choosing an appropriate unit in content analysis. He suggests, for example, that both the unit and any context provided should be separated and defined.

Secondly, the material has to be categorised into a system in a way that is meaningful and reproducible. This means that any system has to be proved reliable before it is of use; hence it has to be used in a similar and consistent way by coders who are to place the data into the system. Normally content analysis of units into categories is carried out by coders who have received training in the system to be used. Most reasonable systems include details of the type of training required for coders and the number of coders thought appropriate for effective use of the system, as well as information concerning its validity and reliability.

In summarising some of the points raised above, it appears that selection of the best category system for the performance of content analysis is somewhat difficult, although critical for accurate understanding of the data

analysed by it. Goodman and Dooley (1976) suggested that six criteria should be observed when devising a category system: firstly, there should be a small set of criteria determining inclusion in a category, so that the system is parsimonious and comprehensible. Secondly, the units should be easily identifiable (preferably by laymen), hence not dependent on technical sophistication. Thirdly, categories should be as applicable to small units such as a sentence, as to larger units, such as an entire conversation. Fourthly, the system should be pan-theoretical, and include most of the important categories covered by other systems. Fifthly, the process rather than content should be emphasised, hence the system should be of use for a variety of purposes. Lastly, the system should have multi-setting applicability. It seems to me that this set of six criteria clearly and comprehensively defines the type of system which seems desirable for analysis of the data obtained in this thesis; hence these criteria, as well as the other points made above, should be borne in mind when considering the variety of classification systems on offer.

The next section of this chapter will examine a number of category systems which have been used for structuring the responses of participants in psychological therapy when such systems have relevance to the question of the helpful (and unhelpful) factors involved in therapy. It will also briefly outline the situations in which they have been applied, and consider their conceptual adequacy in the light of the discussion above.

4.2.3) Category systems used.

One of the first attempts to describe interactions in a systematic way was the analysis of group interactions by Bales (1950). Working within the classical model of content analysis, Bales drew a distinction between social/emotional and instrumental/adaptive aspects of interaction. Although usually applied in the analysis of social encounters, a number of clinical researchers

developed Bales' basic system into more sophisticated systems for use in understanding psychotherapeutic interaction involving individual patients, for example Sloane et al, (1975). However, in the analysis of group interactions, Corsini and Rosenburg in 1955 presented the first attempt to produce a taxonomy of curative mechanisms in therapy, which was later revised and extended by Berzon, Pious and Parson, (1963). Lieberman, Yalom and Miles (1975) produced a total of nine categories of critical incidents in therapy, such as group closeness, expression of feeling and identification. This was of course subsequently modified and extended by Yalom, as has been described above in chapter three. In 1979, Bloch, Reibstein, Crouch, Holroyd and Themen modified this modification to produce their list of ten therapeutic factors, including self-disclosure, installation of hope and catharsis. (See section 5.5.1 for a discussion of Bloch's work.) All of these systems work within the pragmatic mode of analysis, in that they rely on inference for the categorisation process.

Turning to the content analysis of helpful and unhelpful aspects of therapy in individual therapy, the literature is relatively sparse until the seventies. In 1956, Murray published a study in which he content analysed the utterances of seven pairs of therapists and patients, again within the classical mode of analysis. In 1957, Strupp outlined a multidimensional system for analysing techniques with five types of therapeutic activity and three intensity scales. Later in the same year he published one case study to illustrate its usage. In the sixties, Meyer, Borgatta and Fanshel (1964) analysed the case worker relationship in terms of six variables; and Strupp and Wallach (1965) analysed responses of fifty nine psychiatrists to a filmed consultation in terms of seven types of therapist statement, such as clarification and direct guidance. Also in 1965, Lorr presented a factor analysis of patients' responses to statements about therapists, which he suggested indicated five dimensions of therapeutic interaction, such as accepting and

critical/hostile.

From this fairly limited beginning, however, content analysis of psychological therapy research data then made enormous progress during the seventies and early eighties; in a review of the available literature on the topic, I managed to isolate fourteen different systems which had been used in a variety of different contexts, all devised within a few years of one another. Only those of direct relevance to the questions raised in this thesis, that is, the helpfulness of certain aspects of the therapeutic interaction, will be discussed in detail here. Two systems, restricted to unhelpful events only, will also not be included in this discussion.

In 1971, DiLoreto published a study which compared three different types of therapy: rational emotive therapy; client centered therapy, and systematic desensitisation, in terms of the therapeutic behaviour involved. The data used were tape recordings of therapy, and the measures obtained were employed to look at the frequency of use of specific techniques by the different therapeutic schools. There were eleven categories, including techniques such as reflection; questioning; free association; direct confrontation and interpretation. This system was criticised by a number of writers, including Boy (1971) who pointed out that the system (in the classical mode) was very confused and did not use mutually independent categories, although it claimed to do so. Although the inter-rater reliability was good (DiLoreto reported it as .831), Boy suggested that the raters were merely united in being confused. The system however seemed potentially useful, and it was later adapted and reduced to six categories (questioning; information seeking; reflection; reinforcement; interpretation; and "other") by Dole, DiTommasso and Young (1982). This study was of particular interest to the research carried out in this thesis, because the data used by Dole et al were retrospections by therapists concerning activities in therapy, using tape recordings of the therapy sessions. Therapist/patient

couplets were the units rated. However, it did not include the views of patients about the process, and the precise wording of the categories used was thought to be too broad for effective use. Hence this system was rejected as inappropriate for use in this study.

In 1978, Hawton and Bancroft produced a categorisation system (in the pragmatic mode of content analysis) for analysing recordings of the therapeutic behaviours of therapists dealing with suicidal patients. The system consisted of nine factors which they felt could reliably describe the essential features of the helping interaction. Responses were sorted according to a manual of the different helper behaviours, which included factors such as goal setting; interpretation; facilitation of emotion; and confrontation. A study by Hawton, Reibstein, Fieldsend and Whalley in 1982 illustrated its use. Although well constructed and apparently fairly comprehensive, the system was again devised only to describe therapist behaviour, and did not meet some of the criteria laid down by Goodman and Dooley, or by Russell and Stiles (see section 4.2.1). Hence it was not thought appropriate for use in the present research study.

Drawing on the work of Russell and Stiles, described above, as well as on the research into types of therapy sessions carried out by Orlinsky and Howard (1978) and Stiles (1980) as described in section 3.2.1, Stiles and Sultan (1979) tried to develop a taxonomy of verbal response modes which would be mutually exclusive and exhaustive. This consisted of the following eight responses: disclosure; questioning; edification; advisement; interpretation; confirmation; reflection; and acknowledgement. The scheme was designed to be of equal applicability to psychotherapy, medical interviews and other interpersonal interactions. Although a reasonably well constructed system, it was not used in this study because it is again not appropriate for use with patient responses.

Three other systems of interest should perhaps be mentioned which have been published recently, and which illustrate both the growing interest in the question of the value of particular therapeutic interactions, and the seeming inability of any one set of researchers to use and build upon the systems devised by any other. In 1978, Gottleib described a total of twenty six helper behaviours which he grouped into four main categories: emotionally sustaining behaviour; problem solving behaviour; indirect personal influence; and environmental action. This system was used in a study of the type of help that was reported by single parents to have been beneficial. However, the system has as yet received no external validation, and has not been widely used. Another attempt to classify therapeutic techniques was made by Rounsaville, Weissman and Prusoff (1981) who described eight main types of technique, which appear to relate very closely to some of the existing systems. Their list of techniques includes clarification; advice; insight development; and exploration. Both of these systems appear to function within the pragmatic content analysis mode. The third system recently devised was that by Frey and Raming (1979) who used 1400 representative processes and goal items from the works of fourteen major American therapists, which they subjected to content analysis by student raters. Seven "goal" clusters emerged, such as strengthened ego functioning, together with six process clusters, such as manipulation of the client's anxiety. This study has not been replicated or, as far as I am aware, used in any subsequent studies.

4.3) The Elliott system.

It was another attempt to compare different types of therapy which was the impetus for the content analysis system underlying the system used in this thesis. Goodman and Dooley (1976) devised a system which looked in detail at response modes, according to their six criteria as presented in section 4.2.1. This system consisted of six types of helper behaviour: advisement; acknowledgement;

reflection; interpretation; and questioning, and formed the conceptual basis for the research carried out by Elliott (1979). Elliott reviewed 150 descriptions of help-intended communications and developed six classes of perceived intentions: guiding; reassuring; communicating understanding; explaining; gathering information; and using self. This was also the system used by Caskey, Barker and Elliott (1984), who looked at therapist intentions; by Elliott, Barker, Caskey and Pisrang (1982) who looked at client, therapist and rater perceptions; and (with modifications) by Elliott and Feinstein (1981) who studied descriptions provided by clients and therapists of helpful and unhelpful behaviour. Details of this system will be given in section 4.3.1.

This proliferation of different schemes, many of which appear to have face validity and yet which differ in many details, suggests that there may be some confusion in the classification strategy employed; in other words some of the classifications may include both the underlying intentions of the subjects as well as their overt behaviours. Further, some of the systems are designed to apply to units of very different sizes, that is, some systems carry out content analysis on a report of a whole therapy session (for example, Orlinsky and Howard), others classify only therapist retrospections (for example, Dole et al).; yet others have looked at single therapist responses (for example, Frey and Raming). In an attempt to clarify at least some of these issues, Elliott and James (1982) pointed out that any helpful or unhelpful interaction could be understood as belonging to one of four possible classes of phenomenon; therapist intention; client intention; client state; and event type, all of which imply different levels of inference. Table 1 indicates those aspects of the interaction included by them in each of these classes of phenomena. Elliott suggested that some of the problems encountered by previous systems of content analysis for therapeutic interactions resulted from a failure to distinguish between these levels of analysis; for example they have confused intentions with

actions. (This is a criticism that can be made of the system devised by Hawton and Bancroft, for example.)

The situation was then clarified a little further by a common statement written jointly by a number of major researchers in the area. In a paper published in 1982, Elliott, Stiles, Shiffman, Barker, Burnstein and Goodman discussed the origins of content analysis as applied to therapeutic communications, and made the following important point: a distinction should be drawn between "content" (what the participants talked about); "action" (those events seen by linguists and philosophers as speech acts, but in psychological therapy as response modes); and "style" (what the participants intend to achieve by what they say). However, in my view, there are still difficulties remaining in this attempt to clarify the situation; namely that the terminology chosen, that is "actions" or speech acts, is itself confusing. This is because in the classic literature in psycholinguistics, for example Austin (1975), speech acts are seen to have within them both illocutionary aspects and perlocutionary aspects, that is, both an intention to do something, and also an impact. This confusion has some importance for the method chosen in this research, because of the specific focus of interest which was the views of both therapists and patients about the helpful (or therapeutic) factors in individual therapy, hence on the impact of certain events, not on what the actor intended to achieve. Section 5.7.3 discusses the way in which this question was resolved in the current research study.

As has been mentioned above, one of the characteristic features of this area of research is the tendency of each group of researchers to ignore previously designed content analysis systems, and to design their own anew. Although there may be advantages to this strategy in that the system designed is therefore tailor-made for the particular focus of the study, it has led to a proliferation of different findings which cannot easily be compared or even combined with each other. It was felt, therefore,

that in this study a category system which had at least some tradition of research behind it, should be employed. An additional point is of course that without an existing category system, an enormous amount of time must be spent in establishing the system before any conclusions can be drawn from its application. Interestingly, some time after completion of the empirical study carried out in this thesis, a paper was presented at the most recent international conference of the Society for Psychotherapy Research, which attempted to "translate" the coding systems of a number of individuals into the terms used by the others; called the "Rosetta Stone" study, this was a welcome (but for me belated) effort to reduce the confusion in the field, (Hill, Elliott, Stiles, Friedlander, Mahrer and Margison, 1984).

For the purposes of the current research study, what was wanted therefore was a content analysis system which would classify the responses of both therapists and patients according to the impact of certain events. As was indicated in section 2.4.5, the most appropriate available system was that part of the work of Elliott and his colleagues (1982), which concerned the impact of events. The next section will describe this system in detail.

4.3.1) Therapeutic Impact Content Analysis System: structural and formal characteristics.

As was indicated in section 2.4.5, and in the previous section of this chapter, Elliott and Feinstein published in 1981 a cluster analysis of responses which they reported to have been based on research into the sociolinguistic aspects of conversation, carried out by Goodman and Dooley (1976), and Labov and Fanshel (1977). They obtained, through Interpersonal Process Recall (as outlined in section 2.3.1), a large number of responses to questions about the experiences of subjects in an analogue therapy study. This material was sorted freely by raters into clusters which were then developed with modifications, into content categories, using the complete linkage

method of statistical analysis devised by Horowitz (1979).

Subsequent work using I.P.R. with patients validated some of these categories and not others. In 1982, as a section of the four-part content analysis described above in Table 1, the event type system was produced. As can be seen, there are four parts in Elliott's system, although the concern here is with the helpful and unhelpful event part only. Henceforth, therefore, only the event type part of the system will be considered. Further discussion of the content of the system is included in the next section of this chapter, 4.3.2.

First, however, the structural and formal characteristics of the system will be outlined, together with a discussion of its advantages over the systems reviewed above. Originally designed for use with retrospections, the system does not require tape recordings of sessions to provide the data for analysis, and can thus deal with data obtained through the less intrusive method of post-sessional interview or questionnaire. Although the retrospections originally used by Elliott were obtained through interviews, the procedure employed is adaptable enough to be of use in a variety of different settings, and with a number of different methods of data collection. Unlike many other systems, it is equally appropriate for use with either therapist or patient responses; hence it is possible to make direct comparisons between therapists' and patients' views. One additional point of no small importance in the choice of a system for content analysis is the fact that it has a very clearly designed manual and set of examples on which it is possible to train coders.

It has been suggested above that one important point that should be made in sorting out the multiplicity of studies which employ different categorising strategies, is the level of analysis used. The classification strategy operated by the event type system is pragmatic, in that any therapeutic event can only be understood in terms of the impact it has on the patient; hence the

categorisation process has to include inference. However, as will be made clear in chapter 6 below, this use of the event type system solely in the pragmatic mode, was not observed strictly in the analyses of all of the results, in that the assumption was not made in all of the analyses that frequency of response indicated importance of the event. Thus in some analyses a strategy more akin to the nonquantitative was used. Nevertheless, in the assigning of responses to categories, a pragmatic strategy was employed.

The other point made above by a number of psychological therapy researchers using content analysis was that it should be made clear at which level of analysis the content analysis is operative: content, response mode or intention. As has been discussed above, this content analysis system looks at impact, hence it falls into the response mode category; although as I have pointed out, I am uneasy about the implication of intention that this carries, which is specifically not of concern to the current research study. This point will be discussed further in section 5.7.3.

In concluding this section, it is perhaps important to note that Elliott's event type system meets the six requirements of a good content analysis system laid down by Goodman and Dooley. It is reasonably parsimonious, comprehensible by laymen and thus not requiring the coders to have extensive technical knowledge. It is equally applicable to units of different sizes and in different settings; it is free of excessive theoretical formulations or assumptions (as will be shown below); and it concerns process rather than specific content. For these reasons, and because of the other points made above, it was selected for use in this study.

4.3.2) Therapeutic Impact Content Analysis System: details of categories.

As indicated above, the system employs a total of thirteen categories, to which one was added for present

purposes: unclassifiable. The first eight are helpful events, the second five are unhelpful. Each of these categories will now be discussed in turn. The details of the system are as published in the Manual for raters on the Psychotherapy Events Content Analysis System; Event Type, by Elliott, James, Reimschuessel, Cislo and Sack, (1984), with only a few modifications. These modifications will be discussed in chapter 5 below.

A) Helpful Events

1) Personal Insight.

Personal Insight refers to the patient realising something about him or herself, which is new. The informant describes the patient gaining cognitive insight; the experience is one of discovery. (In subsequent editions of the events system, Elliott has renamed this category New Perspective, Elliott, 1983.) Examples of the type of event included in this category are: "The therapist started to help me to see things about myself in a new way"; and "the session made him realise that he had previously misperceived the intentions of his father".

2) Clarification of Problem.

Clarification of Problem refers to the patient's and therapist's tasks in therapy becoming clearer; thus the informant describes the patient arriving at a better understanding of the issues facing him or her, either in the therapy itself or in more general terms. Examples include: "What the therapist said allowed me to map out my hopes for therapy: my goals and plans"; and "We discussed the way in which all the problems intermingle and thus seem worse".

3) Awareness.

Awareness refers to the patient approaching uncomfortable experiences, that is, emotions such as guilt, sadness or a lack of self control. There is an increase in affective insight, so that previously warded-off experiences emerge into awareness. (Subsequent revision of this helpful events system has led to this category being re-titled

Focusing Attention.) To be included in this category, either or both of the following conditions must be satisfied: the patient must experience awareness of an increase of some uncomfortable emotion; or there must be reference to the experience being uncomfortable or previously avoided. Examples of awareness include: "She wanted to help me to bring out my feelings of grief, that I'd avoided before", and "He had been refusing to discuss the issue of how he felt about himself and I brought it out".

4) Problem Solution.

Here the category refers to progress being made towards a plan of action; the informant talks of some problem solving activity which has some practical import, such as specifying alternatives to a particular course of action, learning how best to cope with situations outside therapy, or solution development. (It is important to note that there is no specific implication that either the patient or the therapist is the problem solver.) Examples include: "I suggested a particular plan of action, and we discussed how feasible it was", and "The therapist outlined a way for me to control my nervousness".

5) Involvement.

Involvement consists of a strengthening of the working alliance, or the cognitive stimulation of the patient to engage in therapeutic work. Alliance strengthening refers to the increasing confidence on the part of the patient in the tasks of therapy or the ability of the therapist to help; patient stimulation refers to the patient's increasing willingness to participate in therapy, especially in revealing him or herself to the therapist. Examples include: "I got the ball rolling and she really started to think about where the therapy was going", and "She asked my opinion on progress which made me want to respond".

6) Understanding.

Understanding refers to the experience of the patient of being properly understood. This can occur in two ways: firstly the patient is described as having a very personal

experience of being understood regarding him or herself as a person; secondly the therapist's accuracy as a follower is noted, in terms of the therapist's ability to give feedback to the patient. Examples of understanding are: "I felt that what she said showed that she had really got the point of what I was trying to say", and "Somebody really understanding what she was experiencing".

7) Reassurance/Relief.

This category refers to the patient's experience of relief, reassurance and support. This can be either a positive feeling of being worth something and having self-confidence, or it can refer to the relief of being able to talk about feelings such as guilt. Examples include: "I felt more at ease after I had talked about the problem", and "She described a feeling of self confidence and optimism about her future after our discussion".

8) Personal Contact

Personal Contact refers to the experience of the patient that the therapist is a real person or fellow member of the human race. The therapist may be recognised as having faced similar issues as the patient. There are two ways in which personal contact may be experienced: firstly, the therapist is recognised in terms of positive personal characteristics such as honesty, personality or professional skill; or secondly, a sense of mutuality is expressed in terms of sharing, the patient not being alone, or the patient feeling closer to the therapist. Examples include: "The therapist made me feel that I wasn't the only one to have the problem; he knew what it was like too", and "I showed her my personal concern for her as a person".

B) <u>Unhelpful Events</u>.

(Note: this set of categories has subsequently been substantially reworked by Elliott; however the categories described below were the ones that were available when this research was carried out, hence they were the ones employed.)

9) Misdirection.

Misdirection refers to distraction from the tasks of therapy. The informant describes the patient as having been interrupted in exploration or focusing on a particular problem, or the therapist is seen as having jumped to topics which seem irrelevant and pointless to the patient. Examples are: "There was an interruption in what I wanted to say and the therapist kept dragging me back to discuss my work which I didn't think was at all relevant", and "I didn't seem able to point the discussion in the right direction".

10) Misperception.

This category refers to the therapist's inaccuracy, in which the therapist is seen as misunderstanding, not seeing the point, employing the wrong words or simply being inaccurate about what the patient is trying to communicate. Examples include: "I felt that maybe the therapist wasn't understanding what I was trying to say", and "I didn't feel that I got it right".

11) Disappointment.

This category refers to a sense that the help offered to the patient is inadequate. The patient becomes dissatisfied, critical of the therapist's interventions and expresses the feeling that no progress is being made. The informant reports that the patient has requested help and is not getting it. The patient feels hopeless and demoralised, and feels pessimistic about therapy. There are three types of disappointment: the therapist or patient may be demoralised; the patient may be critical; or expectations may be unmet. Examples are: "She wanted me to give her an answer to the problem which I refused to do", and "I felt that the therapist really didn't know what to suggest next".

12) Negative Therapist Reaction.

Negative Therapist Reaction refers to the therapist either withdrawing from the therapy or attacking. Firstly, the therapist may be described as uninvolved and inattentive;

secondly, the therapist may be seen as critically hostile or rejecting. Examples include "I'm afraid that I was bored", and "She was angry with me and obviously didn't approve of what I was trying to say".

13) Unhelpful Confrontation.
This category describes the patient as being confronted in an unproductive way; the discomfort is unhelpful. This feeling can result from a number of sources: firstly, the patient may be forced to confront unpleasant memories or thoughts without a sense of relief; secondly, the patient may experience pressure to take more responsibility than he or she is capable of; or thirdly, the therapist is seen as unwilling or unable to terminate an unpleasant activity in therapy. The essence of this category is that the confrontation, rather than increasing insight or relief, actually leads to an increase in defensiveness or emotional distance. Examples are: "The therapist made me discuss my relationship with my wife again. The whole thing upset me; it made me want to close down again", and "I put pressure on her to think about her future and I think that led her to become even more despairing than before".

C) Unclassifiable.
This fourteenth category is simply available for those events which cannot be classified in any of the above categories.

4.3.3) Therapeutic Impact Content Analysis System: recent developments.

Since I made the choice of this events system for use in this thesis, Elliott has further refined the system as indicated above. He has also posited the existence of "super-clusters" which subsume the above categories. The first supercluster (obtained through further cluster analysis) consists of New Perspective, Problem Solution, Clarification of Problem and Focusing Attention, and is labelled the "Task" supercluster. The second supercluster consists of Understanding, Client Involvement, Reassurance

and Personal Contact, and is labelled "Interpersonal". (In some ways it could be suggested that these superclusters parallel the task/social-emotional factors proposed by Bales.) As indicated above the unhelpful events system has been revised substantially and now consists of the following six types of event: Misperception, Negative Therapist Reaction, Unwanted Responsibility, Repetition, Misdirection and Unwanted Thoughts. It might be of interest to note that Elliott's current work concerns detailed analysis of events within particular categories such as the New Perspective or Personal Insight category, through I.P.R. (Elliott, 1983; Elliott, James, Shulman and Cline, 1983).

4.4) Methodology employed in the use of the content analysis system: differences from Elliott's methodology.

Like any other content analysis procedure, administration of the Elliott Helpful Events system requires that coders should make judgements concerning the category into which a given event should be placed. Prior to coding the experimental data, the coders have to be trained on sample items, until their reliability levels are adequate. For Elliotts's coders a prior task was to sort the data into the four aspects of the system referred to in Table 1. After this was carried out, coders were asked to make judgements about the event type system as follows:

"Event types correspond to types of significant impact on the client... i.e. ways in which clients can be positively or negatively affected by therapeutic interventions. Each of the following rating scales corresponds to a category or type of significant event found in previous research. The scales are more or less applicable to a given significant event. The scales are unipolar and non-mutually exclusive... All events should be rated on all scales, because negative and positive impacts are sometimes mixed." (from Elliott et al, 1982).

It will be noted that the coders were asked to code events on all scales, leading to a possibility that any

one event could be included in a wide range of categories. This of course leads to difficulties in any attempt to measure the reliability of the coding procedure, although Elliott reports that his raters attained a 71% agreement rate for helpful events and a 79% agreement rate for unhelpful events, (Elliott, 1983). As will be discussed in section 5.7.4, this problem of obtaining adequate reliability data was circumvented in the present research study by some modifications in the method. In addition, it should be noted that as a part of some subsequent sortings, Elliott's coders were asked to give a score to their confidence in the classification; this again was not the procedure followed in the current study.

The sorting described above established the categories which are now described as constituting the Therapeutic Impact Content Analysis system. There has been only very limited validation carried out using this system, and as yet, I have been unable to trace any research that has been published using it, apart of course from Elliott's own work. This is perhaps not very surprising since it was only published late in 1982. Elliott himself (personal communication) pointed out that further validation of his system is needed as it was developed using brief one-session therapy, and with a relatively small number of events. The next chapter discusses the application of this system in the current research, and explains the modifications in administration which were considered necessary.

Chapter Five

Questions Asked and Methods Used in the Empirical Study.

5.1) Introduction.

The previous chapter introduced the procedure of content analysis and outlined the reasons for the choice of the particular system to be used in the current study. In the second part of this chapter (sections 5.4 to 5.7), the details of the empirical study will be given, together with an account of the classification process. First, however, following on from the research discussed in previous chapters, there will be (in section 5.2) a statement of the questions to be considered in the current research study, and after this (in section 5.3), some further methodological points will be made concerning the particular focus of interest of the research.

5.2) Questions raised in this study.

It was argued in sections 1.8 and 3.4.2 that the pressing need in psychological therapy research at the present time is for the development of more adequate methods of data collection, and for a "discovery oriented approach" in therapy research, (cf. Elliott, 1983). The view was also reported in chapters 2 and 3 that our understanding of psychological therapy would not be further advanced by yet more theory-driven research, and the premature testing of hypotheses. It was therefore decided that in this research study the particular issues to be examined in detail would not be formulated in terms of particular hypotheses, but would instead be presented as a series of questions. These questions have already been referred to in earlier chapters, but will now be listed below in brief, (the section included after the end of each of the questions provides further detail on the issues raised). The first two questions concern the content analysis system used and methodology followed, and the subsequent seven questions concern the responses of

the subjects.

5.2.1) Research Questions.

1) Is the Elliott Therapeutic Impact Content Analysis system a reliable and valid measure for use with sessional data, as opposed to its use with more limited data collected using I.P.R.? (see section 4.4.)

2) Can an instructive, informative and valuable picture of therapeutic interaction be obtained through subjective session by session reports from participants? (see sections 2.6.1 and 3.5.)

3) What do therapists and patients see as having been the most helpful events occurring in a therapy session? and what do they see as the most unhelpful events? (see sections 2.7 and 3.5.)

4) Are there any differences between therapists' and patients' views regarding the most and least helpful events? (see section 2.7.)

5) How do the views of participants change over time? (see sections 2.7 and 3.5.)

6) What categories of event are seen by participants to have been more helpful than others, and which categories of events occurred during particularly helpful, and particularly unhelpful sessions? (see section 3.5.)

7) How do the views of participants on the types of events seen to be helpful, relate to outcome? (see section 2.7.)

8) How does the degree of concordance or dissonance between perceptions of participants relate to outcome? (see section 2.7.)

9) How do participants experience helpful factors such as "insight" or "reassurance"? (see section 3.5.)

These, then, are the main questions raised by this research study. Some tentative answers are given in chapters 6 and 7. Now, however, there will be some further consideration of some important methodological issues.

5.3) Methodological Issues.

5.3.1) Choice of unit for study.

The questions to be considered by this research concern the helpfulness of certain aspects of the therapeutic process from the viewpoint of the participants in therapy. One choice that has to be made immediately when contemplating a study of therapeutic interaction concerns that portion of the interaction that should be investigated. Clearly, the smaller the unit studied, the more detailed can be the analysis, and the more that the researcher can control the variance occurring in the interaction. Numerous studies in the past, usually concerned with minute aspects of the interaction such as body posture, use of particular words and so on, have used a sampling method by which segments of interaction are subjected to detailed examination, and are presumed to be representative of the whole. However, if the focus of attention is the helpfulness of the overall interaction, then such a sampling procedure is not appropriate. Any given session of therapy, typically lasting up to fifty five minutes long, usually consists of a large number of events, some of which may be helpful, others of which may be unhelpful and yet others of which may be neutral in that they have no particular effect as far as can be detected. Thus an investigation of the helpfulness of therapy cannot reasonably focus on a very short period of interaction, since nothing of particular import may occur during that selected period. Rogers (1967) reported that "experiencing" does not occur in a monotonic fashion, but peaks at different points in therapy; if the researcher is interested in this variable it is clearly inappropriate to sample sessions at random from throughout the therapy. In addition, Mintz and Luborsky pointed out that "broad

dimensions of therapist relationship qualities may be the one major aspect of therapy interaction for which brief segments are not appropriate substitutes for whole sessions... session based descriptions are more integrally tied to the interactional character of psychotherapy" (Mintz and Luborsky, 1971, p.189). Similarly, Bachrach, Curts, Escoll, Graff, Huxster, Ottenburg and Pulver (1981) suggested that "brief segments cannot be naively substituted for the study of the psychotherapeutic process" (p.32). This is particularly true if the point of interest is an event that by definition does not happen regularly; as Elliott (1983) has pointed out, significant events occur only rarely; (it has been suggested that there are on average about two or three significant events per session, Elliott, James, Shulman and Cline, 1981), so that a studying only a segment of therapy would not be appropriate.

Selection of the appropriate focus for study also involves deciding whether whole sessions are looked at in isolation or whether a series should be considered in total. Although it may lead to a loss of precision and detail, looking at the interaction in an integrated way may allow insight into the development of therapeutic impact; as Horn-George and Anchor point out: "the linking of process variables to outcome... have (in the past) looked at too small or isolated an aspect of the therapy process" (p.484). Others (for example Luborsky, Mintz, Auerbach, Christoph, Bachrach, Todd, Johnson, Cohen and O'Brien, 1980) have concluded that psychotherapy is essentially unpredictable so that an entire series of sessions is needed to understand the impact of the whole process. As many therapists know from experience, it is possible for a number of apparently profitless sessions to occur before anything of major impact occurs; hence selecting a few sessions only might not pick up events which are crucial. Orlinsky and Howard point out that: "sometimes after a prolonged period of "getting nowhere", the patient shows some dramatic improvement that may seem, in retrospect, to be the cumulative effect of these long and

"pointless" sessions." (1968, p.131).

As a consequence, it was decided that the focus of this study was to be the entire course of therapy sessions from beginning to end, and within those sessions, the units of analysis were to be the few significant events that participants might decide to have had the most impact. Further, it was decided that patients and therapists should have the opportunity to specify, of all the helpful events which may occur in therapy, which was of the greatest importance. This would allow for the fact that some sessions might indeed consist of nothing of particular importance, whereas others might contain a number of extremely helpful events.

5.3.2) Choice of subjects for study.

An additional point that must be considered before undertaking a study of therapeutic interaction is whether the research should concern only certain types of patients with certain types of therapists holding particular theoretical orientations, or whether the sample should be heterogeneous. In many ways it is desirable for subject populations to be as homogeneous as possible because this is more likely to produce unequivocal results; the "uniformity myths" against which Kiesler warned psychological therapy researchers can lead to meaningless results because individual differences or particular group characteristics may be swamped. On the other hand, it is sometimes difficult to obtain large enough samples of specific groups of patients or therapists who are willing to participate in fairly time-consuming research, so that the researcher has to accept a sample which is less specific than might be desired. Auerbach and Luborsky, for example, defended their use of a heterogeneous sample as follows: "To a certain extent we had to take what data we could get, and we were pleased to get it because it is not normal for private practitioners to let outsiders into the privacy of their therapy sessions." (1968, p.156).

Certainly in the current research study, I had to be aware not only of the question of the representative nature of my sample, but also of the pragmatic considerations of obtaining adequate research data, in what was clearly to be a moderately taxing research study. In addition, as will be seen, one of my major concerns was to try to understand the experience of patients who were not "special" in any way; I wanted to involve patients who had not been selected or given any form of treatment which was different from that which might have been offered if they had not been research subjects. Therefore no very careful sampling procedure was carried out, largely because of practical constraints. Erikson has remarked that "sampling is the strategy of persons who work with vast universes of data; it is the strategy of plenty." (Erikson, 1973, p.15). Therapists and patients who are willing to co-operate with research procedures such as were involved in this study, do not, unfortunately, constitute a "vast universe".

A further question concerns the theoretical orientation of the therapy that was to be studied. For the a variety of reasons noted above (some pragmatic and some based on a concern to study a "normal" therapy population), it was felt that an unselected population of therapies should be sampled. In addition, the evidence that there is little to distinguish outcome between the different types of therapy (as noted in chapter 1), together with the prevalence of eclecticism calls into question many research strategies which place a great deal of emphasis on the theoretical "purity" of their samples. Nevertheless, this lack of selectivity of the types of therapy involved must be borne in mind in the interpretation of the the results.

5.3.3) Choice of method.

Another choice that has to be made in researching psychotherapy process concerns the balance between research and clinical interests. Some studies have been

carried out in which the balance is clearly weighted in favour of the former, such that patients are subjected to artificially produced waiting list delays, manipulation of therapeutic responses, lengthy post-sessional questionnaires or interviews, invasive monitoring of autonomic responses and so on. It was my concern in this research project to minimise the disruption to the patient in becoming a part of the research process. This was for two main reasons: scientific and ethical. Firstly it seemed to me that it was not justified to expect patients (who very rarely refuse requests from "authority") to accept complications or anxieties in addition to their involvement in therapy, for example by tape recording sessions, if other research methods could be found which would provide interesting answers to the questions concerning me. Secondly, as stated above, I was eager to study psychological therapy as far as possible, just as it occurred, in an unselected population, which was in no way "special" and whose therapy sessions would be as far as possible typical of patients receiving psychological therapy in the National Health Service in the U.K.. Hence I wanted to use a research method which would not involve therapists or patients in doing anything which was substantially different from that which they would normally have done.

5.3.4) Use of accounts.

One last but fairly substantial point needs to be made concerning the research methodology, before precise details are given. This was that although one of the main points of interest of the study was the types of event that patients and therapists found helpful and unhelpful, I was also curious about the development of the therapeutic interaction as a whole. Hence some of the findings should be of interest as they reveal the development of the therapeutic relationship, which is an aspect of the process that is not easily grasped by content analysis alone, when carried out in the manner outlined in chapter 4. Working from within a phenomenological perspective,

Snyder (1982) has suggested that psychotherapeutic "mood" is a more appropriate way of trying to understand therapeutic interactions than any questionnaire study concerning techniques. Mood, he writes, is "concerned with a relationship between two individuals" and represents a changing interactive process which is based on the therapist's skill and knowledge. Orlinsky and Howard (1968) emphasise the centrality of communication in therapy and suggest that "the therapist's sense of communication rapport is a more reliable clue to the patient's sense of movement or progress than is the therapist's reflective judgement of therapeutic progress" (p.135). If communication is a central aspect of therapeutic interaction (as of course it must be) it is probably best understood in context. Therefore it was felt that at least some of the emphasis of this research should be on the full-length reports produced by therapy participants of their therapeutic experience. The use of case studies has of course a long and distinguished history in the development of theory and practice of therapy; but is usually presented only from the therapists' or observers' viewpoint. In the current research study, as in the recent paper by Hill, Carter, and O'Farrell (1983), the patient also gets a chance to speak.

The question of how to make use of these full length reports then becomes relevant. The place of personal documents in research has declined in the last fifty years; as Wrightsman (1981) has pointed out, the classical text by Allport (1942) has not really been superceded, probably because the notion that peoples' perceptions of their experiences might be of some value, has had so little credibility. However, there has always been a very thin trickle of research using personal documents which has in recent years developed into a healthy stream, through a number of innovations in methodology, such as ethogenics and account analysis, (for example Harre and Secord, 1972; Smith, 1978; Brown and Sime, 1980). A recent publication by Plummer (1983) suggests that some social scientists are beginning to turn back again to

personal documents as a source of extremely interesting data; Plummer's book contains details of research strategies and methods of data analysis to be employed, as well as considering questions such as reliability, representativeness and so on. In a study of personality development using biographical data, Howe (1981) describes his answer to the question frequently put to him by dubious colleagues: "How are you going to use the information that you get?" as follows: "as intelligently as I can". In order to understand development, he suggests, "we shall have to ask questions, and direct empirical enquiries, that draw upon a deeper and more detailed conceptual understanding than is presently available", (Howe, 1981, p.41).

In this research study a good deal of the interesting information is to be found not in the statistical processing of data, but in the understanding that can be derived from an thoughtful reading of the accounts provided by therapists and patients of their therapy experiences. The way in which these accounts will be analysed is, following Howe, as intelligently as possible. Myers (1972) once pointed out that in research we must "use our brains as well as our F-ratios to draw inferences" (Myers, 1972, quoted in Gurman, 1983, p.169). Chapter 7 consists of annotated personal accounts which rely on an attempt to comprehend rather than quantify.

5.4) Methods used.

This section will describe in detail the methods used in data collection. There were a number of different stages of data collection, as indicated below:

1) Selection of subjects, a) therapists; b) patients.
2) Preliminary information gathering from subjects.
3) Session by session data gathering from subjects.
4) End of therapy data gathering from subjects.

There will also be a discussion of the materials used.

5.4.1) Selection of subjects.

a) Therapists.

As many therapists as possible were recruited into the study. They were all known personally to the researcher, who approached each therapist individually to ask them to participate in the research. Approximately two thirds of those approached agreed to participate; those who refused generally gave a lack of time as the reason for not participating. Other reasons included a lack of suitable patients, an impending job change and organisational difficulties. Therapists were given an Instructions Sheet (see Appendix 1b), together with copies of letters to be sent, if the therapist thought this to be appropriate, to the Consultant or G.P. responsible for the medical care of each patient to be included in the study. Therapists were drawn from a mixture of different professional groupings, notably clinical psychologists, nurse therapists and psychiatrists. They worked in a number of different settings, including G.P.s' surgeries, psychotherapy clinics, out-patient clinics, and psychiatric hospitals. All of the therapists were employed by the National Health Service, and worked in the North and Midlands of England.
Full details are given in the Results section, (6.2.1).

b) Patients.

Therapists were asked to select patients according to the following criteria:
i) The patient was aged between 15 and 60;
ii) The therapy was expected to last for at least six sessions. (However, in practice, subjects were included in the study if at least four sessions took place, and in one case, only three sessions took place before data collection was terminated. It is perhaps worth noting at this point that Barrett-Lennard, quoted by Gurman, 1977, suggested that, in psychological therapy process research, a minimum of five sessions was needed before a basis for a relationship could be established so that meaningful data

could be obtained; and in addition, Garfield (1980) and Auerbach, Greenberg and Howard (1984) have reported the rather surprising finding that that the mean number of sessions in clinical practice is only six. Hence four sessions was considered in practice acceptable for inclusion in the study).

iii) There were no obviously organic features relating specifically to the patient's difficulties;

iv) The distress experienced by the patient fell within the broad category of "neurotic"; ie., phobias, sexual difficulties, depression, interpersonal problems, and the like;

v) The patient was thought to be able to follow instructions without too much difficulty, and would be co-operative.

The therapist was asked to consider the next three patients accepted for treatment, for inclusion in the study. Three was the total chosen as the optimum number of patients for any one therapist to have in the study, for two reasons: firstly, any less than three would have greatly diminished the number of participants in the study because of a lack of available therapists (but not of patients); and secondly, any more than three could have lead to an imbalanced set of results in which certain therapists were over-represented. It was felt that three patients from any one therapist would be unlikely to distort the results in any major way.

Having selected the patient, the therapist was then asked to outline the study and request that he or she join the research. The patient was given a copy of the Patient Instruction Sheet (see Appendix 1a) and was told that he or she had every right to refuse without prejudice to the course of therapy. If the patient declined, the therapist was to ask the next patient, and if this one refused or was unsuitable, to ask the next one until a maximum of three was reached. It was stressed to the therapists that they should include patients without regard to the likely outcome of the treatment, and that they should endeavour

to use the therapeutic methods that they thought appropriate to the case. Further it was stressed to both participants that they could discontinue participation in the study if at any time they felt that it was interfering in the course of therapy. (In the event only one subject requested that he might discontinue the research, the reason for this being that he joined a group that was being led by the researcher in another capacity.) Therapists were also asked to include another patient in the study if one dropped out before enough data had been obtained. They were asked to do this until a total of three patients had been obtained, or until the researcher requested them to stop.

5.4.2) Collection of preliminary information from subjects.

Therapists were asked to complete the Therapy Information Sheet on every patient to be included in the study. This sheet consisted of three parts: firstly, details of the therapist, (nature of training, theoretical orientation, years of experience and so on); secondly, details of the patient, (age, sex, social class, diagnosis, seriousness of complaint and the like); and thirdly, details of the therapy to be undertaken, (likely duration, therapist's expectations of success, theoretical approach to be used and so on). This sheet was completed immediately after the first interview, when the patient had agreed to participate in the study, and was then returned to the researcher.

Patients were also asked to complete the Patient Information Sheet after the first session. There were four questions on this sheet, requesting the patient's view of the problem, the likely duration of therapy, hopefulness, and so on. This sheet was to be handed to the therapist in a sealed envelope, addressed to the researcher, at the start of the next session. It was made clear to the patient that their therapist would not see their responses at any time. Both Information Sheets may be found in

Appendix 2.

5.4.3) Session by session data.

After each therapy session both participants were asked to complete the Helpful Aspects of Therapy (H.A.T.) questionnaire, independently of each other. Patients were asked to seal their completed questionnaires in envelopes addressed to the researcher, and either give them to their therapist at the start of the following session, or give them to a secretary, receptionist, or other neutral person. (In a number of cases, patients chose to send them by post to the researcher.) Therapists were simply asked to return the completed forms to the researcher, at some convenient time. Examples of both H.A.T. questionnaires can be found in Appendix 3. The two forms were essentially similar, with a variation in wording according to the intended recipient. Five main questions were asked, as follows:

1) Of the events which occurred in this session, which one do\ you feel was the most helpful for you/for this patient? It might have been something you said or did, or something the therapist/the patient said or did. Can you say why it was helpful?

2) How helpful was this particular event? Mark this on a scale where 1 is very helpful and 3 is neither helpful nor unhelpful.

3) Can you rate how helpful the session was overall? (Note: a five point scale was provided, with a range from 1 as very helpful to 5 as very unhelpful.)

4) Did anything else of particular importance happen during this session? Include anything else which may have been helpful or anything which might have been unhelpful.

5) Has anything particularly important happened in your life/your patient's life since the last session? (Note:

The data obtained in answer to this question has not been analysed or used as part of this thesis.)

In addition, the therapist was asked to provide a little more information concerning the nature of the treatment and the attendance of the patient.

Session by session data were collected until the therapy was terminated, or until six months of therapy was completed. Six months as a cut-off point was chosen for two reasons; firstly, pragmatic, in that it was hoped to complete the research within a reasonable period of time; and secondly, clinical, as evidence suggests that much of the therapeutic progress that will occur has taken place within this time (Malan, 1976; Frank, 1979).

5.4.4) End of therapy data collected from participants.

At the end of therapy, both therapists and patients were requested to complete two additional questionnaires. The first concerned the views of the informant on the progress of the patient, satisfaction with treatment and so on. The therapist was also asked to give information about the nature of the termination of treatment, and to describe the theoretical orientation actually used in the treatment. Both participants were then asked to think back over their period of time spent in therapy, and to write down again the aspects of therapy that seemed to have been most helpful, in retrospect. They were also asked to list any aspects that may have been unhelpful. Examples of these questionnaires may be found in Appendix 4.

The second was a copy of the Llewelyn and Hume Helpfulness of Therapy Questionnaire, (Llewelyn and Hume, 1979). This eighteen item questionnaire asks the respondent to indicate whether various events (such as relaxation, mutual respect, discussion of the therapist's feelings etc.) occurred during therapy, and if so, to rate their helpfulness on a five point scale. In the event,

the results of this part of the study were not used, and will not therefore be reported in this thesis.

Therapists were asked simply to return these questionnaires to the researcher, and patients were given a stamped addressed envelope to send the completed forms back to the researcher. If the patient had failed to do so within a month, a reminder letter was sent to the patient, and if necessary, another stamped addressed envelope was provided.

5.5) Notes on the materials used.

In this section there will be a discussion of the materials used in the study.

5.5.1) The Helpful Aspects of Therapy Questionnaire (patients and therapists).

The H.A.T. was designed specifically to elicit the view of the respondent on the helpful aspects of the therapy session just completed. It was decided not to use the word "important" as was used by Bloch, Reibstein, Crouch, Holroyd and Themen (1979) in their study of therapeutic factors in group psychotherapy, as the emphasis here was intended to be on helpfulness, and it was thought that the word "important" could be taken by a respondent to mean a number of other qualities such as "emotionally difficult" or "theoretically significant", for example. Apart from this, the precise details of the wording is similar to that used by Bloch et al, who report that their questionnaire was based on the work of Berzon, Pious and Parson, (1963). Following the comments of Hawton, Reibstein, Fieldsend and Whalley (1982), it was decided to add a rating scale to the H.A.T. so that it would be possible to locate events that were seen as being particularly helpful, and sessions that stood out as being especially helpful in comparison with others, which were only fairly helpful. The questions relating to other events in the patients' lives were included in an attempt to take account of significant life events occurring concurrently

with therapy; in the event however this question proved to be too global to be of use, and as was noted before, the data obtained was not subsequently analysed.

It was decided to ask the participants to complete the H.A.T. on a session by session basis for a number of reasons, some of which have been noted above in section 5.3.1. As Caskey, Barker and Elliott (1984) have suggested, significant events are by their very nature rare, so that taking measures of anything less than a whole session runs the risk of inflating fairly run-of-the-mill interactions to being of therapeutic significance, when in fact nothing of particular importance was happening; or worse, missing the crucially significant events. In addition, it was decided that in this study reports from each session should be studied, rather than every third session, as has been done by Bloch et al 1979, and Lietaer, 1983. This frequency was chosen for a variety of reasons, including as mentioned above the risk of omitting significantly helpful events because of poor recall; also because of the need to gain a more comprehensive picture of the therapeutic interaction than might be possible from a more fragmented set of data.

5.5.2) The End of Therapy Questionnaires.

The questionnaire sent to participants upon completion of their therapy consisted of a number of questions about the experience of therapy in retrospect. It was hoped to get some measure of the success or otherwise of the therapy, but in a very limited study such as this one it was difficult to obtain data on outcome that was adequate. There are a number of reasons for this. Firstly, it is notoriously difficult to establish a criteria for outcome, (Imber, 1975), without an extremely comprehensive study of the effects of the therapeutic process on a variety of forms of functioning and as seen from a variety of perspectives. A number of studies, for example Green, Gleser, Stone and Seifert (1975), and Cartwright, Kirtner and Fiske (1963), have suggested that there is no

relationship between a variety of measures of outcome. Secondly the meaning of "success" is debatable, and really only makes sense as part of an analysis of the particular social and personal context within which it is assessed. Thirdly, it is perhaps only legitimate to estimate the success of a process such as psychological therapy after the elapsing of a considerable period of time, although this, too, is debatable. Fourthly, it is especially difficult to obtain an "objective" estimate of outcome if the source of information is the participants in the therapy; obviously they may have particularly strongly held views on the success or otherwise of the experience, for a variety of reasons. In particular it is often felt that it is inappropriate to include the patients' view of outcome, as the patient is assumed to be an especially unreliable source. (Some of these points have already been dealt with in section 2.2.)

Having said all of this, however, it must of course be recognised that both therapists and patients do make judgements about their progress, and that this judgement has an immediate effect; that is, the patient may be discharged having been seen by himself or herself, or the therapist, as having improved; alternatively the therapy may be discontinued, either because the patient fails to turn up, or because the therapist decides there is no point in continuing. In addition, some studies have shown that the judgement of others who are presumed to be more "objective" may, in fact, be no better than the judgement of patients; this is the implication of the review by Parloff, Waskow and Wolfe (1979). Further, it was felt that a measure of the subjective feelings of the patient and therapist on the outcome of the therapy would be an additional source of evidence concerning the experience of the two within the therapy, and it would allow at least a tentative answer concerning the relationship between outcome and helpful events, raised in questions seven and eight, in section 5.2.

For these reasons, it was felt that a subjective measure of outcome would be included in the questionnaire given to participants at the end of therapy. Imber (1975) recommends that if a self-report is to be used, the most appropriate measure is the C.P.Q., a very straightforward set of questions concerning the respondent's opinion on the outcome of therapy. This was also used by Cartwright, Kirtner and Fiske (1963) in the Method Factors study, as well as the study by Strupp, Wallach and Wogan (1964), both of which have been cited above. This was therefore the measure included in the questionnaires. The inclusion of this measure within the End of Therapy measures is not intended to imply that it is an adequate way of measuring the complex question of outcome; it is seen simply as an indication of subjective experience. As Lipkin (1948) pointed out, it is after all the patient's views that we accept when he or she comes for help; it seems reasonable therefore that we should accept at least to a degree his or her estimation of outcome.

The other questions within this End of Therapy questionnaire concerned a number of factual matters, and also a repeat of the H.A.T., but this time applying the questions to the whole of the period of time spent in therapy rather than just one session. In this last questionnaire the respondent was asked to indicate the most helpful aspects of therapy and any aspects that may have been unhelpful, with benefit of hindsight. In each case plenty of space was provided for answers. This questionnaire was included in order to try and obtain an overview of the treatment which might be a little more comprehensive than that obtained on the session by session forms, and also to allow an examination of any changes that might occur over time in the views of participants concerning helpful events, as indicated in section 5.2, question five, above.

5.6) Empirical Procedure Followed.

The above procedure was followed for a period of approximately fourteen months. By this time forty subject

pairs had been completed, with partial data being available on an additional fourteen subjects who dropped out, or who failed to stay in therapy. The researcher played an active part in encouraging subjects to complete questionnaires, including writing letters to eight patients, and having regular telephone contact with all of the therapists.

5.7) Content Analysis: Procedure.

Chapter 4 described the Therapeutic Impact Content Analysis system used in the current research; this section describes its implementation.

5.7.1) Preparation of data for analysis.

All of the reports of sessions provided by therapy participants were typed onto separate index cards, omitting identifying material. Each set of cards from both therapist and patient was paired, although sorted separately. Both /the participants' descriptions of the problem for which the patient entered therapy were also typed onto cards, and were placed at the beginning of the series of sessional reports. The end of therapy helpful and unhelpful factors were also added, on separate cards, to the series for each participant. The entire series of sessions was therefore presented for each participant, so that the analysis of each event could occur in context. (The decision to present each event in its sequence was based on the suggestion by Caskey, Barker and Elliott (1984) that it was found to be difficult to code the impact of events in isolation. This was confirmed by the coders in the present study.)

In summary, then, for each patient there were two sets of cards: the therapist's account and the patient's account, each card being presented in sequence. On each card (excluding the first and last cards), the most helpful event was typed, as was any other important event. The last cards presented the most helpful and most unhelpful factors as seen in retrospect.

In addition, coding sheets were prepared for coders (an example can be seen in Appendix 5) on which they could record both the dominant and the subsidiary category into which each event was sorted. In section 4.4 there was a brief discussion of the rationale for this modification of the sorting procedure, which was carried out in order to simplify the process of examining the reliability of the content analysis system. It was decided to allow the coders to use both a dominant and subsidiary category for their initial coding of the events because multiple classifications (as used by Elliott) were not allowed; the provision of two categories recognised the complex nature of the task that was to be carried out by the coders, (although the scoring system meant that only one of the categories was chosen for analysis). These sheets were also used for recording the consensus decisions that were reached, for events for which there was no immediate agreement, (see section 5.7.3).

5.7.2) Coders.

Two coders were employed in the content analysis, both were friends of the researcher and had some knowledge of psychological therapy; one as a social psychologist and the other as a psychotherapy trainee in private practice, who had had no formal qualification in psychology. Initial training in the Therapeutic Impact system took approximately six hours, and continued until reasonable agreement between coders was established. The coders then worked separately, although repeated discussion took place between the coders over the period during which coding took place, in order to ensure that both were interpreting the category system in the same way, and in the way intended by the system. The coding process occurred over a period of five months with repeated meetings between the coders and the researcher, and probably occupied a total of well over one hundred hours.

Before starting the coding procedure, the research was outlined to the coders, and they were given an adapted

version of the Therapeutic Impact system (as can be seen in Appendix 6) together with an Instruction Sheet. This was based on the instructions given to raters in the content analyses described by Hawton et al (1982) and Bloch and Reibstein (1980), and can be seen in Appendix 7. A set of examples was provided by which the coders were trained; a copy of this can be seen in Appendix 8. After training, the two coders were asked to work independently of each other, and indeed often carried out the coding procedure in their own homes.

5.7.3) Instructions given.

The main points made in the Instruction Sheet were as follows:

1) Coding data requires concentration as well as persistence. Do not continue coding for long periods without a rest.

2) Re-read the manual frequently to refresh your memory of the categories.

3) Read the manual and work through the practice cards of sample items.

4) Each set of cards represents the views of participants in therapy regarding the helpful events in therapy. Read through the entire set of cards so that you get a grasp of the entire course of therapy.

5) Starting with card 1, work your way through the entire set of cards placing them in categories according to the manual.

The problems raised in the discussion concerning the distinction drawn between intention, content and impact, in section 4.2.2, was resolved by the very detailed instructions which were given to coders, concerning the way in which they should interpret the reports from the therapy participants. In order to ensure that impact was the focus of the analysis, the point was reiterated by the following important points made to the coders, both in the Instruction sheet and during training.

6) Your task is to pick out from the material provided by the informant, the event found to be helpful/unhelpful. You should treat each answer as a description of the event and its impact on the patient.
7) Do not code the intentions of participants as events, unless it is clear that the intended event actually occurred.
8) Do not confuse the content of an event with its impact; be sure to categorise it in terms of its impact.
9) Any response on the cards may be taken to refer to an impact on the patient, i.e., you may assume that the answer is a report of an impact even if the informant *does* not explicitly say so.
10) If the respondent makes an explicit distinction between impact and/or intention or content, then always code in terms of impact.
11) Some reports include accounts of the patient's behaviour subsequent to the most helpful event discussed. These should be treated as substantiating the *impact of* the reported helpful event.
12) If there is more than one way in which the event can be categorised, then choose the dominant category but note the other on the coding form.

On the Instruction Sheet, the coders were given examples of all of the above points so that the distinctions being drawn were clear.

In practice, both of the coders sorted the therapist reports and the patient reports from one particular dyad, before moving on to the next. They did so in random order.

5.7.4) Resolution of disputed category sortings.

When the categorisation was completed by each of the coders, the researcher identified all of the events on which there was no agreement. For an event to be placed into any given category, both of the coders had to have placed it into that category either as the dominant category, or with one of the coders (but only one) noting it as a subsidiary category. If both coders agreed on the

subsidiary category and disagreed on the dominant category, then this was taken as a disagreement. The coders were then re-presented with the events in which the disputed events occurred and asked to reach a consensus concerning the categorisation. This process of reaching consensus of rating through debate was carried out in line with the "legalistic" model of research proposed by Levine, 1974, (as described by Hill, Carter and O'Farrell, 1983). In practice, the time taken by this discussion varied between a few seconds when one of the coders recognised that a simple mistake had been made, and thirty minutes, when coders identified a particularly difficult semantic problem, which could not easily be resolved. Each decision was reached by consensus, rather than either coder having more weight in the process.

5.7.5) Categorised data: summary.

The output of the content analysis was a series of classification scores for each session of therapy, on which the coders had either agreed immediately or on which they reached a consensus. There were a maximum of two events provided by each participant for each session, one of which was the most helpful event and the other of which was any other important factor. The End of Therapy data also provided a series of classification scores; up to six helpful and six unhelpful events were classified per participant.

The next chapter gives the results of the content analysis, together with details of the reliability of the content analysis procedure. It also presents an examination of the relationship between the results of the content analysis and a variety of additional measures, in order to try to answer the questions raised in section 5.2. The fuller, more comprehensive method of account analysis is given in chapter 7.

Chapter Six

Results, Part One: Empirical Data and Statistical Analyses.

6.1) Introduction.

The results of the empirical study carried out in this research study will be given in two parts. Chapter 6 will give full demographic details of the subjects of the study, and will report on the results of the content analysis, and the questions examined by it. Chapter 7 will give more detailed accounts of the therapeutic interactions, through four selected case studies. What follows in this chapter, therefore, is firstly the description of the sample; secondly a report of the content analysis procedure and data concerning its reliability; thirdly, a presentation of the results of the content analysis; and fourthly, a detailed presentation of the statistical analyses carried out on the data and the results of those analyses.

6.2) Sample Description.

As reported in chapter 5, there were a total of forty completed therapist-patient pairs on whom data was available. In addition, fourteen patients (from henceforth called "dropouts") failed to provide adequate data, either because they never commenced therapy, or else because they withdrew from therapy or participation in the research before adequate data was collected. Table 2 gives full details of the sample of forty completed pairs as well as details of the dropouts.

6.2.1) Therapists.

As can be seen in part 1 of Table 2, two thirds of the sample of therapists were male; just over two thirds (72.5%) of the therapists were clinical psychologists, and the training received by just under two thirds (60%) was eclectic in orientation. The vast majority of therapists

TABLE 2: Demographic Details of Subjects.

PART ONE Variable	Frequencies of all Subjects		A Completers N=40		B Dropouts N=14	
			%	N	%	N
1. Sex of therapist	(female)	1	32.5	13	64.3	9
	(male)	2	67.5	27	35.7	5
2. Nature of training of therapist	(clin. psych.)	1	72.5	29	85.7	12
	(nurse)	2	20	8	7.1	1
	(psychiatrist)	4	7.5	3	7.1	1
3. Degree of therapist	(MSc)	1	65	26	85.7	12
	(SRN)	2	5	2	7.1	1
	(M.R.C.Psych)	4	7.5	3	7.1	1
	(PhD)	5	7.5	3	-	-
	(Nurse Therapist)	6	15	6	-	-
4. Theoretical orientation of training	(Psychoanalytic)	1	10	4	-	-
	(Behavioural)	2	30	12	50	7
	(Eclectic)	7	60	24	50	7
5. Years of therapist experience	(1-2 yrs)	1	15	6	14.3	2
	(3-6 yrs)	2	35	14	64.3	9
	(7-12yrs)	3	32.5	13	14.3	2
	(more than 12)	4	12.5	5	7.1	1
	(missing)	5	5	2	-	-
6. Theoretical orientation	(Psychoanalytic)	1	15	6	7.1	1
	(Behavioural)	2	10	4	7.1	1
	(Client centred)	3	2.5	1	-	-
	(TA)	4	7.5	3	-	-
	(Kellian)	6	5.0	2	-	-
	(Eclectic)	7	60.0	24	85.7	12

PART TWO

7. Patient's age	(15-20)	1	7.5	3	14.3	2
	(21-25)	2	12.5	5	14.3	2
	(26-35)	3	35.0	14	35.7	5
	(36-45)	4	25.0	16	21.4	3
	(46-60)	5	17.5	7	7.1	1
	(missing)	0	2.5	1	7.1	1
8. Sex of patient	(F)	1	67.5	27	63.3	9
	(M)	2	32.5	13	35.7	5
9. Marital status of patient	(single)	1	42.5	17	42.9	6
	(married)	2	50.0	20	50.0	7
	(separated)	3	2.5	1	-	-
	(widowed)	4	5.0	2	7.1	1
10. Patient's social class	(middle class)	1	47.5	19	35.7	5
	(lower class)	2	50.0	20	57.1	8
	(missing)	7	2.5	2	7.1	1
11. Previous therapy	(yes)	1	17.5	7	14.3	2
	(no)	2	82.5	33	78.6	11
		7	-	-	7.1	1
12. Problem category	(anxiety)	1	27.5	11	7.1	1
	(depression)	2	5.0	2	7.1	1
	(phobic problems)	3	10.0	4	-	-
	(sexual problems)	4	5.0	2	7.1	1
	(personality ")	5	7.5	3	14.3	2
	(obsessional ")	6	7.5	3	7.1	1
	(relationship")	7	15.0	6	7.1	1
	(mixed)	8	20.0	8	5.0	7
	(missing)	0	2.5	1	-	-
13. Degree of disturbance	(very serious)	1	2.5	1	-	-
	(fairly serious)	2	42.5	17	42.9	6
	(inbetween)	3	45.0	18	42.9	6
	(mildly disturbed)	4	10.0	4	14.3	2
14. Length of problem	(less than 1 yr)	1	5	2	21.4	3
	(1-2 years)	2	27.5	11	14.3	2

duration	(3-5 years)	3	17.5	7	21.4	3
	(more)	4	50.0	20	42.9	6
PART THREE						
15. Theoretical orientation of therapy	(psychoanalytic)	1	20	8	14.3	2
	(behavioural)	2	22.5	9	7.1	1
	(TA)	4	7.5	3	14.3	2
	(eclectic)	7	50.0	20	64.3	9
16. Estimated length of therapy (by therapist)	(1 - 6 sessions)	1	5	2	21.4	3
	(7 -12 ")	2	57.5	23	50.0	7
	(13-20 ")	3	20.0	8	21.4	3
	(< 20 ")	4	17.5	7	7.1	1
17. Hopefulness of therapist	(very)	1	15	6	7.1	1
	(fair)	2	72.5	29	64.3	9
	(d.k.)	3	12.5	5	21.4	3
	(not)	4	-	-	7.1	1
PART FOUR						
18. Length of therapy (by patient)	(1 - 6 sessions)	1	17.5	7	21.4	3
	(7 -12 ")	2	32.5	13	7.1	1
	(13-20 ")	3	5.0	2	-	-
	(< 20 ")	4	12.5	5	28.6	4
	(d.k.)	5	32.5	13	42.9	6
19. Hopefulness of patient	(very)	1	42.5	17	14.3	2
	(fair)	2	42.5	17	21.4	3
	(d.k.)	3	15.0	6	2.4	3
	(missing)	0	-	-	42.9	6
20. Nature of problem (by patient)	(neurotic)	1	95	38	50	7
	(psychotic)	3	2.5	1	-	-
	(unknown)	0	2.5	1	50	7
21. Seriousness of problem (by patient)	(very serious)	1	35.0	14	14.3	2
	(fairly)	2	52.5	21	35.7	5
	(inbetween)	3	10.0	4	7.1	1
	(mild)	4	2.5	1	42.9	6

were fairly experienced in therapeutic work; 68.5% had been practising for between three and twelve years since qualification. The theoretical orientation used in their therapeutic practice was described by 60% as "eclectic", although 15% labelled themselves as psychoanalytically oriented and 10%, behaviourally oriented. The remaining 15% described themselves as client-centred, Kellian, or oriented towards Transactional Analysis.

6.2.2) Patients.

Part 2 of Table 2 shows that the sex distribution of the patients was a complete mirror image of that of the therapists: two thirds were female and one third was male. 60% were aged between twenty six and forty five. 50% of the sample were married or cohabiting, while 42.5% were single. 50% were estimated by the therapist to be working class and 47.5% to be middle class. The vast majority (82.5%) had not had any previous therapy. The problems presented to therapists were varied. 27.5% were described as having anxiety problems and 15% were seen to have relationship problems. The other diagnostic categories used included depression (5%); phobic problems (10%); sexual problems (5%); personality problems (7.5%); obsessional problems (7.5%); and "mixed" (20%). The degree of disturbance was rated by the therapists to be fairly serious for 42.5% of the patients, and between serious and mild for another 42.5%. Only one patient (2.5%) was described as being seriously disturbed, and over 50% had had the problem for more than five years.

6.2.3) The therapy: therapists' pre-therapy assessment.

Part 3 of Table 2 shows the details of the therapy itself, as described by the therapist before therapy began. As can be seen, 50% of therapists said that they intended to use eclectic methods of treatment; 22.5% said they would use behavioural methods, and 20%, psychoanalytic. The majority of therapists (57.5%) estimated the length of therapy would be between seven and twelve

sessions, and 37.5% estimated that it would last more than twelve. Over two thirds of therapists were fairly hopeful that the therapy would be successful; only six (15%) were very hopeful. 12% didn't know, but no therapist reported that they were not hopeful at all.

6.2.4) The therapy: patients' pre-therapy assessment.

Part 4 of Table 2 shows the views of patients before commencement of therapy. Their expectation of the length of therapy was shorter than the therapists': 17.5% (as compared with 5% of therapists) thought the therapy would last for less than six sessions, and 32.5% thought it would last for between seven and twelve sessions. Only 17.5% thought that it could last for more than twelve sessions. The patients were also more hopeful than the therapists; 42.5% were very hopeful (as compared with 15% of therapists) and 42.5% were fairly hopeful. Also, more patients than therapists (35%) thought their problems were very serious, and 52.5% thought they were fairly serious.

6.2.5) Comparison between completers and dropouts

All four parts of Table 2 also show the the data collected on the patients who did not complete therapy. In order to determine whether there were any significant differences between patients who completed treatment, and those who dropped out, (in other words, whether the "completers" were in any way unrepresentative of the total group of patients), data from the two groups were compared. Table 3 shows the results of tests carried out on the differences between the two sets of data. Chi-square tests were performed with nominal data in order to determine the statistical significance of the difference between the means of the two groups; where this was not appropriate, t-tests were carried out.

As will be seen, no significant differences between completers and dropouts were found using the t-tests. Because of the unequal numbers (40 completers and 14 dropouts) the F-max test for homogeneity of variance was

TABLE 3: Completed and Dropout Subjects: Comparisons of Demographic Data.

	t/chi square	df	p	Significant of the .05 level
1. Sex of therapist	$x^2 = 4.34$	1	< 0.04	✓
2. Nature of training	$x^2 = 2.97$*	1	< 0.09	NS
3. Type of qualification	$x^2 = 6.40$*	1	< 0.01	✓
4. Theoretical orientation	$x^2 = 0.42$*	1	< 0.5	NS
5. Years of experience	t = 1.40	52	< 0.17	NS
6. Theoretical orientation	$x^2 = 9.26$*	1	< 0.002	✓
7. Patient age	t = 1.10	50	< 0.28	NS
8. Patient sex	$x^2 = 0.05$	1	< 0.83	NS
9. Patient marital status	$x^2 = 0$	1	< 1.00	NS
10. Patient social class	$x^2 = 0.41$	1	< 0.52	NS
11. Previous therapy	$x^2 = 0.21$*	1	< 0.65	NS
13. Degree of disturbance seen by therapist	t =-0.40	52	< 0.69	NS
14. Duration of problem	t = 0.82	52	< 0.42	NS
15. Theoretical orientation of therapy	$x^2 = 0.85$	1	< 0.36	NS
16. Estimated length of therapy of therapist	t = 1.35	52	< 0.18	NS
17. Hopefulness of therapist	t =-1.71	52	< 0.09	NS
18. Estimated length of therapy by patient	t =-0.04	46	< 0.97	NS
19. Hopefulness of patient	5 =-1.41	46	< 0.17	NS
21. Degree of disturbance seen by patient	t =-0.27	46	< 0.79	NS

* Because of the small size of the dropout subject group, the numbers in all cells on these calculations had to be increased (as recommended by Seigel, 1956) so as to permit analysis. This procedure increases the power of the test to detect significant differences.

applied before carrying out the t-tests; this indicated that there was homogeneity of variance on all variables, meaning that the t-test was indeed an appropriate test for this data. Tests for significant differences between the two groups on the nominal data using chi-square showed that there were three variables on which significant differences could be found between completers and dropouts. These were the sex, type of training and theoretical orientation of the therapist. This means that dropout patients were more likely to have come from female clinical psychologists, and therapists with an eclectic orientation than any other group of therapists. However, it is possible, at least in the case of theoretical orientation and type of training, that this is merely a spurious result of the statistical manipulations that were necessary before the chi-square statistic could be applied. The small numbers of the dropout patients meant that all numbers had to be proportionately increased (as recommended by Seigel, 1956) before the calculations were completed; this inevitably inflated the effect of any differences in the data. Nevertheless, the probability has to be accepted that there may well be significant differences between the dropouts and the completers on these points.

6.2.6) Summary of demographic data.

Although there was no systematic attempt to carry out a representative sampling of patients receiving psychological therapy, it seems from the descriptive data collected on the subjects of this study that these subjects are fairly typical of patients normally attending for psychological help, especially those attending clinical psychology services. The bias towards eclectically oriented therapists is, according to Prochaska and Norcross (1983), more or less representative, as is the sex ratio of clinicians and of patients. Possibly there are more unmarried patients than might be expected; it is not clear why this is so. There is no reason to expect that the other variables (such as hopefulness of therapists or of

patients) would distinguish this group of patients from any other group of patients; a fairly standard finding in this field, (see for example some of the research reviewed by Goldstein, 1962), is that, on the whole, patients are more hopeful than therapists. Also a fairly standard finding in this field is that patients estimate the time needed for therapy to be less than the therapist (see for example, Fitzgibbons, Cutler and Cohen 1971). It must be stressed, however, that the sampling of patients and therapists was not done systematically, so that the results of the study should not therefore be overgeneralised. These points will be discussed in more detail in section 8.3.3.

Equally, the possibility that the subjects who completed therapy were different in significant ways from those who did not, cannot be entirely ruled out. The differences between dropouts and completers do not appear to be great, although the fact that there are some differences must limit the extent to which the study can be said to apply to all the patients of the particular therapists studied. On the other hand, the study was an attempt to study patients who were in therapy, not those who were not. These points will also be discussed further in section 8.3.3. It is of course impossible to say whether those two patients who remained in therapy, but discontinued full participation in the study, were different from those who continued participation.

6.3) Correlational analysis of demographic and attitudinal data.

A full correlational analysis was performed on the demographic data; however no significant correlations were found between any of the variables included; hence there seems little point in reproducing the analysis here. The results of the correlations obtained between data collected before therapy (for example, concerning hopefulness) and data collected upon completion of treatment, will be given in Table 11b below (see section 6.5.2).

6.4) Coding and Content Analysis.

The content analysis procedure, as outlined in chapter 5, was used to analyse the answers on the questionnaires provided by both patients and therapists in their descriptions of the helpful and unhelpful aspects of therapy. It may be recalled that the first question to be answered by this research study, in the list of questions presented in section 5.2, was as follows: "Is the Elliott Therapeutic Impact Content Analysis system a reliable and valid measure for use with sessional data, as opposed to its use with more limited data collected using I.P.R.?". The remainder of this section addresses this question.

6.4.1) Methodological Note

In the data collection period, a total number of 1076 events were obtained, both during and after the end of therapy. However, the total number of events with which the examination for the reliability of the coding procedure was carried out, was in fact only 1068. This was because one patient and therapist pair returned their completed End of Therapy questionnaires too late for inclusion in the calculation of the reliability data. It was felt that these missing eight events would not have any significant impact on the reliability estimation (being only 0.06% of the total!); and all remaining calculations were carried out with the complete total of 1076. However, in this discussion of the reliability of the coding system, note that only 1068 events were included.

The total number of sessions from which data was gathered was 399, and the mean number of sessions per patient was 9.98. Of the 1068 reported events on which *reliability data were calculated*, 307 were "helpful events" from the patients' viewpoint; 146 were "other events" from the patients' viewpoint; 380 were "helpful events" from the therapists' viewpoint; and 239 were "other events" from the therapists' viewpoint. (These figures can also be seen in Tables 7 and 8 below.)

6.4.2) Reliability of Content Analysis.

The first step in the examination of the reliability of the content analysis procedure carried out, was the calculation of the number of events placed by the two coders into each of the categories. Table 4 shows the total numbers of events, in each category in the system, on which both coders were agreed; and Table 5 shows the number of events that each coder separately placed in each category.

The second step was the calculation of the percentage agreement between the two coders. Table 6 shows the result of this calculation. Of the 1068 events, the two raters were agreed on 68.1% of occasions. If helpful and unhelpful events are treated separately, it can be seen that for the 912 helpful events and the 61 unhelpful events, reliability figures of 69.7% and 52.4% were obtained. (Note: 95 events were judged to be unclassifiable, which represents 8.9% of the total.)

Tables 7 and 8 show the percentage of times per category that each of the two coders were in agreement with the other; that is, Table 7 shows the percentage of times that Coder 1 was agreed with the "consensus" decision, and Table 8 shows the number of times that Coder 2 was agreed with the "consensus" decision. These tables therefore provide some indirect evidence of the way in which each of the two coders was using the system, for example it can be seen that Coder 1 makes far more use of categories 1 and 4, whereas Coder 2 uses categories 6 and 8 more frequently.

The third step in the examination of the reliability of the content analysis procedure was the application of the Kappa statistic to the ratings. Kappa is a statistic which was devised by Cohen (1960) to relate "the level of actual agreement to the level of chance agreement defined in terms of the category proportions for each rater" (Jackson, 1983, p.145). This is the statistic that has

TABLE 4: Reliability Data: Number of Events Coded by both Coders in Each Category.

Category	Patient Helpful Event	Therapist Helpful Event	Patient Other Event	Therapist Other Event	All Events Combined
1	34	87	13	34	168
2	13	19	4	11	47
3	3	14	2	12	31
4	45	49	12	26	132
5	10	26	4	17	57
6	11	4	2	3	20
7	70	43	20	18	151
8	7	8	3	12	30
9	0	1	5	1	7
10	0	0	1	0	1
11	3	0	5	1	2
12	0	0	1	2	3
13	1	1	6	4	12
14	30	9	3	17	59

Note: This table indicates how many events were placed in each category, when both coders chose the same category.

TABLE 5: Reliability Data: Number of Events Coded per Category by both Coders shown Separately.

Categories	Patient Helpful Event		Therapist Helpful Event		Patient Other Event		Therapist Other Event		Event Combined	
	C1	C1	C1	C2	C1	C2	C1	C2	C1	C2
1	48	47	112	110	18	20	43	50	221	227
2	20	21	36	38	10	8	19	18	85	85
3	6	12	22	34	7	7	15	19	50	71
4	49	55	61	62	13	21	34	34	156	172
5	24	16	44	33	14	11	36	26	116	86
6	13	13	5	5	4	4	4	3	26	25
7	84	89	61	57	29	26	23	25	197	197
8	19	12	16	18	11	6	19	16	65	49
9	0	0	2	1	10	8	3	3	15	12
10	0	0	0	0	2	2	2	1	4	3
11	3	5	1	2	6	13	7	3	17	23
12	1	0	0	0	3	2	6	4	10	6
13	4	1	2	3	11	8	8	5	25	17
14	36	36	15	17	8	10	22	32	81	95

Note: This table shows the use of each category by coders 1 and 2. See Tables 6 and 7 for the conversion of these figures to percentages.

TABLE 6: Reliability Data: Summary of % Agreement between Coders.

All Events	
Total Number of Events Coded	1068
Number of Events Coded in the same way by Coders 1 and 2	727
% Agreement:	68.1%
Helpful Events Only	
Total: 916 (Coder 1) 912 (Coder 2)	
No. of events coded in the same way	636
% Agreement: 69.4% (Coder 1) 69.7% (Coder 2)	
Unhelpful Events Only	
Total: 71 (Coder 1) 61 (Coder 2)	
No. of events coded in the same way	32
% Agreement: 45.1% (Coder 1) 52.4% (Coder 2)	

TABLE 7: Reliability Data: Percentage of Events Coded by Coder 1 in the same way as Coder 2.

Coder 1 / Categories	Patient Helpful Event	Therapist Helpful Event	Patient Other Event	Therapist Other Event	All Events Combined
1	70.8	77.7	72.2	79.1	76.0
2	65.0	52.8	40.0	57.9	55.3
3	50.0	63.6	28.6	80.0	62.0
4	91.8	80.3	92.3	76.5	84.6
5	41.7	59.1	28.6	47.2	49.1
6	84.6	80.0	50.0	75.0	76.9
7	83.3	70.5	68.9	78.3	76.7
8	36.9	50.0	27.3	63.2	46.2
9	100	0	50.0	33.3	46.7
10	100	100.0	50.0	0	25.0
11	100	0	83.3	14.3	52.9
12	50	0	33.3	33.3	30.0
13	25	25.0	54.5	50.0	48.0
14	83.3	60.0	37.5	77.3	72.8

TABLE 8: Reliability Data: Percentage of Events Coded by Coder 2 in the same way as Coder 1.

Coder 2 / Categories	Patient Helpful Event	Therapist Helpful Event	Patient Other Event	Therapist Other Event	All Events Combined
1	72.3	79.1	90.0	68.0	74.0
2	61.9	50.0	50.0	61.0	55.3
3	25.0	41.2	28.6	63.2	43.7
4	81.8	79.0	57.1	76.5	76.7
5	62.5	78.8	36.4	65.4	66.3
6	84.6	80.0	50.0	100.0	80.0
7	78.7	75.4	76.9	72.0	76.7
8	58.3	44.4	50.0	75.0	61.2
9	0	100.0	62.5	33.3	58.3
10	100.0	100.0	50.0	0	33.3
11	0	0	38.5	33.3	8.6
12	100.0	100.0	50.0	50.0	50.0
13	100.0	33	75.0	80.0	70.6
14	83.3	52.9	33.3	53.1	62.1

been used in the studies involving content analysis carried out by Bloch, Reibstein, Crouch, Holroyd and Themen, (1979); Dole, DiTomasso and Young (1982), Shapiro, Barkham and Irving (1984); and Hawton, Reibstein, Fieldsend and Whalley, (1982); it was also recommended for use with this data by Elliott (1983, personal communication). Its value in the analysis of this data is, simply, that it disentangles absolute from relative agreement. Table 9 gives the Kappa coefficient for each of the thirteen categories, plus the unclassifyable category, number 14, together with the generalised Kappa which gives the overall level of reliability.

It must be noted that any Kappa value with a Z score exceeding 1.96 is statistically significant at the $p<0.05$ level, and any Kappa value with a Z score exceeding 2.575 is significant at the $p<0.005$ level. In other words, Kappa values above these levels indicate reliability.

To summarise, it can be seen from tables 4 to 9 that the overall categorisation process was reliable, although the Z-scores for Kappas for some categories (notably 9 and 11) were rather low, and the Kappas for categories 10 and 12 did not reach an acceptable level of statistical significance. However, the overall score for all categories reached agreement significantly above the level that might be expected by chance, and therefore, it can be concluded (by way of an answer to the first question raised in section 5.2), that Elliott's Therapeutic Impact Content Analysis System can be accepted as reliable (although it must also be noted that the unhelpful events categories are much less reliable). Issues of validity will be discussed in chapter 8 below.

Since a number of disagreements did occur over at least a proportion of events, the question of exactly how each disputed event should be coded, had to be considered before proceeding with subsequent analyses. The coders therefore debated these disputed events until a consensus was reached on their categorisation, (as was described in

TABLE 9: Kappa Co-efficient between Coders on all Categories.

Category	Kappa	Z	
1	.684	8.398	**
2	.514	5.270	**
3	.483	4.448	**
4	.769	9.138	**
5	.519	5.573	**
6	.779	5.138	**
7	.714	8.675	**
8	.500	4.407	**
9	.512	2.550	*
10	.283	0.741	NS
11	.440	2.610	**
12	.370	1.443	NS
13	.563	3.414	**
14	.641	6.632	**
TOTAL	.632	53.177	**

** $p < .005$

* $p < .05$

section 5.7.4). From this point onwards, therefore, all presentation of the results will be based on the consensus decisions of the two coders only.

6.5) Therapy as seen by Patients and Therapists.

In this section, the main results of the study will be presented, in terms of the questions posed in section 5.2. Question one has already been answered, and question two (concerning the extent to which an informative and valuable picture of therapy can be gained by using this particular research strategy of gathering accounts from therapy participants), will be answered in chapters 7 and 9 below. The remaining questions (with the exception of question nine which will also be dealt with in chapters 7 and 9 below) will be answered in the subsequent sections of this chapter.

6.5.1) Details of sessions and events.

Firstly, some details of the therapy experienced by participants will be presented. It is from this data that subsequent analyses were performed. Table 10a shows the total numbers of sessions and events per patient and therapist; the data is summarised in Table 10b.

As can be seen, the number of sessions per patient ranges from three to eighteen (although the last patient, with only three sessions, was included somewhat reluctantly in the sample because of the small number of sessions). The division between helpful and unhelpful events can also be seen, with the patients providing a slightly higher percentage of unhelpful events than therapists, (8.7% compared with 3.7%).

6.5.2) End of Therapy: details.

Secondly, details of the outcome of therapy are given. Table 11a shows the End of Therapy data, with details of outcome and type of therapy carried out.

TABLE 10a: Number of Sessions and Number of Events per Session.

Patient No.	No. of Sessions	Patient No. of Events	Therapist No. of Events
1	4	6	6
2	7	7	13
3	10	12	12
4	17	21	31
5	10	17	13
6	5	6	7
7	6	2	6
8	14	23	23
9	13	14	21
10	6	10	9
11	9	9	13
12	6	7	11
13	8	12	14
14	9	11	11
15	6	10	9
16	8	4	12
17	15	30	24
18	18	20	27
19	7	11	13
20	9	15	15
21	6	7	12
22	15	15	25
23	5	4	7
24	18	22	25
25	18	9	23
26	17	22	29
27	5	7	7
28	5	6	6
29	6	11	10
30	12	13	20
31	9	17	14
32	6	2	12
33	17	15	27
34	15	15	19
35	14	21	22
36	7	1	13
37	6	1	9
38	13	10	22
39	12	10	18
40	3	6	5
TOTAL	399	461	615

TABLE 10b: Summary of Number of Events, Therapists and Patients, Combined and Separately.

	Total no. of events	Total no. of helpful events		Total no. of unhelpful events		Total Unclassified	
	N	N	% of Total	N	% of Total	N	% of Total
Patient & Therapist Combined	1076	931	86.5%	63	5.9%	82	7.6%
Patient	460	379	82.4%	40	8.7%	41	8.9%
Therapist	616	552	89.6%	23	3.7%	41	6.7%

All of the therapists completed their End of Therapy questionnaires, but two patients failed to do so despite being contacted on a number of occasions by post. Nevertheless, this represents a 95% response rate. Table 11a shows the results of the outcome questions, and Table 11b shows the results of the correlational measures obtained, concerning outcome and a number of demographic and treatment variables. Table 11a shows that the majority of patients (80%0 and the majority of therapists (77.5%) thought that the therapy had been helpful, although slightly more therapists than patients thought that the patients were much better (77.5% versus 72.5%). Table 11b shows that the outcome measures are all highly correlated with each other, which may give some confidence in the reliability of the measure, even if it cannot guarantee its validity.

6.6) Helpful and unhelpful factors as seen by therapists and patients during and after the end of therapy.

Question three from section 5.2 read as follows: "What do therapists and patients see as having been the most helpful events occurring in a therapy session? and what do they see as the most unhelpful events?". This section seeks to answer that question.

6.6.1) During Therapy.

Table 12a shows the most helpful and unhelpful events, as seen by patients and therapists, during therapy. (The number of events placed in each category by each patient and each therapist can be seen in Appendix 9. This is the "raw" data from which all subsequent analyses were performed.)

It must be noted that, because of the different numbers of events reported by participants, each categorised event was scored as a proportion of the total number of events reported by that particular respondent, and then summed to reveal the total number of proportioned responses per category. This is a much more accurate way

TABLE 11a: End of Therapy Data.

Part 1: Therapists (N=40)

	Variable		Q	Percentage	N
1.	Theoretical Orientation used in Treatment	(psychoanalytic)	1	15.0	6
		(behavioural)	2	17.5	7
		(Rogerian)	3	5.0	2
		(TA)	4	2.5	1
		(Kelly)	6	5.0	2
		(Eclectic)	7	55.0	22
2.	Actual Length of Therapy	(1 - 6 sessions)	1	27.5	11
		(7 -12 ")	2	32.5	13
		(13-20 ")	3	30.0	12
		(< 20 ")	4	10.0	4
3.	Nature of Termination	(mutual agreement)	1	60	24
		(patient initiated AMA)	3	7.5	3
		(patient failed to appear)	5	7.5	3
		(ongoing)	6	25.0	10
4.	Therapist Rated Helpfulness of Treatment	(very)	1	30	12
		(fairly)	2	47.5	19
		(neither)	3	15.0	6
		(fairly unhelpful)	4	7.5	3
		(unhelpful)	0	-	-
5.	Therapist Rated Improvement	(much better)	1	30	12
		(certain amount better)	2	47.5	19
		(neither)	3	15.0	6
		(certain amount worse)	4	5.0	2
		(missing)	0	2.5	1

6. Therapist Overall Rated Benefit of Treatment	(on scale 1-8 from high to low benefit)	2	25.0	10
		3	15.0	6
		4	35.0	14
		5	7.5	3
		6	10.0	4
		7	2.5	1
		8	5.0	2

Part two: Patients (N=38)

7. Patient Rated Helpfulness of Treatment	(very helpful)	1	47	18
	(fairly)	2	34	13
	(neither)	3	3	1
	(fairly unhelpful)	4	5	2
	(unhelpful)	0	11	4
8. Patient Rated Improvement	(much better)	1	47	18
	(certain amount)	2	26	10
	(neither)	3	13	5
	(certain amount worse)	4	2.5	1
	(much worse)	0	10.5	4
9. Patient Overall Rated Benefit of Treatment	(on scale 1-8 from high to low benefit)	2	45.0	17
		3	5.0	2
		4	26.0	10
		5	2.5	1
		6	5.0	2
		7	2.5	1
		8	2.5	1
		0	10.5	4

TABLE 11b: End of Therapy Data: Therapy Outcome Measures and Attitudinal Measures.

N = 40 Variables	r	p
T rated helpfulness/T rated improvement	0.83	<.001
T rated helpfulness/P rated improvement	0.71	<.001
T rated helpfulness/P rated helpfulness	0.77	<.001
T rated helpfulness/T rated benefit	0.94	<.001
T rated helpfulness/P rated benefit	0.68	<.001
T rated improvement/P rated improvement	0.73	<.001
T rated improvement/P rated helpfulness	0.76	<.001
T rated improvement/T rated benefit	0.95	<.001
T rated improvement/P rated benefit	0.67	<.001
P rated helpfulness/P rated improvement	0.88	<.001
P rated helpfulness/T rated benefit	0.79	<.001
P rated helpfulness/P rated benefit	0.97	<.001
P rated improvement/T rated benefit	0.78	<.001
P rated improvement/P rated benefit	0.97	<.001
T rated benefit /P rated benefit	0.71	<.001
T estimated length of therapy/ actual length	0.48	<.01
T estimated seriousness of problem/ T hopefulness	-0.41	<.01

Note: Only correlations achieving an acceptable level of statistical significance are shown. No other correlations reached significance.

of calculating the true percentages of responses in each of the categories, than simply summing the total number of responses per category. Thus, for example, a total of 71 events in category 1 were reported by patients. In order to calculate the importance of events in category 1 for each patient relative to all of the other types of event reported by that patient, each event in this category was given a "proportioned" score, according to the number of events in all categories given by that particular patient. Thus a patient who reported three events in category 1, out of a total of six events, would obtain a proportioned response score of 50, whereas a patient who reported a total of three events in category 1 out of a total of twelve events, would obtain a proportioned response score of 25. In this way the 71 events in category 1 were calculated to represent a total of 497 proportioned responses scores, (i.e., 12.3% of the total of all patient responses); whereas a total of 77 responses were reported in the category 4, which (following the procedure described above) represents a total of 822 proportioned responses scores, (i.e., 20.3% of the total of all patient responses). The magnitude of this difference would be obscured if simple totals were used.

A summary of the results of the helpful events can be seen in Table 12b, both in terms of the percentages of responses, and in terms of the rank given to each particular category. These findings can also be seen in Figures 1 and 2.

For all the calculations of the relative importance of events, answers to the question about the most helpful event and the "other" helpful event, (questions 1 and 4 on the questionnaires) were treated together. In other words, it was assumed (on the basis of simple visual inspection), that there were no significant differences in the distribution of the events over the fourteen categories between these two types of question. Hence the total number of events per category may be made up of events reported to be either the most helpful or the other most helpful (or

TABLE 12a: Helpful and Unhelpful Events as seen by Patients and Therapists During Therapy.

	Patients			Therapists		
Category	Total No. of Events	Proportion Total*	%**	Total No. of Events	Proportion Total*	%**
1	71	497	12.3	164	1109	27.8
2	28	231	5.7	56	369	9.3
3	15	140	3.5	45	283	7.1
4	77	822	20.3	97	694	17.4
5	41	367	9.1	60	298	7.52
6	16	120	3.0	9	41	1.0
7	112	1028	25.5	85	615	15.4
8	19	171	4.2	36	189	4.7
9	8	45	1.1	5	19	0.5
10	3	22	0.5	4	22	0.6
11	16	107	2.7	2	8	0.2
12	5	30	0.7	5	45	1.1
13	8	97	2.4	7	39	1.0
14	41	363	9.0	41	253	6.4
Total	460	4040	100	616	3984	100

* The total at the end of this column is meaningless in itself; it is used merely as a step in the process of calculating the true percentage of responses per category. Firstly, each event was scored as a proportion of all of the events given by each subject; then these scores were summed and the percentage of responses in each category was calculated as a percentage of the total proportion.

** Figures were rounded up or down, which means that the total of percentages may not equal exactly 100.

TABLE 12b: Summary - Most Helpful Events seen by Patients and Therapists.

Rank	Patients	Therapists
1st	7 (25.5%)	1 (27.8%)
2nd	4 (20.3%)	4 (17.4%)
3rd	1 (12.3%)	7 (15.4%)
4th	5 (9.1%)	2 (9.3%)
5th	2 (5.7%)	5 (7.5%)
6th	8 (4.2%)	3 (7.1%)
7th	3 (3.5%)	8 (4.7%)
8th	6 (3.0%)	6 (1.0%)

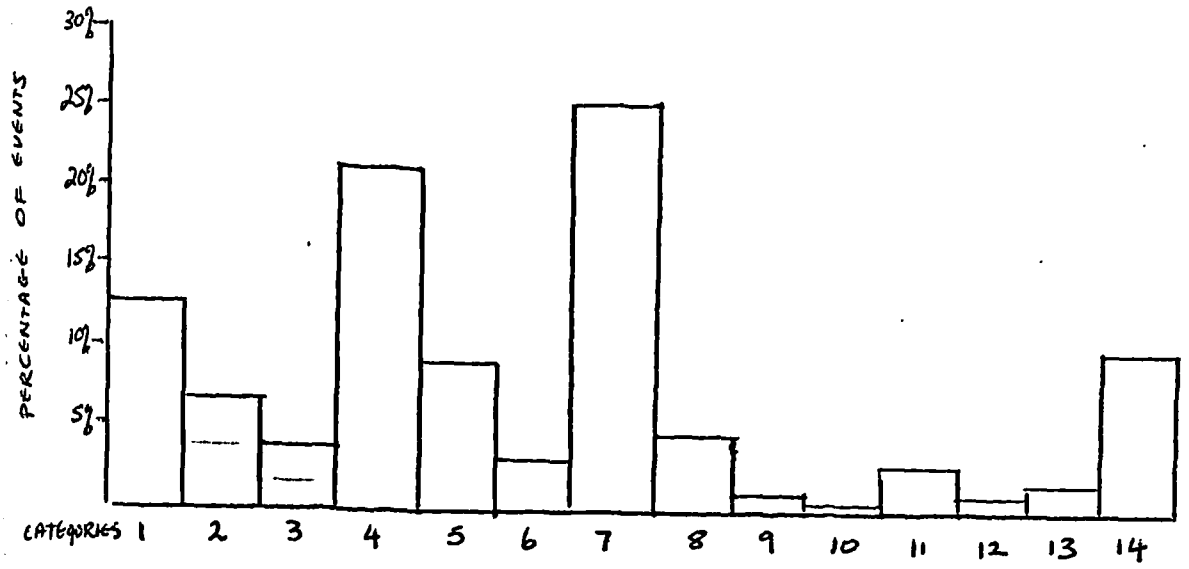

FIGURE 1 = HELPFUL AND UNHELPFUL EVENTS AS SEEN BY PATIENTS (PERCENTAGE OF EVENTS IN CATEGORIES 1→14), SESSIONAL DATA

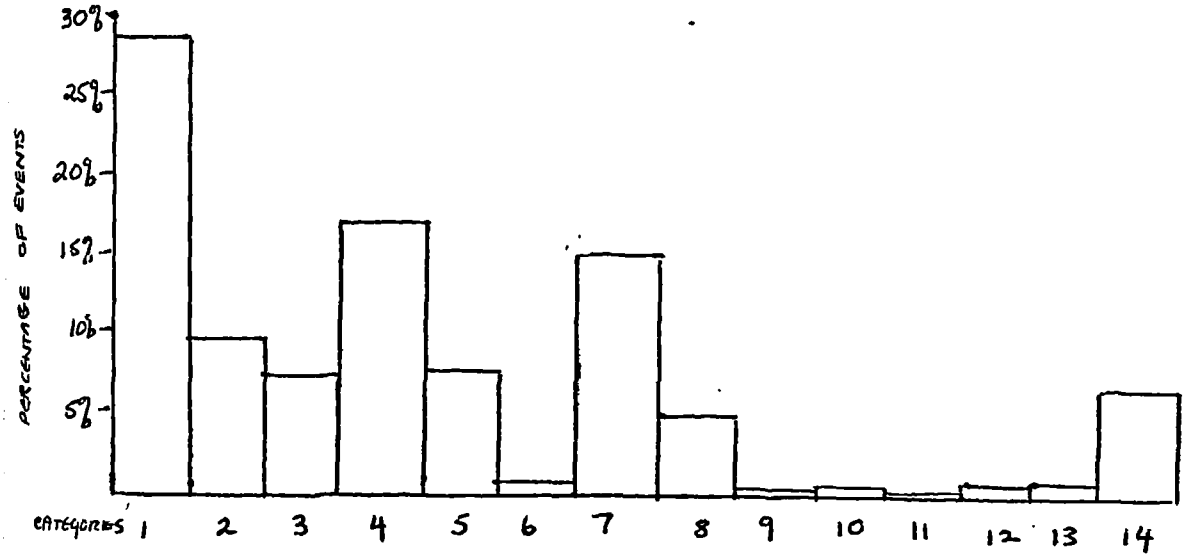

FIGURE 2 = HELPFUL AND UNHELPFUL EVENTS AS SEEN BY THERAPISTS (PERCENTAGE OF EVENTS IN CATEGORIES 1→14), SESSIONAL DATA

unhelpful) event. The numbers of events seen to be helpful and unhelpful, divided according to whether they are the most helpful event, or the "other" event, are shown in Appendix 10. Here also the "simple" percentages for each category are shown, (without the calculation of proportions as described above). Also shown in Appendix 10 are the total percentages of responses per category for helpful and unhelpful types of events.

As shown in Tables 12a and 12b, the most helpful type of event most frequently experienced from the therapists' viewpoint, is Insight (category 1), whereas from the patients' viewpoint it is Reassurance/Relief (category 7). 25.5% of patient responses and 15.4% of therapist responses were placed into the Reassurance/Relief category, while 12.3% of patient and 27.8% of therapist responses were placed into the Insight category. If cognitive insight and affective insight are placed together, (categories 1 and 3), the differences are even more marked; patient events fall into these categories on 15.8% of occasions, while this is the case for 34.9% of therapist responses; i.e., therapists are more than twice as likely to use these two categories than patients. Nevertheless, it is also the case that Insight events are seen by patients, on 12.3% of occasions, as the third most important type of event, although it follows quite far behind 20.3% for Problem Solution (category 4). Therapists also rate Problem Solution quite highly; this category is used by them on 17.4% of occasions.

It can also be seen that some categories are relatively rarely used. Category 3 (Affective Awareness), Category 6 (Understanding) and Category 8 (Personal Contact) are all used on less than 7.5% of occasions by both groups of participants.

The results for the unhelpful events are also shown in Table 12a. The most frequently used unhelpful category for patient events was category 11, (Disappointment), with 2.7% of responses, followed by category 13 (Unhelpful

Confrontation) and category 11, (Misdirection), with 2.4% and 1.1% of responses respectively. Therapist views are slightly different; 1.0% of responses fall within category 13, (Unhelpful Confrontation), while a total of 1.1% fall into category 9, (Misdirection). The percentages of unhelpful events, expressed as a percentage of all unhelpful events, can be seen in Appendix 10.

All of these results suggest very strongly that patients see the reassuring aspects of therapy to have been the most helpful to them, whereas therapists report that the aspects that are most helpful for patients, are those designed to produce insight. It is also interesting to see that the emphasis in the unhelpful aspects is also slightly different; patients choose disappointing events, that is, not getting what they wanted (maybe reassurance?); while therapists see the unhelpful aspects of therapy to be their own failure to direct the therapy correctly (not producing insight?).

6.6.2) After therapy termination.

Table 13a and Figures 3 and 4 show the results of the End of Therapy questionnaires, asking for the retrospective views of subjects concerning the helpful and unhelpful aspects of therapy. Note that the wording of questions on the questionnaires used at this point was rather different from the sessional questionnaires; see section 5.5.2 for details. (The number of events seen as helpful and unhelpful by both patients and therapists, after the end of therapy, can be seen in Appendix 11.)

This table shows that on termination, 125 patient events and 136 therapist events were collected, of which 105 and 103 (respectively) were helpful. As can be seen, the views of therapists and patients differ. The three most helpful event categories from the viewpoint of the patient are Problem Solution (22.1%), Personal Contact (16.3%), and Reassurance/Relief (15.1%); whereas for the therapist they are Insight (19.1%), Personal Contact (14.5%) and Problem Solution (11.7%). The least used

TABLE 13a: End of Therapy Events seen to be Helpful and Unhelpful by Patients and Therapists.

	Patients			Therapists		
Category	Total No. of Events	Proportion Total*	%**	Total No. of Events	Proportion Total*	%**
1	14	368	10.9	26	743	19.1
2	5	170	5.0	6	194	5.0
3	4	103	3.1	10	233	6.0
4	25	748	22.1	17	456	11.7
5	4	104	3.7	7	208	5.3
6	9	220	6.5	3	182	4.7
7	23	510	15.1	16	368	9.4
8	21	553	16.3	18	564	14.5
9	4	92	2.7	11	365	9.4
10	1	25	0.7	2	70	1.8
11	4	154	4.6	4	98	2.5
12	3	73	2.2	2	50	1.3
13	4	83	2.5	7	190	4.9
14	4	183	5.4	7	178	4.6
TOTAL	125	3386	100	136	3899	100

* The total at the end of this column is meaningless in itself; it is used simply as a step in the process of calculating the true percentage of responses per category. First each event was scored as a proportion of all of the events given by each subject; then these scores were summed and the percentage of responses in each category was calculated as a percentage of the proprotions.

** Figures were rounded up or down, which means the total of percentages may not equal exactly 100.

TABLE 13b: Summary: End of Therapy, Most Helpful Events seen by Patients and Therapists

Rank	Category of Patients' Events	Category of Therapists' Events
1st	4 (22.1%)	1 (19.1%)
2nd	8 (16.3%)	8 (14.5%)
3rd	7 (15.1%)	4 (11.7%)
4th	1 (10.9%)	7 (9.4%)
5th	6 (6.5%)	3 (6.0%)
6th	2 (5.0%)	5 (5.3%)
7th	5 (3.5%)	2 (5.0%)
8th	3 (3.1%)	6 (4.7%)

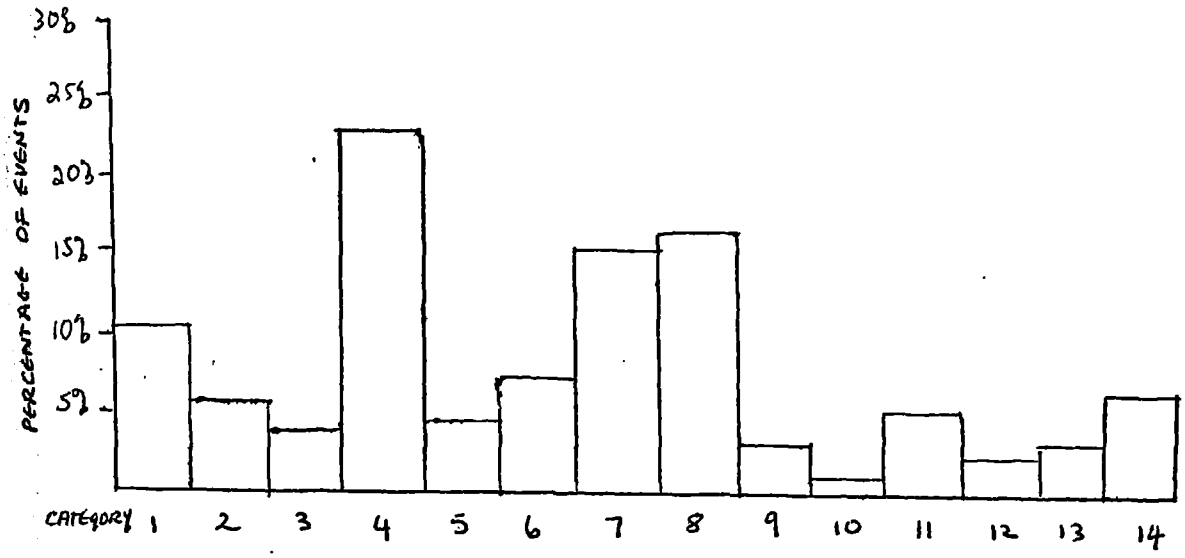

FIGURE 3: END OF THERAPY DATA : HELPFUL AND UNHELPFUL EVENTS AS SEEN BY PATIENTS

(PERCENTAGE OF EVENTS IN CATEGORIES 1 → 14)

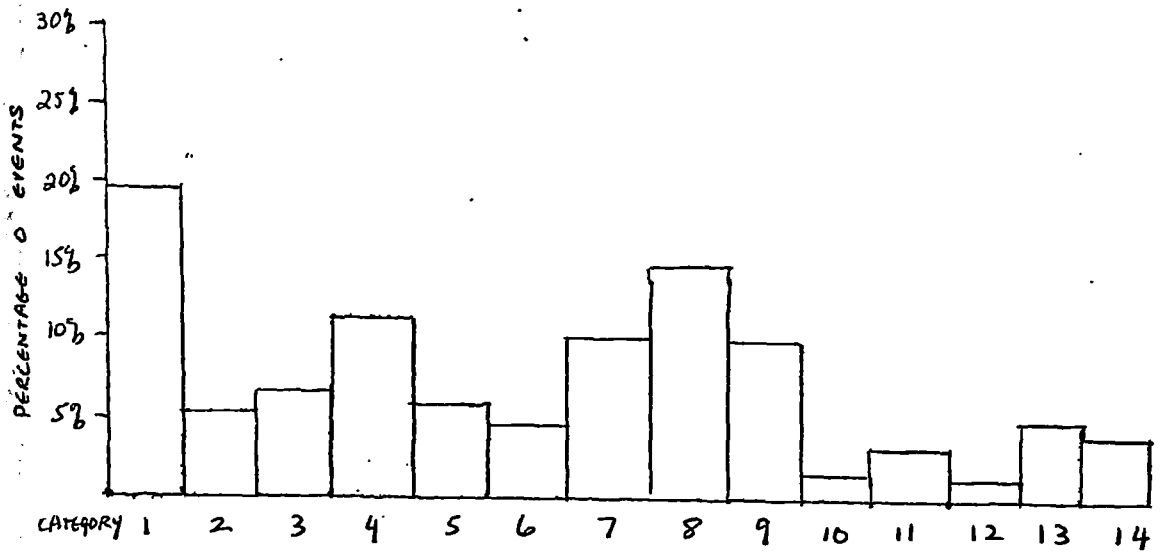

FIGURE 4: END OF THERAPY DATA : HELPFUL AND UNHELPFUL EVENTS AS SEEN BY THERAPISTS

(PERCENTAGE OF EVENTS IN CATEGORIES 1 → 14)

categories, according to both groups of participants, are Understanding, Affective Awareness, Clarification and Involvement.

This table also shows the end of therapy views of subjects concerning the unhelpful events that occurred in therapy; as can be seen, 9.4% of therapist unhelpful events are seen as due to Misdirection, whereas this only accounts for 2.7% of patient events. Again, the type of event seen more frequently by patients to have been unhelpful, was Disappointment, with 4.6%.

Table 13b also shows the results of ranking the views of patients and therapists.

6.7) Difference between patients' and therapists' perceptions.

Question four from section 5.2 read as follows: "Are there any differences between therapists' and patients' views regarding the most and least helpful events?". This section seeks to answer that question.

Table 14a shows the differences between the viewpoints during therapy, and Table 14b shows the differences at the end of therapy.

(Note that in the calculation of the difference in number of events placed by coders into each category for each patient and therapist, the overall number of events provided by each respondent was taken into account; hence it was, as in previous calculations, the percentages, rather than the absolute number of events placed into each category, that was compared. This was again necessary because more therapist than patient events were obtained overall, and also because respondents varied widely in the numbers of events reported. This procedure (of proportioning responses) was also followed in all subsequent calculations.)

As can be seen, there are a number of statistically significant differences in perspective during therapy.

TABLE 14a: Differences betweent Patient and Therapist Views (Sessional Data) using the Friedman Two-Way Analysis of Variance and Wilcoxon Matched Pairs Test.

Category	N	T	p**
1	37	72.5	p <.001*
2	32	191	N.S.
3	22	63.5	p <.02*
4	32	216	N.S.
5	27	178	N.S.
6	15	21.5	p <.05*
7	35	134	p <.001*
8	23	120.5	N.S.
1 and 3 combined	38	89.5	p <.001*
9	9	10	p <.10
10	total numbers too small to permit analysis		
11	11	3	p <.01 *
12	7	13.5	N.S.
13	10	34	N.S.

* A difference reaching an acceptable level of significance was obtained only on those items asterisked.

** The significance test applied was two-tailed.

TABLE 14b: Differences between Patients' and Therapists' Views (End of Therapy Data) using the Friedman Two-Way Analysis of Variance and Wilcoxon Matched Pairs Test.

Category	N	T	p**
1	25	86.5	p <.01*
2	9	16.5	N.S.
3	11	16.5	N.S.
4	25	100.5	p <.10
5	9	11.5	N.S.
6	9	13	p <.01*
7	21	129	N.S.
8	22	129	N.S.
1 and 3 combined	31	115	p <.01*
9	12	11	p <.05*
10	total numbers	too small to	permit analysis
11	6	9	N.S.
12	total numbers	too small to	permit analysis
13	8	8.5	N.S.

* A difference reaching an acceptable level of significance was obtained only on those items asterisked.

** The significance test applied was two-tailed.

Firstly, there is a highly significant difference between therapists and patients concerning the number of Cognitive Insight events; therapists being very much more likely than patients to choose this category, ($p<.001$). Secondly, therapists are much more likely than patients to choose an Awareness (affective insight) event, ($p<.05$). Thirdly, patients are very much more likely than therapists to choose a Reassurance/Relief event, ($p<.001$). They are also much more likely to select an Understanding event than therapists, ($p<.05$). Fifthly, it is also interesting to note that if the two insight categories (affective and cognitive) are summed, the difference between the viewpoints is even more significant ($p<.001$). On the remaining four helpful events categories (Problem Solution, Clarification, Involvement and Personal Contact), there were no significant differences.

Turning to the unhelpful events, therapists are more likely than patients to choose events within the Misdirection category (although, the difference is only statistically significant at the $p<.10$ level). Meanwhile, patients are more likely to select events within the Disappointment category, ($p<.01$). On two of the remaining unhelpful events categories (Negative Therapist Reaction and Unhelpful Confrontation), there were no significant differences, while there was insufficient data for an examination of different views on Misperception.

Table 14b shows the differences in perception at the end of therapy. As can be seen, a number of statistically significant differences were again found at this point. In particular, a difference was found on category 1 (Insight), at the $p<.01$ level. Combining categories 1 and 3 also showed a difference at a statistically significant level, ($p<.01$), although no statistically significant difference was found on category 3 on its own (possibly because of the very small number of events involved). On termination, a difference (although only at the $p<.10$ level) was also found on category 4 (Problem Solution), with more patient than therapist events occurring in this

category. There was again a statistically significant difference between the two groups on category 6 ($p<.01$). Of the unhelpful events, a difference was found between patients and therapists only on category 9 (Misdirection) which was used more frequently by therapists than patients, ($p<.05$). However, it must be noted that the total numbers of unhelpful events at this point were so small that it is difficult to know how meaningful these differences are. Interestingly, therapists reported more unhelpful events at this stage, than patients; (the total numbers being 16 and 26 respectively).

Returning to the question posed at the start of this section, it seems fair to conclude that there are indeed some very significant differences between participants during therapy, although there are also some categories on which the two are agreed in the sense that the two groups reported them as important with equal frequency. With the exception of Problem Solution (which both sets of participants see as important on about one fifth of occasions) it is on the least important categories that they are agreed, and on the more important categories that they are in disagreement. (The terms "least" and "most" are used here in terms of the rank order of frequencies with which particular categories of event are reported.) The differences in importance accorded to the Insight, Affective Awareness and Reassurance/Relief categories by the two sets of participants seem particularly worthy of note. Some (but not all) of these differences can also be observed in the data obtained at the end of therapy. Of particular interest is the finding that Reassurance/Relief (which so clearly distinguished the two groups during therapy), can no longer be differentiated at the end of therapy. Although the numbers of events were much smaller in the end of therapy measures, this change seems worthy of further exploration.

6.8) Differences in perception over time.

Question five from section 5.2 read as follows: "How

do the views of participants change over time?". There are a number of ways in which this question could be answered. As described in previous chapters, several researchers have looked at the effects of different aspects of therapy at different stages of therapy. For example, Meyer, Borgatta and Fanshel (1964) carried out a sequential analysis of their therapy cases to see which variables seemed to have importance at which stages of therapy; and Crowder (1972) compared ratings at different stages in therapy. In this particular study, I decided to examine the differences in perception of the relative helpfulness of events obtained during therapy with those obtained after the end of therapy. Table 15 shows the differences that could be observed over this period of time.

As shown, statistically significant differences of an acceptable level can be seen in the perceptions of patients concerning the relative helpfulness of three types of event. As might be expected from the results reported in the previous section, the importance that is given by patients to Reassurance/Relief diminishes over time (the difference being statistically significant at $p<.01$ level). Also, the importance given to Involvement diminishes, ($p<.02$). However, the importance given to Personal Contact increases even more significantly ($p<.001$). There is a suggestion that the relative helpfulness of Clarification (category 2) also diminishes over time ($p<.10$). It must be noted that the other categories were found to be more or less stable.

Turning to the therapists, more changes in the helpfulness given to events can be observed over time. The importance accorded to Insight diminishes ($p<.05$); also Clarification drops significantly ($p<.001$), as well as the importance given to Problem Solution ($p<05$). Both Personal Contact and Reassurance/Relief are seen as having greater value at the end of therapy (with statistically significant differences at the $p<.05$ and $p<.02$ level respectively).

TABLE 15: Differences between Therapists and Patients on Categories 1-13 over Time (Sessional Data versus End of Therapy Data)

	Patients			Therapists		
Category	N	T	p**	N	T	p**
1	26	114	N.S.	35	178.5	p <.05*
2	20	59.5	p <.001*	26	71.5	p <.001*
3	13	29	N.S.	23	122.5	N.S.
4	28	166.5	N.S.	28	103	p <.05*
5	21	44	p <.02*	24	97	N.S.
6	14	65	N.S.	11	30	N.S.
7	35	152.5	p <.01*	34	152.5	p <.02*
8	23	45.5	p <.001*	21	55.5	p <.05*
1 and 3 combined	27	133.5	N.S.	35	183.5	p <.02*
9	9	30	N.S.	13	6	p <.01*
10	total	numbers	too small to	permit	analysis	
11	12	32	N.S.	numbers	too small to permit analysis	
12	total	numbers	too small to	permit	analysis	
13	7	14	N.S.	10	10	p <.10

* A difference reaching an acceptable level of significance was obtained only on those items asterisked.

** The significance test applied was two-tailed.

Two unhelpful events are seen differently in retrospect. In most cases, the numbers of events were too small to permit analysis, but in the case of *Misdirection*, therapists thought it was even more likely to have occurred after the conclusion of therapy, ($p<.01$); there is also a suggestion that therapists are more likely to see Unhelpful Confrontation to have occurred, in retrospect, ($p<.10$).

Another way of looking at the comparison of the views of both sets of participants over time can be seen in Table 16. Here the direction of change is shown (although not the magnitude).

Thus it can be seen that, from the patients' viewpoint, the following types of helpful events diminish in importance: Insight, Clarification, Affective Awareness, Involvement, and Reassurance/Relief; while the following increase in importance: Problem Solution, Understanding, and Personal Contact. Similar changes can be seen in the reports of therapists over time, with the following exception: Problem Solution decreases in importance.

6.9) Helpfulness ratings.

Question six from section 5.2, read as follows: "What categories of event are seen by participants to have been more helpful than others, and which categories of events occurred during particularly helpful, and particularly unhelpful sessions?". It had been decided (following the suggestion of Hawton, Reibstein, Fieldsend and Whalley, 1982) to include some measurement of the relative helpfulness of helpful events, while gathering the events from participants, so that judgements about the importance of certain types of events relied not only on their frequency of occurrence, but also on their rated helpfulness. Consequently, ratings were obtained from participants on each of the most helpful events in each session (although not on the "other" events), as well as ratings of the helpfulness of the session in which each event occurred. In this

TABLE 16: Direction of Change over time in Patients' and Therapists' Views on Categories 1-13 (Each Category Scored as a Percentage of the Total Number of Events).

Category	Patients	Therapists	
1	↓	↓	
2	↓	↓	
3	↓	↓	
4	↑	↓	*
5	↓	↑	*
6	↑	↑	
7	↓	↓	
8	↑	↑	
9	↑	↑	
10	↑	↑	
11	↑	↑	
12	↑	↑	
13	↑	↑	

* Indicates a difference in direction of movement between therapists and patients

NB A downwards pointing arrow indicates that this category decreased in importance from the sessional data to the end of therapy data, an upwards pointing arrow denotes the reverse.

way it would be possible to see how helpful the most helpful events had been in comparison with one another, and whether there was any relationship between the frequency of occurrence of particular types of event, and their relative importance.

Table 17a shows the ratings given by patients and therapists to the categorised events; this is also shown in Figures 5 and 6.

According to these ratings, the highest scores are given by patients to Reassurance/Relief, and Problem Solution events; whereas for therapists, the types of event which receive the highest ratings are Affective Awareness, Involvement and Insight. It can be seen from these rankings, that at least from the viewpoint of the patient, there is a clear parallel between the ratings given to certain events, and the number of events placed in that category. It may be recalled that, as shown in Table 12b, from the patients' viewpoint the most helpful type of event occurring during therapy was Reassurance/Relief, and the second most helpful type of event was Problem Solution. This is identical to the highest rated events. From the therapists' viewpoint, there is not quite such a clear relationship, although the first three types of event rated as most helpful, occur within the top four events most frequently seen as helpful by therapists during therapy.

Equally, it can be seen that the types of events seen as the least helpful of the helpful events, according to the ratings, are also the least helpful according to the frequency by which they are reported. As shown in Table 17a, the least helpful events as rated from the patients' viewpoint are Understanding and Affective Awareness; so also are they the least frequent in occurrence, as shown in Table 12b. For the therapists, this also holds in that the two least helpful of the helpful events according to the ratings are also the least helpful according to the frequency of occurrence (Understanding and Personal

TABLE 17a: Ratings Given by Patients and Therapists to Categorised Events 1-14.

	Patients			Therapists		
Category	No. of Events*	Average Helpfulness Rating of Event**	Rank Helpful Events	No. of Events*	Average Helpfulness Rating of Event**	Rank Helpful Events
1	48	15.0	3rd	120	18.04	3rd
2	18	17.2	5th	37	19.7	6th
3	9	19.5	8th	22	17.3	1st
4	47	14.8	2nd	61	18.6	4th
5	21	17.4	7th	32	17.8	2nd
6	11	17.3	6th	5	20.0	7th
7	10	11.6	1st	58	18.8	5th
8	12	15.8	4th	18	20.3	8th
9	0	0	-	2	20.0	-
10	0	0	-	3	20.0	-
11	3	23.3	-	1	30.0	-
12	0	0	-	0	0	-
13	0	0	-	1	30.0	-
14	17	23.5	-	11	25.0	-

* Only events where a rating was given are included in this analysis.

** The events could be scored on a scale from 10 (very helpful) to 30 (neither helpful nor unhelpful). High scores therefore indicate a higher helpfulness rating.

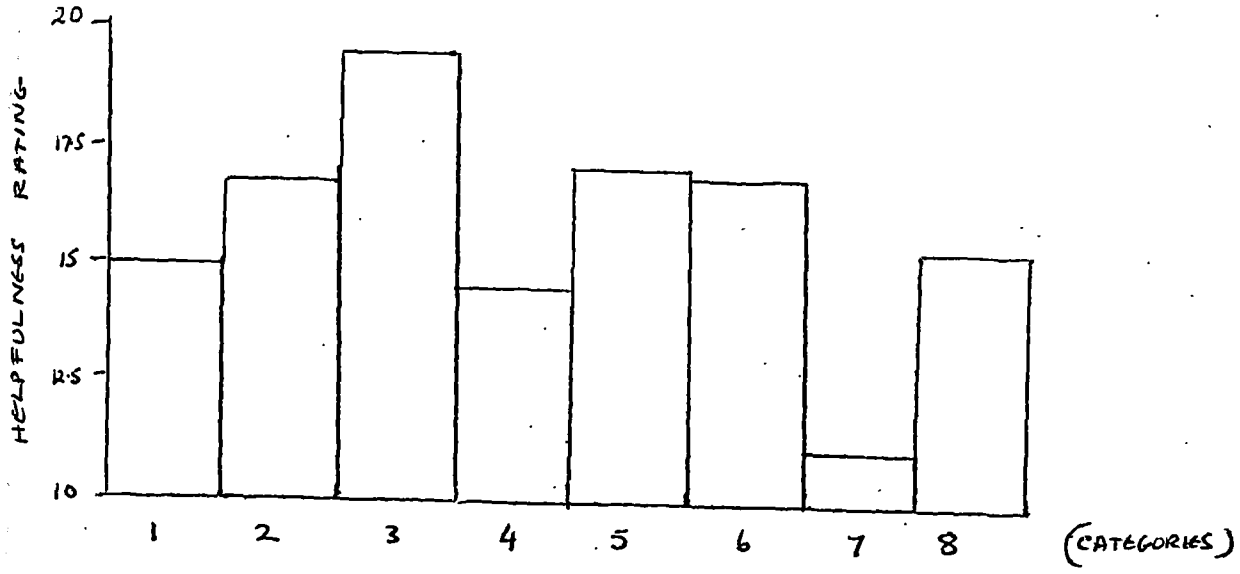

FIGURE 5 : RATINGS OF EVENTS GIVEN BY PATIENTS TO CATEGORISED EVENTS 1–8

NOTE : LOW SCORES = MORE HIGHLY VALUED EVENTS

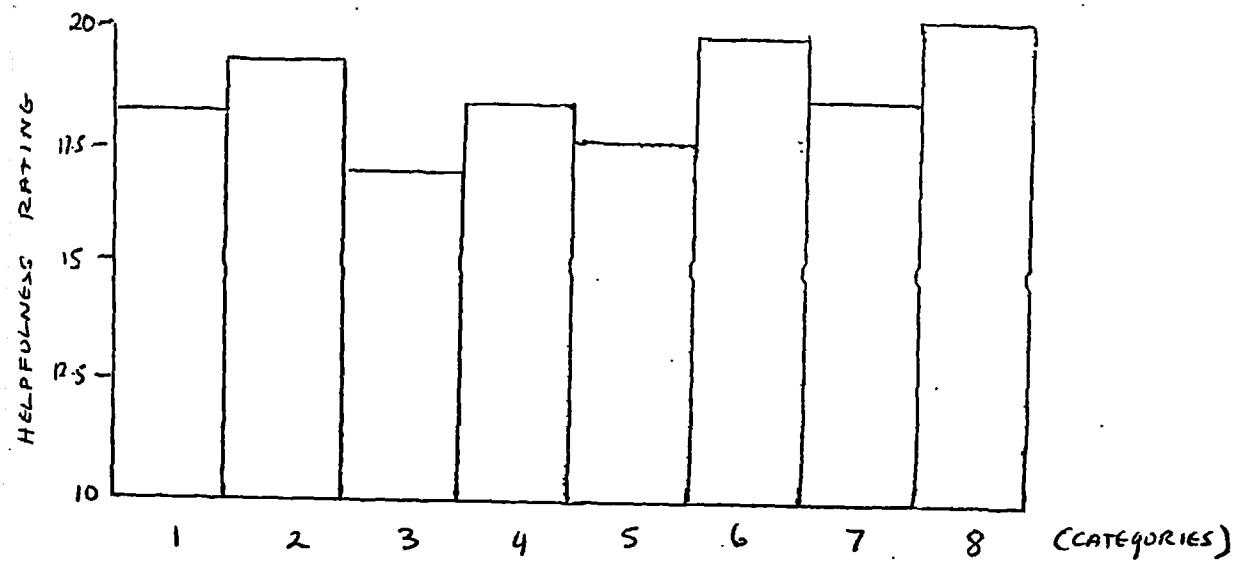

FIGURE 6 : RATINGS OF EVENTS GIVEN BY THERAPISTS TO CATEGORISED EVENTS 1–8

NOTE : LOW SCORES = MORE HIGHLY VALUED EVENTS

Contact). An interesting difference can however be spotted between the ratings given by therapists and patients to Affective Awareness events; although they are not very frequently reported by therapists, when they are, they are given high ratings. Patients neither report them very frequently, nor rate them highly. It may also be recalled from Table 14a, that there is a significant difference between therapists and patients on the frequency of reporting these events, in favour of the therapists.

Turning to Table 17b, and Figures 7 and 8, a rather similar picture emerges. The ratings of sessions in which particular types of events occurred, can be ranked, and compared with one another. The most helpful sessions for patients occurred when there was a Problem Solving, or Reassurance/Relief event, while for therapists, the most helpful type of sessions occurred when there was an Involvement, Insight, or Affective Awareness event. Again, there is a close parallel between the ratings given to events, and their frequency, as shown in previous tables.

Taken together, these two tables allow some confidence to be placed in the findings obtained from measures reported in earlier sections. This is because the relative helpfulness of events does not seem to be merely reflected in the frequency of their occurrence; but also in their absolute helpfulness, as indicated by both the specific event type ratings, and the sessional ratings in which particular events occurred. This is especially true for the patients, but also holds for the therapists.

Incidentally, it might be worth noting at this point that therapists gave, on average, lower helpfulness ratings to both events and sessions, than did patients. This is consistent with other work in this field, for example, Caskey, Barker and Elliott (1984) and Stiles and Snow (1984).

Returning to the question posed in this section: the events seen as most helpful according to ratings of both

TABLE 17b: Ratings Given by Patients and Therapists to Sessions in which Events Occurred, According to Category of Event.

	Patients			Therapists		
Category	No. of Events*	Average Helpfulness Rating of Event**	Rank Helpful Events	No. of Events*	Average Helpfulness Rating of Event**	Rank Helpful Events
1	50	16.8	=4th	120	20.2	2nd
2	20	16.8	=4th	38	22.4	7th
3	8	17.5	7th	23	20.4	3rd
4	57	14.8	1st	60	20.7	4th
5	22	17.3	6th	32	18.8	1st
6	12	16.6	3rd	5	22.0	6th
7	84	15.9	2nd	59	21.5	5th
8	12	18.3	8th	18	22.8	8th
9	0	0	-	2	15.0	-
10	0	0	-	3	23.3	-
11	3	23.3	-	1	25.0	-
12	1	30	-	0	0	-
13	1	30	-	1	20.0	-
14	34	21.8	-	16	29.3	-

* Only events where the session in which it occurred, was given a rating, are included in this analysis.

** The sessions could be scored on a scale from 10 (very helpful) to 50 (very unhelpful). Higher scores therefore indicate a higher helpfulness rating.

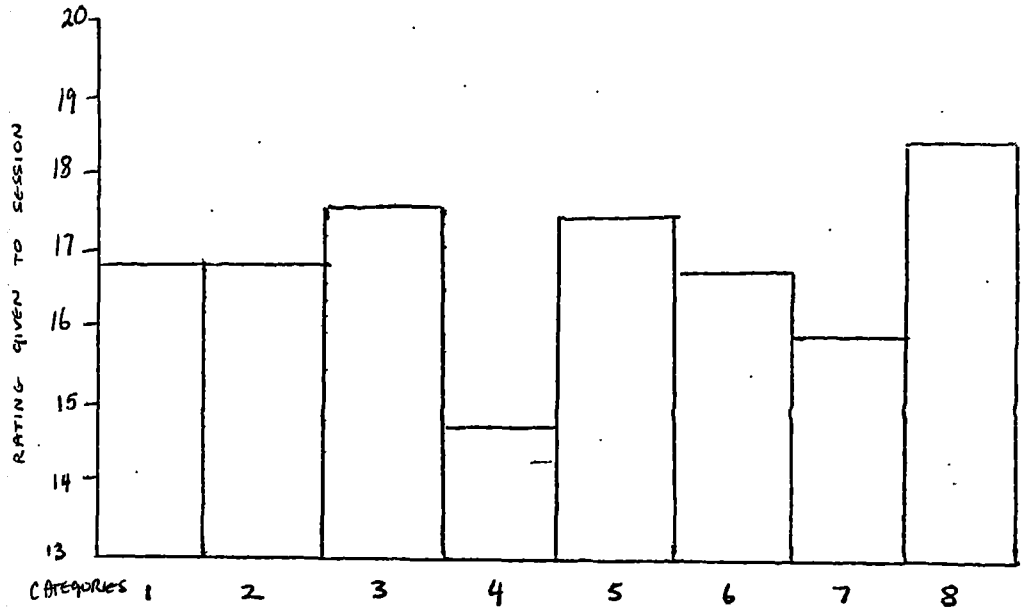

FIGURE 7 : RATINGS GIVEN BY PATIENTS TO SESSIONS IN WHICH CATEGORISED EVENTS 1→8, OCCURRED

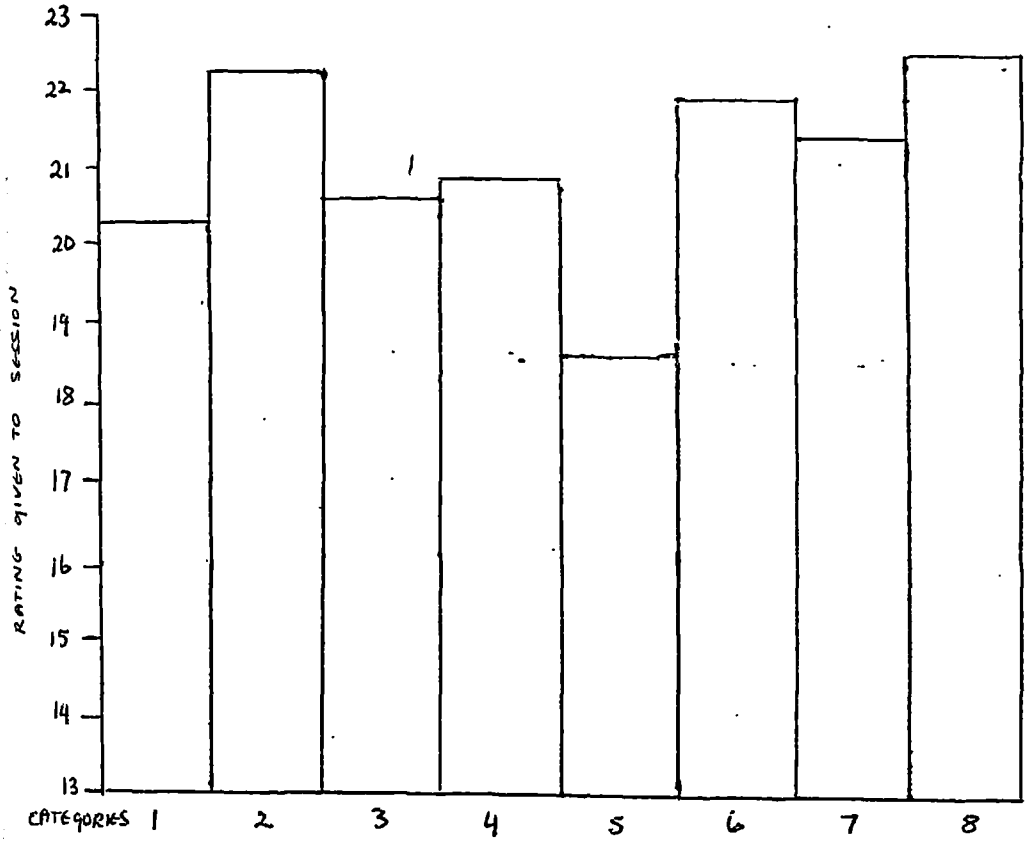

FIGURE 8 : RATINGS GIVEN BY THERAPISTS TO SESSIONS IN WHICH CATEGORISED EVENTS 1→8 OCCURRED

NOTE: IN BOTH FIGURES, LOW SCORES = HIGH VALUE PLACED ON SESSION

events and sessions are, for the patients, Reassurance/Relief, and Problem Solution, and for the therapists, Affective Awareness, Involvement and Insight.

6.10) Outcome and helpful events.

Question seven from section 5.2 read as follows: "How do the views of participants on the types of events seen to be helpful, relate to outcome?". Tables 11a and 11b showed the outcome of therapy for the whole group of participants; Table 18 shows the outcome for each individual patient, and allocates each patient into a subgroup, A, B, or C. It will now be explained how the total group of patients was divided into these three sub-groups for the purposes of this particular examination.

All outcome data was pooled for each patient; that is, ratings from both therapist and patient on the questions concerned with the improvement of the patient, and the degree to which therapy was thought to have been helpful, were summed. Since all four questions (two from each viewpoint) were scored on a 5-point rating scale, the maximum possible score (the worst possible outcome) was 20; while the minimum possible score (and therefore best possible outcome) was 4. Although it was pointed out in section 5.5.2 that the outcome measures employed in this study were rather limited, it was thought to be worthwhile considering whether there were any differences in type of event reported to have been helpful, between patients for whom an obviously "good" outcome was reported, with those for whom an obviously "poor" outcome was reported. Figure 9 shows how the groups were divided into the three sub-groups. However, it must be noted that the division into three was arbitrary, and other cut-off points could quite easily have been chosen, which would probably have meant that different results would have been obtained.

It must also be pointed out that, because of the largely favourable outcome achieved by most participants in this study, this procedure meant that some patients with scores as "good" as 9 were assigned to the "poor"

TABLE 18: OUTCOME RATINGS (Highest Possible Score = 4
Lowest Possible Score = 20)

Patient Number	Outcome Score	Outcome Group	Patient Number	Outcome Score	Outcome Group
1	8	B	21	5	A
2	4	A	22	6	B
3	4	A	23	9	C
4	4	A	24	8	B
5	6	B	25	10	C
6	7	B	26	6	B
7	5	A	27	5	A
8	4	A	28	6	B
9	4	A	29	6	B
10	14	C	30	9	C
11	8	B	31	9	C
12	6	B	32	8	B
13	16	C	33	11	C
14	4	A	34	8	B
15	11	C	35	4	A
16	6	B	36	12	C
17	4	A	37	14	C
18	6	B	38	6	B
19	10	C	39	6	B
20	8	B	40	8	B

Group A (good outcome) scores 4-5 (N = 11)

Group B (moderate outcome) scores 6-8 (N = 18)

Group C (poor outcome) scores 9-16 (N = 11)

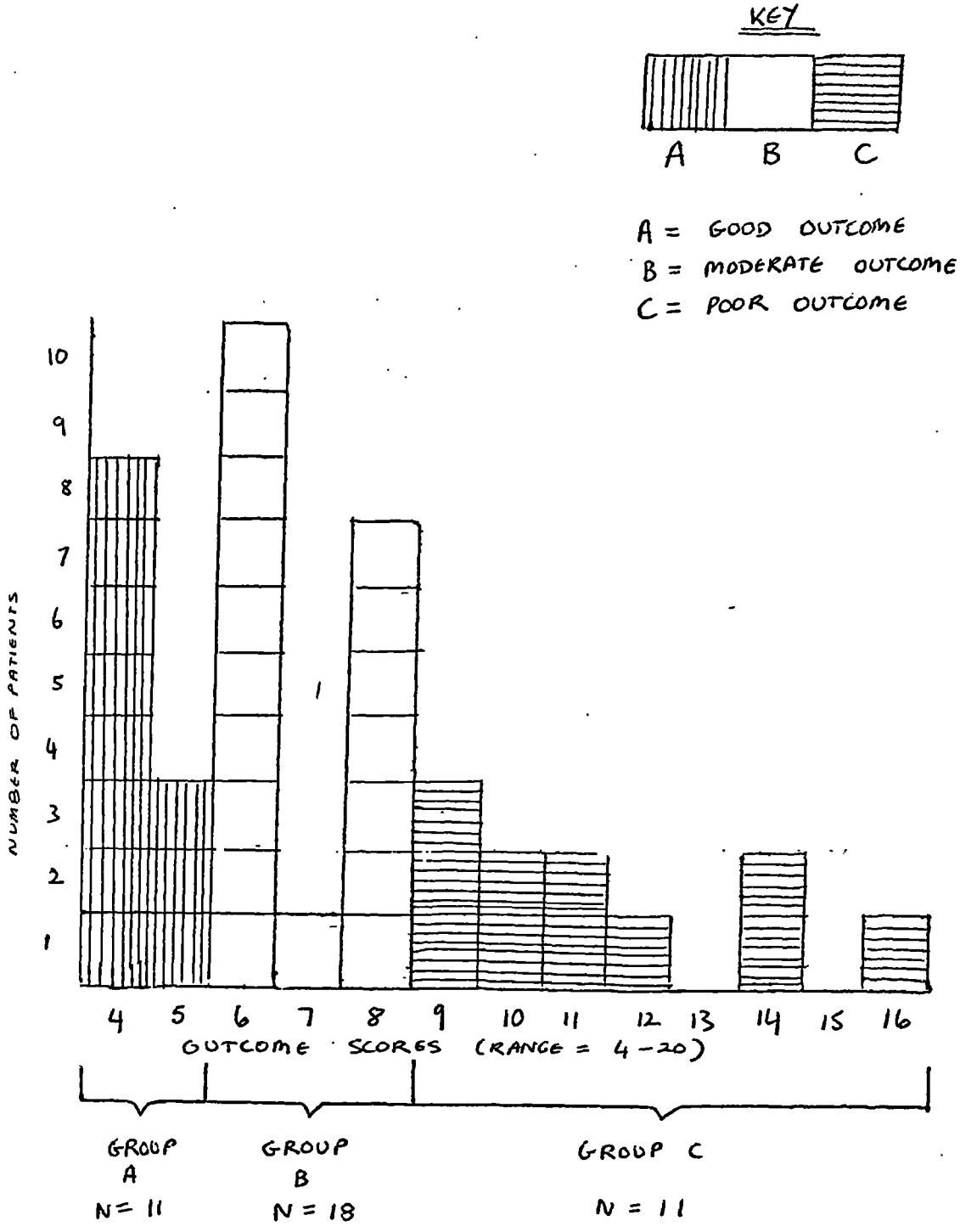

FIGURE 9
DISTRIBUTION OF OUTCOMES

NOTE: LOW SCORES = GOOD OUTCOME

outcome group. However, this had to be done in order to obtain a "poor" outcome group which was large enough to compare with the "good" outcome group.

Appendix 12 gives the total numbers of events seen by the two extreme groups, according to outcome. Table 19 shows the differences between group A (good outcome) and group C (poor outcome) on their scores on categories 1-13.

Note that it was not considered worthwhile to examine the scores for the middle, moderate scoring group B. It can be seen from Table 19 that the two extreme groups can be distinguished from each other on only a few categories of event. From the patients' viewpoint, successful outcome is more likely to have occurred when more Problem Solving events were seen as having been helpful, and fewer Involvement events. However, both these differences are significant only at the $p<.10$ level (using a two-tailed test). Of greater interest is the difference to be found in the therapists' responses; where there was a good outcome, the therapist was far more likely to have perceived Reassurance/Relief events to have been helpful, than when there was a poor outcome ($p<.02$).

From these results, then, it would seem that the one reliable indicator of a successful outcome from the perceptions of patients and therapists, is the valuing on the part of the therapist of Reassurance/Relief events; (it may be recalled from previous tables that this was seen to be the most helpful event overall from the patients' viewpoint). There is a hint that more Problem Solution and fewer Involvement events as perceived by patients, may also be linked to good outcome.

6.11) Differences between patients and therapists according to outcome.

Question eight from section 5.2 read as follows: "How does the degree of concordance or dissonance between perceptions of participants, relate to outcome?". In other words, do the responses of patients and therapists with

TABLE 19: Differences between Group A (Good Outcome) and Group C (Poor Outcome) on Categories 1 - 13*

	Patients			Therapists		
Category	N	U	P	N	U	P
1	11	50	NS	11	59	NS
2	11	34.5	NS	11	39.5	NS
3	11	43.5	NS	11	47.5	NS
4	11	33	p <.10	11	48	NS
5	11	32.5	p <.10	11	55.5	NS
6	11	55	NS	11	58.5	NS
7	11	57	NS	11	25	p <.02**
8	11	60	NS	11	51	NS
9	11	56	NS	11	49.5	NS
10	11	number of events too small to permit analysis				
11	11	44	NS	11	55	NS
12	11	number of events too small to permit analysis				
13	11	number of events too small to permit analysis				

* The test applied was the MANN-WHITNEY 'U' test.

** The difference was statistically significant at an acceptable level using a two-tailed test.

better outcomes correspond or differ from each other more or less than those with poorer outcomes? Because of the low numbers of events involved, it was not possible to carry out correlations between the two sets of pairs in order to answer this question; however, it was possible to examine whether there were any significant differences within each set of pairs, and then to compare the number of significant differences between the two sets of pairs. Table 20 shows the results of this comparison.

As can be seen, there is only one statistically significant difference between therapists and patients on the fourteen categories in the good outcome group, where a difference is found only on the number of Problem Solution events, ($p<.05$). It is interesting to compare this result with that obtained using the whole group, as in Table 14a, where a number of differences were found. However, in the poor outcome group, differences were found on three categories, Insight, ($p=<.05$) Clarification, ($p=<.05$), and Reassurance/Relief, ($p=<.05$). (The scores on which these tests were performed can be seen in Appendix 12). In other words, more therapist/patient differences are seen in the poor, rather than in the good outcome group, although the number of differences is not very great.

Poor outcome is therefore associated with more Insight and Clarification events perceived by the therapist to be helpful for the patient, and less Insight or Clarification events perceived by the patient to be helpful for him or herself. Also, poor outcome is associated with the patient perceiving more Reassurance/Relief events to be helpful than his or her therapist. Good outcome is to a limited extent associated with a higher level of patient/therapist agreement. This finding is consistent with that reported by Cooley and Lajoy (1980), who found that similarity in perception of factors involved in therapy is associated with better outcome. However, it is also interesting to see that good outcome is associated with disagreement on the frequency of Problem Solution events, a finding that is possibly somewhat surprising,

TABLE 20: Differences between Therapists and Patients According to Outcome*

	Group A (good outcome)			Group C (poor outcome)		
Category	T	N	p	T	N	p
1	13	10	NS	7	10	p <.05**
2	25.5	9	NS	5	9	p <.05**
3	0	5	NS	4.5	7	NS
4	11	10	p<.05**	12	8	NS
5	7	6	NS	21.5	8	NS
6	2	3	NS	1	4	NS
7	23.5	11	NS	2	8	p <.05**
8	.9	7	NS	6.5	6	NS
9	0	2	NS	0	1	NS
10		numbers too small		to permit analysis		
11	0	2	NS	1	6	NS
12		numbers too small		to permit analysis		
13		numbers too small		to permit analysis		

* The test applied was the Friedman two-way analysis of variance and Wilcoxon matched pairs test.

** The difference was statistically significant at an acceptable level, using a two-tailed test.

and may need further exploration. It is also interesting to note that the differences between the two outcome groups is not very great, a point which will be raised again in chapters 9 and 10.

6.12) Summary of Results.

This research study has provided at least some answers to the questions posed in chapter 5 above. The picture of psychological therapy as perceived by therapists and patients is different, at least in some respects, whereas in other respects it is remarkably similar. As a whole group, during therapy, patients value most highly Reassurance/Relief, and Problem Solution, and value least, Affective Awareness and Understanding; (the term "value" is used here both in terms of the frequency with which respondents report these events, and in terms of the ratings which are given to these events and the sessions in which they occur). Therapists, on the other hand, value most highly Insight and Problem Solution, and value least Personal Contact and Understanding. On termination of therapy, patients in retrospect report more Problem Solution, Personal Contact, and Reassurance/Relief events to have been helpful, and fewer Involvement and Affective Awareness events. Therapists, in retrospect, report more Insight and Personal Contact, and fewer Clarification and Understanding events, to have been helpful.

In some respects, patients and therapists are agreed. They concur on the outcome of therapy, in terms of how successful the therapy has been, and they are also agreed on the relative place of some aspects of the process, such as Personal Contact, which for both sets of participants plays a relatively minor role during therapy, but is seen in retrospect to have been very important. During therapy, they are also agreed on the relative importance of Problem Solution, and the relative unimportance of Involvement and Clarification. On termination, they are again agreed on the relative unimportance of Involvement and Clarification, and the lowered importance at this point of

Reassurance/Relief.

However, with these exceptions, the perceptions of participants differ. During therapy, participants disagree on the relative importance of Insight, Affective Awareness, Understanding and Reassurance/Relief; whereas after termination, they disagree on the frequency with which Insight, Problem Solution, and Understanding are reported. Consistent differences both during and after therapy are found in the frequency with which unhelpful events are reported; therapists are more likely to report Misdirection events, whereas patients are more likely to report Disappointment events.

Differences were also found over time. In retrospect, patients report more helpful events in the Problem Solution and Clarification categories, and fewer events in the Clarification, Involvement, and Reassurance/Relief categories. Therapists report in retrospect more Involvement and Personal Contact events, and fewer Insight, Clarification, Problem Solution, and Reassurance/Relief events.

Patients with better outcomes could be distinguished from those with poorer outcomes on three types of events: patients from the better outcome group report a greater number of Problem Solution and fewer Involvement events to have occurred; while therapists in the better outcome group report a higher frequency of Reassurance/Relief events. A slightly higher level of agreement was found between therapists and patients in the good outcome group than in the poor outcome group; the better outcome group disagree on the frequency of occurrence of Problem Solution events, while in the poorer outcome group, therapists report more Insight and Clarification events, and fewer Reassurance/Relief events, than patients.

These, then, are the answers to the questions raised in chapter 5. The picture gained of therapy is informative and interesting, and in my view, novel. The different questions asked, tapped different aspects of the

perspectives of participants, but the answers obtained from within each perspective, were fairly consistent with each other, which encourages confidence in the meaningfulness and validity of the answers. In chapter 9 there will be a discussion of these results both in terms of existing findings in the field, and in terms of a general understanding of the process of psychological therapy. In the next chapter, however, four case studies will be presented which will illustrate some of the findings already described in this chapter. Some of the methodological issues concerned with this study and the interpretation of the results, will be discussed in chapter 8.

Chapter seven

Results, Part Two: Case Studies.

7.1) Introduction.

This chapter presents a selected number of case studies which were collected in the research, and of course formed part of the data used for the analyses described in chapter 6. The reason for including these case studies as an integral part of the presentation of the results (instead of presenting them as a subsidiary appendix which is probably the more normal practice) is the belief, outlined in section 5.3.4, that much can be gained from viewing the therapeutic relationship as a whole, and in observing its development through various stages. It was also felt, following the examples of the case studies presented by Strupp, (1981), that much can be learned from detailed examination of specific case histories. However, the accounts will not be presented without interpretation; points of relevance to the questions raised by this thesis will be discussed as they emerge from each case study. This will be done as it was felt that "an intelligent reading" (cf. Howe, 1981) requires interpretation as well as presentation. Of course each reader must decide for him or herself whether the implications drawn seem accurate; in keeping with the relativistic stance taken by this research it is clear that a multiplicity of interpretations are in fact possible. Allport (1942) points out that "because every investigator has his own frame of reference to start with, simon-pure induction is perhaps an impossibility, and yet it probably plays a role, sometimes more, sometimes less, in nearly every investigator's contact with personal documents" (p.49).

Obviously with forty completed dyads, there was an enormous variety of cases that could have been chosen for detailed study. However, I have selected just four for further analysis. These four were chosen to represent many

of the issues raised by the other cases; however there is no way that they can be said to be typical. Each case history was remarkably different; no "typical" case existed. Plummer (1983) points out that in the use of personal documents it is extremely difficult to ensure that any given informant is representative of the group; sometimes the criterion must for pragmatic reasons be the quality of the information provided. Certainly this was one of the criteria employed in selecting the particular cases for detailed consideration in this thesis. The verbal abilities of the informants in cases one, two and four are probably above average. The other criteria which I used, included the type of therapy being given, the sex of the patient and therapist, and the duration and outcome of therapy. Case one is a male patient with a female therapist who at least intended to use behavioural methods; case two is a female patient with a female therapist who used psychotherapeutic methods; case three is a female patient with a male therapist who used primarily behavioural methods; and case four is a male patient with a male therapist who used psychodynamic methods. The first three treatments were seen by the participants as having been successful, in contrast with the last case. The first two were of longer duration (more than ten sessions); the last two were of shorter duration. As such, therefore, the cases do portray a reasonable picture of the cases in the study.

What follows are the four case studies:

1) C.S., a patient with spider phobia, receiving "behavioural" therapy.
2) A.N., a patient with interpersonal and work difficulties, receiving psychotherapy.
3) M.M., a patient with an anxiety state, receiving behaviour therapy.
4) D.S., a patient with interpersonal difficulties, receiving psychoanalytic therapy.

7.2) Case Study One: C.S.

C.S. was referred for treatment by his general practitioner. Aged 40, he was employed as a polytechnic lecturer, and was divorced with no children. His work as a social anthropologist led him to spend considerable periods of time abroad. Both his ex-wife and current girlfriend were also anthropologists. He requested help with a phobia of spiders, which did not cause too much difficulty at home, although he reported not being too happy about spiders encountered particularly in closed spaces. The main problem lay with the larger species often found abroad, especially in Australia and the Far East. The referring letter also mentioned frequent migraines and insomnia, although the patient did not mention this in the initial description of his difficulties. The therapist described his difficulties as "a phobia of spiders in the setting of a schizoid personality".

The treatment lasted for 17 sessions. The therapist indicated that she would use behavioural means of treatment although her approach was eclectic. She said that she expected the therapy to last between 7 and 12 sessions, and both she and the patient were fairly hopeful that the therapy would be successful.

From the reports given by both participants, it was clear that the relationship was a warm one, and progressed further than either had predicted. The initial work was behavioural. In the first session, C.S. says that learning the relaxation exercises was helpful as was the construction of a hierarchy of feared situations. He commented "structuring encounters with spiders was also very helpful. I thought initially it would be a little like asking a victim to grade his torturer's techniques, but it wasn't as bad as I had feared. Gave me glimmerings of a feeling that at least part of the fear might be controlled".

The next session continued to concern the behavioural programme. In session 3 however, C.S. starts to write at length about other factors occurring in the therapy. For

example he writes, in response to question 4 about other helpful factors occurring in the session: "a partly justified admonishment about expecting an "off-the-shelf" cure without contributing the necessary time and effort... another example of the strengths and weaknesses of single-mindedness". Also he writes: "when being warned of the long-term dangers of being workoholic, letting slip the comment that I had tended to circumvent these by assuming that there were no long-term (ie. post 40 years old) prospects for me. Also mentioned my friend dying at the age of 38 as an embodiment of that fear/guilt. Regretted afterwards letting that particular cat out of the bag as it probably goes back a very long way and because I'm beginning to see myself differently. But maybe it would be worth trying to exorcise".

It is clear from the above that much more is occurring than would fit into a simple behavioural paradigm. The therapist too is aware of some of the issues that are concerning the patient, particularly the overworking issue, but did not notice the cognitive changes mentioned by C.S. It appears that C.S. thought that his therapist had recognised the "cat" that he had "let out of the bag", although she has not noted it here. She seems to be much more aware of possible transference issues, as shown by her comments: "Discussion of his tendency to overwork; me showing that I could perceive this in him, and empathise," and "him saying that he was disoriented when he left here. Is he talking about the effect on him of our relationship?"

By the fourth session, neither the therapist nor C.S. mention the spider phobia. Both agree that the session was valuable. C.S. writes: "It was very useful discussing my background and early developments and the way both have continued to affect me over the last ten years or more... One very useful comment was to the effect that much of the time since leaving my parents' home seems to have been taken up with resolving problems that should have not been created". The therapist writes: "The patient describing

his childhood, trusting me enough to reveal some very difficult feelings. C.S. seeing that I was obviously interested and moved by his sad experiences". It is interesting to note that here again the therapist is making self-referential comments, without obvious awareness of the cognitive, sense-making changes occurring in the patient. It does appear, however, that the patient is now very willing to discuss these issues, which implies a rather different relationship than that implied by the use of the phrase "letting the cat out of the bag" in session three.

The fifth session seems to have been one of the most painful and important sessions of the entire course of therapy, as various existential and personal issues are faced. These seem to have little to do with the spider phobia. C.S. writes:"I found this last session more difficult than previous ones to evaluate because it covered wider ground than the others, also perhaps because (the therapist) was trying to make me look at my own mental mirror and evaluate what I am rather than what I've done. And I find that hard to do. I have probably tended to coalesce the two; I am what I do, I do what I am, etc. Perhaps the end result has been a rather cramped view of self. One thing I would probably admit to: that the 18 year old whose photo is on the front of my first passport has done far more than he has ever imagined, but whether he has been more, he might doubt".

The self-absorbed honesty of the report (and presumably of the session) is to a degree recognised by the therapist when she writes: "Talking about his slow emotional development and the emphasis he always puts on his intellectual self. C.S. starting to accept parts of himself that are not just intellectual". It is interesting to note that the therapist also reports "both of us agree that our departure from the fixed behavioural approach is a good idea". In her initial formulation of the problem, the therapist had noted the presence of interpersonal difficulties and a rather "schizoid personality", and it

is interesting to see that she is now clearly working on this observation, despite stating at the outset that the therapy was to be behavioural. It is impossible to say whether this departure from the behavioural technique was planned or whether there was some post-hoc rationalisation occurring here.

There was then a four week gap while C.S. was abroad on fieldwork, and apparently during this time encountered some rather unpleasant spiders, as the treatment reverted to a behavioural focus, on the resumption of therapy. However, the therapist continued to emphasize the interpersonal aspects of the therapy, commenting that the most helpful event was: "the reassumption of trust between us, him being aware that I like him and value him emotionally". The following session was seen as very helpful by both. C.S. reported: "The beginnings of progress insofar as I managed to touch a picture of one albeit not of monstrous size. But the encounter with the spider in the vehicle may have injected an urgency not present before. Realisation also of the extent of the fear that has to be tamed. Scepticism now being supplanted by optimism; sense of self confidence that at least part can be overcome". The therapist's comments were briefer: "Going through relaxation and looking at the phobic object; making him touch it despite his fear, giving him encouragement". However the answers to the supplementary question about other useful events in the session were unusually similar: C.S.: "Productive as they all have been in the implanting of questions". The therapist: "His pointing out that I had a habit of asking useful questions".

It must be clear that an enormous number of events were occurring simultaneously, from the patient's viewpoint, during the session, including the awareness of the need to deal actively with the problem, the growth of self confidence and a sense of hope. However, various other issues are raised by the reports of both participants, over these last two sessions. For example, the patient's comment that the trip to the Far East "injected

an urgency not present before", may suggest a rather complicated motivation for seeking therapy in the first place. Further, the therapist's lack of emphasis on the spider phobia is remarkable, given the presenting complaint and current concern of the patient. There is no obvious recognition of these factors by the therapist, at least in her report.

Sessions eight and nine continue largely in the behavioural mode, although there is some reference by the therapist in session eight to a discussion about C.S.'s ex-wife, which is not mentioned at all by C.S.. In session nine the therapist's comments are as follows: "C.S. clarified the two parts of himself, and the difficulty he has in integrating a) the pushing, achieving part, and b) the lazy, pleasure loving part. Also progress with the phobia, making the choice to get the live spider out of the jar himself, and let it run on his hand". C.S. comments: "Handling a spider albeit not very large, but first time ever; very surprised that I tolerated one on my hand that was large enough to feel, and watched it move around".

In session ten, the therapist returns to make reference to the relationship between her and C.S., with the comment: "Discussion of what was missing in his emotional life, leading to my suggestion that he didn't call out the mothering part in me, maybe suggesting a fear of revealing weakness etc.". This does seem to have made some impact on C.S. in that his description of the most helpful event of the session is: "having a spider on hand and arm again", but includes as his supplementary point: "The comment about mothering was intriguing; and the need to be mothered at times. The thought of being mothered is about as... probably even more... strange than fathering. Have never been prone to categorise emotions in terms of kinship".

During the next two sessions it becomes clearer that the behavioural aspects of the treatment are occurring in parallel with a consideration of a number of wider issues.

In session eleven, C.S.'s comments are as follows: "The most amazingly amazing one was having a spider walking on my hand; of being able to get the blasted thing out of a jar and then to willingly keep picking it up. Definitely something that would have been impossible last term. Almost as odd was walking around with a jar of the bleeders in my pocket; ... the odd feeling was that afterwards it didn't really seem to have been a spider on my arm because I wasn't afraid at the time although I knew (obviously) that it was; but somehow part of me declassified it". In response to question four, he wrote: "The suggestion of trying some scenarios of my life in five years time, following the disclosure that I was thinking of changing my job". Of session eleven the therapist writes: "Discussion of his future; me asking whether he'd really thought through his motives for wanting to move, was it an attempt to escape from the old predicaments, or a liberated step?" In response to question four, she writes: "Touching the large spider".

The enthusiasm with which the patient describes his newly found ability to handle spiders is in no way matched by the therapist's rather terse comment: "Touching the large spider". Equally the therapeutic probe by the therapist seems to have passed C.S. by. Both are clearly working, and the patient in particular is thinking hard about the meaning of the changes he must accommodate in the ways he sees the world in the light of his new experiences. But the two are making sense of the encounter in rather different ways. It would seem that the underlying theory that the therapist is using in this particular case is not at all behavioural; in fact she seems to describe the behavioral aspects of the sessions as briefly as possible.

There is more agreement about the content of session twelve. The most helpful event from C.S.'s viewpoint was: "Looking at pictures (albeit the easiest!) of tarantulae; pretty loathsome but not traumatic. As happened before, the anticipation was worse than the event". He also adds:

"a good comment about disassociating my feelings towards spiders from those I feel towards my mother, and being able to treat the two as independent variables". The description given by the therapist is similar, but rather different in some respects. Her first comment is: "Looking at pictures of spiders, which are gradually getting bigger and more frightening", while her second comment, although similar in terms of topic, is different in terms of precise content. It is: "C.S. understanding how his initial fear of me persuading him to like his mother had not actually been realised; instead, I've helped him to like and expand his self over the last few months". The therapist thus takes the importance of the relationship between "spider" and disliked part of self or mother, further than does the patient, possible assuming that he has gained insight.

Sessions fourteen and fifteen seem to have been almost entirely concerned with spiders, although the patient describes in much greater detail his pleasure and optimism at having made so much progress. It almost appears that the therapist is not particularly concerned with the patient's feelings about this aspect of his treatment. The next session occurred after 2 weeks of holiday taken by the therapist, during which time the patient seems to have been unwell. He comments: "A catching-up session after a two week break, in which time I'd had two very bad (ie. week-long) bouts of insomnia/migraine. Thus felt at a very low ebb, rather hassled and more than a trifle sad. I think what may have been on my mind were my two fears; viz of being enmeshed like my father on the one hand, and on the other, of being isolated/alone; knowing I was probably yearning to be free of one yet heading into the other when I head off abroad next month. On the therapist's part, one very useful (and skilful) probing to get me to articulate some of some of these points. As well we didn't tackle the spider fear on this occasion because of my mood."

The mood is picked up by the therapist, although she does not discuss the details of his distress. In response to the first question, she writes: "Pointing out his lack of honesty with himself, ie. not facing the lack of emotional closeness in his life; this probably underlies his somatic symptoms". In response to the second question she writes: "C.S. starting to face his unhappiness and the choices he must make". On this session the two do seem to be much closer in their pinpointing of the helpful events; possibly the "mood" described by the patient led to this. It is interesting to note however that the reference by C.S. to his therapist is the first one he has made so directly during the entire course of therapy sessions so far, (although he did make an oblique reference to her in session seven).

The next (seventeenth) session is the last session on which there is any data. (The therapy continued after the patient had returned from another prolonged period of fieldwork abroad, although most of the therapeutic work was apparently completed by this point, and the end of therapy data was collected at this juncture.) This session did have many aspects of an end of treatment session. C.S.'s comments were: "A very helpful re- appraisal of much that has happened in the period of therapy since January, and of the implications of some of them, notably long-term conflicts of career with personal relationships of any stability". The therapist's comments are as follows: "A long and very useful discussion of the state of C.S.'s personal relationships, ie., how he doesn't feel as much for M. (his current girlfriend) as she does for him, which led to an examination of his own needs; and him admitting that he does want to be warm and taken care of sometimes". The therapist also adds in response to question four: "Acknowledging that although I don't have all the answers, I was in deep empathy with his difficulties". Here again she is making reference to the relationship between herself and the patient that is not at least overtly acknowledged by the patient. It is clear at this point that the therapist has become very fond of the

patient, and has possibly not resolved these feelings very adequately. Subsequent case studies will demonstrate the way in which therapists frequently refer to their experience of the therapeutic relationship as having been crucial; nevertheless this particular therapist is especially personal in her remarks about the patient.

The end of therapy data obtained by the two participants reflects the two parallel accounts of the therapeutic experience. That provided by the patient is divided into three different parts. Firstly he considers the spider phobia, (it may be recalled that at the outset this was the only problem mentioned by him). His comments are as follows: "the use of graded thresholds when dealing with spiders; from the dead money spider to picking up live house spiders to looking at pictures of the enormous types I encounter on fieldwork"; an obvious reference to the behavioural techniques. The second issue seen as having been helpful by C.S. is one that hardly appeared in the week-by-week accounts: "The relaxation techniques which proved extremely useful in coping with writing the book, fieldwork abroad, insomnia/migraines etc., as well as the spiders".

The third issue merits a much longer description from C.S.. It concerns what C.S. calls "longer term and wider issues". He writes: "It was very useful in at least articulating the problems, and assessing some of the implications of the options; re-assessments of my past were also useful, and helped modify many long held views. The therapy over these months has coincided and interlocked with several developments in my life- notably the writing of my book between Xmas and March, after three years of researching/attempting to write and doing other things; an unexpected rapprochement with my ex-wife after a long, complex and often bitter divorce; a very gruelling season abroad; much pondering over what to do with my next fifteen years now I've come to accept they may actually happen; and how my present life-style and obligations/goals relate to my emotional needs and

desires. In the midst of all this, I found the therapy very useful in helping to puzzle some of these out. In particular, it was very helpful in re-evaluating the view I had acquired of myself from my parents, and from the break-up of my marriage; and in assessing some of the costs of my present life-style. Even though an optimal solution to the main problem of maintaining a worthwhile stable relationship that provides security but which is not asphyxiating along with a demanding, unpredictable and mobile career, is still elusive and may prove unattainable, it was very valuable to talk around this and related issues."

The comments by the therapist were much briefer, although they clearly relate to the phenomena described by the patient. She noted four helpful aspects: firstly "Using systematic desensitisation for the spider phobia"; secondly "C.S. having a chance to talk over his current emotional entanglements and see how he felt about them with me, as an uninvolved person"; thirdly, "my useful questions, and semi-interpretations of his emotional state and preoccupations, and relating them back to childhood trauma and unresolved difficulties"; and lastly, "our friendly relationship; mutually respectful, cordial but also warm." Interestingly, the therapist also adds an unhelpful aspect, (which the patient does not): "Perhaps I did not deal with the transference well enough". Yet an uninvolved reader of the sessional reports might observe that this therapist has in fact not dealt with the counter-transference very well, instead!

Both therapist and patient rated the therapy as having been very helpful overall, and the patient to be "much better". The most obvious and interesting feature of the period of therapy was that both participants clearly did use almost every session constructively and appear to have covered an enormous amount of ground, as indicated by the patient's concluding comments. But the way in which each of the individuals concerned made use of the interaction was unique to themselves. For example, there are

repeated comments by the therapist about the relationship between herself and the patient in ways which are reminiscent of the psychoanalytic, although she does not claim to use this approach generally. Especially in the middle sessions, she makes reference to the patient learning through the relationship that she values him, is aware of his emotional needs and so on. In noting the beneficial aspects of therapy at the end, she repeats this emphasis on the personal relationship between the pair; and indeed cites a failure to deal with transference issues as a possible problem in the therapy.

Now it is of course impossible given the methodology used in this case study to conclude whether or not any of these aspects did or did not take place; what can be concluded is that both participants make sense of the encounters in different ways probably in terms of their own needs to incorporate the transactions of the session into their own worlds. Each session as experienced by the patient seems to have been "taken away" by him and used in some way during the period before the next session. For example, the skills in relaxation are used to help him to cope with pressure of work (as indicated in the comments at the end of therapy about the completion of his book in two or three months), and also with the migraine problems, despite the fact that the therapist only mentions them as a way of dealing with the spider phobia. Further, C.S. clearly thinks hard about the discussion that was held in the third session about the death of his friend and his conclusion that there might not be any life after the age of forty. It is not likely that the therapist did not notice this at all, for indeed she makes some reference to it in a later session; what is of interest is that the patient uses his thoughts about the discussion to reach some important conclusions about himself and his future in ways that the therapist has not necessarily anticipated or even considered.

It appears, therefore, that the important features of this therapeutic interaction are as follows: firstly, the

behavioural technique of desensitisation, which both agree to have been useful in reducing the spider phobia; secondly, the relaxation, which was of use to C.S. in a number of spheres; thirdly, the opportunity which the therapy provided for C.S. to reconsider a variety of personal and interpersonal issues; and fourthly, the relationship in which all of this was allowed to develop. It would be very difficult to say which of these points was primary; indeed they interact. It is also difficult to conclude that the theoretical orientation apparently used by the therapist (despite her original intention to use behavioural methods) had any marked impact on either the therapy itself or the patient, except for the structure it may have given to her. On the other hand, given her last comment about not handling the transference correctly, not even this is certain. However, what does appear to have been skilled about the handling of the case by the therapist was her ability to create a conducive atmosphere for the patient to approach his various difficulties constructively. There does not even seem to have been any need for the therapist to have been particularly aware of the impact of all of the transactions on the patient, nor for the two parties to be in accord about the most helpful features of the interaction, in any detail. In other words, the patient made use of the therapy in his own way according to his own particular set of values and understanding of the world, and the therapist acted in the way that made most sense to her, according to her beliefs and theories (which incidentally did not conform to any apparently coherent framework). This does not mean that the two did not influence each other; they clearly did, but it is the suggestion of this case study that this process of influence only occurs in relation to the sense that the individual has already made of the world, and is always subject to the individual's active accommodation of the interaction into current structures of thought and action.

7.3) Case Study Two: A.N.

The patient was a thirty five year old unmarried teacher, who came for help for a variety of reasons, which she described as follows: "Feelings of inadequacy in handling job, and more particularly social relationships, especially with men of my own age. Have experienced no difficulties in relationships with women, but havn't managed a long term, loving relationship with a man, and have felt in the past that this has "soured" my outlook on life. I have felt a bit of a freak! (Especially during the past 12 months, when there has been a great feeling of insecurity in most aspects of my life)".

The therapist's view of the problem was as follows: "Relationship problems; difficulty in communication, discipline problems at school". The therapy was an extremely helpful one; as can be seen by the comments of both participants, as well as their end of therapy reports. The approach used by the therapist is normally client-centered, and in this case she reported that she intended to use her normal approach. Both participants indicated that they were fairly hopeful that the therapy would be helpful to the patient.

The first session indicates a reasonably high degree of concordance between the two. The description given by A.N. is as follows: "Therapist's comments very helpful, eg. asked me to tell her about childhood, and during conversation, I remembered two incidents concerning men, which gave me food for thought on why I react to young single men in the way I do- with embarrassment, sometimes fear". She then adds: "I'm still thinking along other lines of thought prompted by the therapist, and this will give lots of scope in directing my musings before next session: eg. what are my positive characteristics?".

These events are to an extent paralleled by the therapist's account: "She recalled two events from her childhood relating to threatening experiences with older boys. It helped her to understand a little about her fears

in men's company now." The patient (but not the therapist) notes an unhelpful event: "Interruption from phone or when someone knocks at the door. I did find this off-putting, although I realise that it is beyond the therapist's control. By having to silence myself (when it takes a lot to get going) I start to feel unimportant and inferior again".

The next session is not described very clearly by the patient, who mentions only an event at the end of the session where she asks the therapist for some estimate of her progress, and is somewhat reassured by an apparently very guarded response. The therapist's account is more content specific. She writes: "I asked about a previous relationship which had broken up. I think it helped her to talk about this man and particularly about the sexual side of the relationship and her attitude to sex generally". The therapist interestingly enough does not rate either the session as a whole or this specific event as having been very helpful. The only other helpful event reported by the patient is the fact that there were no interruptions, and that: "since it was after hours it was also quieter and more peaceful therefore, and I felt more relaxed. I find the therapist's reassurance in attitude a stabilising effect". There is no mention of the nature of the discussion of the sexual relationship by the patient, nor any apparent awareness by the therapist of the importance of her simple reassurances to the patient. It is notable that "reassurance" is mentioned twice by the patient in this session.

The most helpful event described by A.N. in the next session is again not noted by the therapist, who makes some self-referential remarks instead. The patient's remarks are as follows: "The comments between myself and therapist, which led to me seriously contemplating my great fear of violent reactions which other people may show towards me, including verbal abuse and physical violence, which has led to feelings of repression and inhibition in me, because I daren't say or do anything to

reveal my true feelings to others, (this stems in part from comments I made about Princess Anne's apparent rudeness to Diana on the birth of her son)". Here we see the patient working hard at reconsidering her understanding of herself, and applying what may have been quite a brief and apparently insignificant interaction from the therapist's viewpoint, to herself, with some important results. In contrast, the therapist's comments are as follows: "I made it clear to A that the therapy could possibly continue for some time. She seemed to welcome the permission to extend therapy and that I was obviously willing to continue seeing her". It is not of course possible to conclude that this was not important to A.N., merely that it was not as immediately helpful to her as the therapist might have presumed, and certainly was not as helpful as some of her other remarks obviously were. Further it does not take note of the patient's discovery of her fear of violence, and the consequences that this fear has for her interpersonally, in ways that clearly exceed the scope of the therapeutic relationship.

The fourth session is equally differently perceived and evaluated by the two. A.N. sees the session as having been very helpful, and cites the following event: "Again, therapist helped me to begin to explore various avenues of personal interest, so all her (few) comments proved very helpful to me. Below is one instance of many: why was I looking forward to next year and the job situation? My answers helped me to come to terms with the fact that I have shed my ambition without feeling a failure. I genuinely was (and still am) happy at prospect at not having to strive for some post of responsibility just to keep up to some image of me by parents, relatives (older) and superiors at work. I feel freed!". The implication that this was an extremely thought provoking and therapeutically challenging session to A.N. is also evident in her response to question four, about anything else that happened of import in the session. Her answer was as follows: "When the therapist picked me up on an apparently flippant remark- I said "Even if Brigitte Bardot walked in

now I'd feel a bit inferior at first, but I wouldn't really want to be like her"- therapist said "that was an interesting comparison- why her?" This led me to explore why, and reasons aren't cut and dried, but I'm thinking along lines of me wanting to be considered "wholesome" and clean living!". In this series of comments there is evidence of both a good deal of thought, and pleasure at the newly discovered honesty with herself, as well as an awareness that perhaps there are still some areas where self examination is needed, in particular in her persisting need to be well thought of by others.

The answers provided by the therapist are so different that it is hard to be convinced that the two really are talking about the same session. Again the therapist is self-referential, indicating as the most helpful event the following: "Nothing in particular. She did refer to me as never ever having to cope with things like she has to- I commented on her fantasy about me and she realised that she does sometimes see me as the "Superwoman" she has always been trying to be. She is now accepting of her limitations". Regarding question four, the therapist responds: "She mentioned that she enjoys filling in these forms as it makes her think about the sessions".

The patient, in her description of the events of this session, has suggested a wide variety of sources of impact arising from remarks and questions from the therapist. Even the words of both participants are quoted from memory as having had special impact. Perhaps not surprisingly the therapist is not aware of which of her remarks were especially effective, and suggests a different remark or interpretation (about the patient's perception of the therapist). But, as in the Case Study 1, the therapist does not seem to be conscious of the extent of thinking that the interaction leads to in the patient, nor the amount of self re-construing that seems to be occurring.

In the interval between the fourth and fifth session, the patient is involved in a fairly serious car accident,

in which she sustained some facial injuries. Consequently the next session is spent talking over the accident. However, the therapist sees the benefit as primarily an opportunity for abreaction, whereas A.N. again describes the thoughts that the therapy session permits, seeing these as the most helpful event of the session. She says: "The major thing was "going over" my recent accident. Therapist helped me realise it wasn't a punishment for allowing myself to be happy, until it occurred." This suggests that more than simple abreaction was taking place in the patient; again it is not being suggested that the therapist did not know this, but that she was not so aware of the impact of other more cognitive factors, and is instead valuing the emotional factors.

Session number six is clearly a fairly difficult one, but is seen as very helpful by both participants. The patients' response is as follows: "The idea therapist introduced that my father is treated by me as "God"- to be appeased and never angered. Initially I found this rather shocking, but it did confirm what I had always suspected: that I hadn't ever really broken away from parental influences enough to lead my own life. Also, that all my relationships with men throughout my life had been coloured by my interaction with my father. Still thinking about the implications of this idea". In response to question four, the patient writes: "The exploration of why I have been punishing myself physically, mentally and emotionally. Why I don't feel entitled to be happy without the threat of consequences to follow". The description given by the therapist is essentially about the same set of events, although the emphasis is different, especially in question four which is again self-referential. The responses are as follows: "She talked about always feeling she must be punished for feeling good; fate always looking down and waiting for a moment to punish. I suggested that this may be feelings of guilt about her father. This produced a shocked but gradually accepting reaction". Question four: "She wept quite a lot and apologised continually- she wants me to see her as strong and

capable". It must be noted that there is no mention of crying by the patient at this point. This could be seen as indicating some form of denial on the part of the patient, or a lack of awareness by her of the significance of this event, or an over-valuing of the emotional reaction by the therapist.

The discussion of A.N.'s relationship with her father dominates the next session. It appears that both participants join together in working through the implications of the growing awareness of her feelings of guilt towards him and a need to appease authority. Yet again, the therapist is self-referential in discussing this with A.N.; her comment is: "Talked about her behaviour towards and thoughts of authority, and her behaviour towards me and how this related to her father". It is not surprising perhaps that the therapist becomes aware of the patient's difficulties by observing the patient's behaviour in the session; what is less easy to understand is the therapist's suggestion that her reflection on this should be seen as the most helpful aspect of that session. It seems that the therapist is working with a model of the therapy that is somewhat akin to the psychodynamic, in assuming the importance of transference interpretations above all else.

During the next session, a Repertory grid is constructed. The patient comments that this makes her reflect on the absence of males in the list of elements. No particular point is made by the therapist about the grid content. In question four, the therapist replies as follows: "She remarked upon my appearance as being slim... then presented me with a meringue as it was her birthday." It should be remembered that question four asks for anything else that happens during the session of importance; it is not immediately obvious what is of importance about the above event, except that it may have given the therapist some insight into the patient's wish for some similar "gift" for herself, or some form of envious attack on the therapist. Given the therapist's previous remarks about

the patient's view of the therapist as "Superwoman", this does seem likely to have been the therapist's understanding. This again implies that the therapist is working with a (modified) version of the psychodynamic view of the importance of transference interpretations. The importance of the gift of the meringue does not seem to have registered in any major way with the patient, however.

Session nine concerns a discussion of "duty". Both participants agree that this involves some reconsideration of morality; A.N.'s comments are as follows: "Exploration of "duty". Why I feel I should or ought to do something- is it because of expectations of others or because I want to do it? My life has been channelled and constrained by such repressions as well as by physical circumstances. How "guilt" feelings reinforce such inhibitions, but aren't necessarily caused by them". This discussion of the origins and perpetuation of neurotic feelings is far from unsophisticated, and indicates yet again a great deal of cognitive activity on the part of the patient. The language that she uses, such as the phrase "my life has been channelled and constrained by such repressions" sounds neither histrionic nor cliched, but rather to reflect a rather painfully reached insight, and sadness.

The comments provided by the therapist in question four of this session and in the main question of session ten concern the therapist's view of A.N.'s feelings about the therapy itself and future developments. For example: "Also concentrated on A.N.'s need to have permission to start the session and how this need is seen in other parts of her life". Understandably, the therapist is working with the data that is immediately available to her, and using this to draw attention to other features of the patient's life, particularly as they occur interpersonally. But again it seems that the emphasis that the therapist is placing on this event implies that it is more than a straightforward reflection, but rather is intended to carry more weight, as would a transference interpretation. In this way, the therapist is operating in a similar

way to the therapist in Case Study 1, and the patient is similarly not picking up the therapist's intentions in any very major way.

In session ten, the patient continues her self discovery, as follows: "Exploration of idea of confrontation and upsetting others and why I avoid it- anything for a peaceful life. How this affects me- obsession and moodiness. How do I make my own feelings evident? Why so scared of aggression? Especially in young men! How can I best cope? (No firm answers, but at least an inkling of understanding to leaven feelings of helplessness)". Her response to question four continues in the same vein: "Discussion of my aspirations, hopes for the future. Everything's possible but one has to make up one's own luck. You can't run away from risk/danger/(ie. of) aggression all the time: do something constructive". These two sets of comments imply that the work of therapy is occurring on a number of different fronts simultaneously: the installation of hopefulness, the gradual self-acceptance, the insight into her own fear of confrontation, and some awareness of the need to face issues of morality and existential choice. Conversely the therapist picks up something far more emotional: "Mention of her outward show of competence when inwardly feeling panicky and tearful".

It is only in the next (eleventh) session that the patient starts to talk about her relationship with the therapist, and interestingly enough the therapist herself doesn't register this change at all. The patient's comments are as follows: "Therapist made several very useful comments (re. me and need for "permission" to live my life, how I project my feelings, not necessarily "image", of how I see myself etc.) at greater length than before. I found this very reassuring for such contact is necessary for me. I felt that at last we were communicating two-ways and not merely slotting into the role of talker/listener. Made the therapist more real to me". This combination of the awareness of the relationship with the therapist and

the gaining of more insight into the nature of her own neurotic need for "permission" makes this a particularly interesting session, where it might be expected that the therapist would have picked up at least one of the patient's concerns. However, the therapist's report is as follows: "Recalled a recurring dream and attempted to interpret it and relate it to herself and her fears of relationships, particularly to men". Again there are suggestions here of the influence of psychodynamic ideas, although the patient makes no reference to the dream, or its interpretation. It must be recalled that the therapist's intention had been to work with A.N. using a client-centered model, yet it does not appear to be the case that the therapist is picking up the patient's concerns at least in terms of the importance of events to her. Nevertheless the patient is clearly registering care and concern on the part of the therapist especially in this session, for in comparison with any other session so far, the therapist is seen by the patient as more "warm, empathic and genuine", in true client-centered fashion, than in previous sessions. This seems to imply that the therapist is having considerable therapeutic impact, but not in the way she had anticipated in this particular session.

The twelfth session concerns the interpretation of the Repertory grid. The patient comments that she found the most interesting part of this exercise to be an examination of where she located two of her male elements, whereas the therapist reports that the patient was most fascinated by where she had placed her father. The patient also says that she found the grid led her to think about "where my ideal partner would come. Also, thinking where I would have rated myself at the very beginning of therapy". This again suggests that she is using the thoughts generated by the session to discover other aspects of herself which may not have been considered by the therapist.

The next session (number thirteen) seems to be a mixed one, and the distress of the patient seems to have

ensured that both of them at least to a degree concur on the events of the therapy. The therapist nevertheless starts off with a self-referential, transference-like interpretation, as follows: "I attempted to draw a parallel between her relationship with her mother and her relationship with me". The answer to question four is as follows: "She became very distressed and openly wept really for the first time in therapy". The patient's comments are: "Don't really know- felt a bit down and for no real reason other than the new job is a bit of a strain. Just felt as I was getting nowhere fast, so I suppose the therapist's reassurance counts as the most helpful event". Question four: "I permitted myself to cry, not to put up a facade". Again the interpretation by the therapist has made no really conscious impact on A.N., although her reassurance clearly has. Interestingly, it may be recalled that the therapist reported the patient as having cried in session six, which has obviously been forgotten in this session by the patient. It is not made clear by either of them why crying is so significant, but both obviously concur on the honesty of the session.

In the fourteenth session the same event is described by both, but has a slightly different impact on the patient than is described by the therapist. The patient reports as follows: "When the therapist suggested that I could possibly visit her less often- it made me feel that I had really progressed, and gave me a lot of pleasure. I'll have to wait and see, but really I do share therapist's optimism about my ability to cope and be more realistic". The therapist's views are somewhat more restrained: "She seemed positive and optimistic in a realistic way. I suggested we meet monthly rather than weekly. She seemed surprised but pleased that I felt she had made progress".

There are no further reports by the therapist, although A.N. provides one last report, as follows: "Therapist's pleasure in and for my glee! I feel that there is much greater rapport between us, and this really

has given me more confidence to really be me, and to tell the truth. Also her cautionary (but not negative) responses gave me ample opportunities to reassess my deeper feelings". This last session sounds even more closely related to a client-centered approach from the patient's viewpoint than any of the preceding sessions, and it is a shame that no therapist report was available on this occasion to see whether it might have been picked up by the therapist.

The end of therapy data provided by both participants indicated that it was a therapy which was a success, and the patient felt much improved. Her detailed comments concerning the most helpful aspects of therapy, written after the conclusion of therapy, were as follows: "Development of self-confidence and self-worth; beginnings of liking for myself (I suppose linked with greater self esteem); clearer view of both parents and their influences on me... I was previously very much distorted against my father; mother's repressive influences also recognised". These comments all seem to be related to the gaining of a new view of herself and of those around her, and interestingly, they also contain references to re-evaluations that were not mentioned during the weekly reports; specifically her new view of her mother. She then goes on to describe further aspects of the therapy that were helpful, as follows: "Feelings more easily expressible. Not afraid to say/do what I feel. Reassuring to find a person who was concerned enough to help me through a very difficult phase, and who was able to be very positive yet detached in her viewpoint of my situation". She then adds one last comment, as follows: "The therapy also helped me to rationalise my ideas, thoughts and feelings, to see my own situation more realistically and to make assessments of my future hopes and aspirations more within my scope, ie. more realistic expectations of myself, instead of trying to be like Superwoman. Don't yet know if attitudes to men have altered as much as I would like. Don't feel as frightened of them, but at the same time not sure if I can cope better, because of lack of practice! However we'll

see what next year brings...."

In this summary, A.N. seems again to be returning to a theme that has occurred throughout the sessions: that of the alterations in her self concept. Of the six or seven different aspects of therapy mentioned at the end of therapy, five of them refer to changes in the way in which she construes the world, either in terms of self or other. In all cases, the patient indicates the importance of being more realistic, both about herself and about others. Only in two of the aspects mentioned does she make any reference to any clearly emotional changes or experiences, and in only one does she refer directly to the person of the therapist. Again this parallels the distribution of her comments during the therapy.

There are, however, interesting differences to be found between the content of the therapist's end of therapy evaluations, and her within therapy reports. The end of therapy data is much more similar to the patient's, than was the previously reported session by session data. For example, two out of the therapist's three comments make reference to changes in attitude or self concept, as follows: "Discussion of feelings towards parents; especially father, and how this has affected her present attitude to men in general", and "therapy encouraged her to drop the facade of "Superwoman" and to admit to weaknesses and failure and to accept this in other people". *The other comment made by the therapist is more* general: "A.N. having the opportunity to talk in detail about herself and relationships past and present". It may be recalled that much of the content of the therapist's session by session reporting centered on descriptions of the relationship between the therapist and the patient and the significance of particular interactions, usually with a high emotional content. This view has not been maintained in the end of therapy data, nor have there been any "transference-like" interpretations reported. It almost seems as if the therapist has returned to the model which she indicated before therapy started, that she intended to

use.

There seem to have been a number of essential features of this case which were of particular therapeutic value. Firstly it seems from the tone of the reports that the relationship between the two was a cordial one, which became warmer and more personal as the therapy progressed. Secondly, the therapist did provide the patient with an opportunity for a number of important self-discoveries, and changes in attitude. Thirdly, the therapist obviously asked some key questions that enabled the patient to consider different aspects of her life. There seems to be no real evidence, however, that these questions stemmed in an intentional way from any particularly coherent plan or scheme, for indeed the aspects thought to be useful by the therapist were often not seen to be so by the patient, and vice versa. Fourthly, the therapy allowed the patient to express and accept her feelings more honestly and openly. However, this seems to have been of lesser importance to her than the considerable number of changes in self construing.

It is not being concluded from this case study that the emotional changes in the patient were unimportant, nor that the relationship between herself and her therapist *was irrelevant; but rather that the major impact of* the therapy seems to have been in allowing for a development of the patient's whole approach to life, which was cognitive as well as emotional, and had to do with the sense that she made of her world. In this way there is a remarkable parallel between A.N.'s therapy, and that of C.S., who presented with a spider phobia, as described in Case Study 1.

7.4) Case Study Three, M.M.

The subject of this case study was a middle-aged, married woman, M.M., who came to see the therapist complaining of a number of minor neurotic symptoms, as follows: "Tension, self conscious, occasional bouts of

depression, very nervous when out alone". The therapist's description of the problem was: "She experiences constant tension, and is unable to relax". They both estimated that she had had these problems for more than six years.

The therapist indicated that although he was trained primarily in the behavioural mode of treatment, he now saw himself as eclectic in his clinical practice, and intended to take a behavioural plus eclectic approach with M.M.. He and the patient both reported that they saw the problem as being fairly serious, and were fairly hopeful that treatment would be helpful. In practice, the therapy was seen by both as having been very helpful and as such exceeded expectations. The therapy lasted for seven sessions, although the therapist had expected it to last for up to twelve sessions.

The most helpful aspect of the first session from both the therapist's and the patient's viewpoint concern the establishment of the therapeutic relationship, as follows: "Being able to talk about how I feel, to someone who would listen and not argue", (M.M.); and from the therapist: "I felt it helped her to be able to talk about her problems with a fairly sympathetic listener". The session as a whole is seen as having been fairly helpful *by both participants.*

The accounts of the second session mark the beginning of diversification in perspective, although this is only seen in the absence of some information by the patient. The patient reports: "Relaxation exercises. I felt a definite relief of tension for a while afterwards". The therapist on the other hand reports "Talking about problems in the marriage, which appear to cause great frustrations. Again simply having someone to talk to about these problems seemed to help, since she has no friends, and is unable to talk about them with her husband". The therapist then continues with question four (other important factors occurring in the session), as follows: "Relaxation exercises: afterwards she stated that she had not been so

relaxed for many years". The inclusion of the discussion of the marriage again features in the therapist's reports of the third session, as follows: "Discussion of marital frustrations. She described being more assertive with her husband, and positive results in terms of her own feelings and being able to express her own needs". The patient doesn't refer to this; however both participants also mention the continuation of the behavioural programme; M.M.: "Discussing my anxiety, and the way I might try to overcome it"; the therapist: "explanation of the nature of anxiety and setting up a programme in order to overcome her anxieties".

It may be becoming evident that the patient appears to be more interested in a straightforward solution to her symptomatic problems than is the therapist, as typified by a lack of any reference to discussion of the marital relationship. The content of the fourth session is apparently perceived in a similar way by both participants, although, as will be seen, the therapist is concerned both with the aetiology of the problem and his role in bringing this issue to awareness; while M.M. is concerned with possible solutions. Hence M.M. responds as follows: "Discussing lack of confidence in meeting and dealing with other people. It will be helpful if I can learn to deal with such situations", while the therapist reports: "Saying that it seemed to me that she was afraid of other people rejecting her. This was reacted to extremely positively, and led on to a discussion of how this was caused by her upbringing and how it affected her in social situations". The fifth session extends the widening gap in perspective (although not in evaluation of the helpfulness of the session, which is seen as fairly helpful by both participants). The patient reports: "Breaking down feelings and events and discussing them. Helpful, because I now feel there is not just one big problem but several different ones and I must try to deal with them separately". The therapist's report, by contrast, is as follows: "My interpretation that she has a tendency to blame herself for any difficulties that may

occur in social relationships. This was linked to her feelings of depression. This seemed to mean something to her, and to explain some of her problems". He then continues in answer to question four: "Talked of her self-consciousness in social situations, her inability to look people in the eyes and a difficulty in asserting herself. Again, talked about her difficulties in making her own feelings known in the marriage".

Here we have a very clear example of the emphasis of the therapist on interpretation and of the patient on problem solution. It does not seem that this difference can simply be explained by a difference in the level of explanation offered by the two; the therapist is talking about a tendency to self-blame while the patient is taking about her new-found ability to gain cognitive control over her difficulties. The content of the reports of the penultimate session can again be distinguished; M.M. writes: "Talking about keeping and increasing my outside contacts with other people", whereas the therapist writes: "General encouragement with progress made so far, especially regarding letting her feelings be known to her husband, and being more forthcoming in social situations". His answer to question four is: "Exploration of strategies to communicate her own feelings, of involving herself in activities outside the home". It must be noted that the patient has as yet made no reference whatever to her husband or the need to recognise and express her own feelings. There could be a number of alternative explanations for this. She may not have experienced this part of the therapeutic interaction as particularly helpful, or she may not in fact be capable of expressing her feelings, despite the therapist's assumption that she is now doing so. She may have felt that the discussion of her husband was not important to the therapy although it presumably took up quite a lot of the therapy sessions. Alternatively she, unlike the therapist, may not realise how she has changed in her feelings towards herself and her husband.

That this latter possible explanation is improbable is suggested by the reports of the last session, and the end of therapy reports, all of which are strikingly different. Of the last session, M.M. writes "Discussing feelings of panic when I am in town unaccompanied. Will not know how helpful until I go into town. Possibly this week". The therapist reports as follows: "She talked about how she had previously felt that she had no control over her own reactions and personality, and that she now realised that the responsibility for change lay with herself, and that she could do something about it".

The realisation and acceptance of personal responsibility for feelings and actions is of course the aim of many psychotherapeutic interventions, and if indeed the patient has reached this point in her personal development the therapist would probably be very pleased with the outcome of his efforts. However, there is nothing in the patient's report to suggest that this is so, except possibly the suggestion that she is willing to go alone into town the following week to see whether the therapeutic discussion has been effective.

The end of therapy data reinforces the notion that the therapist believes the therapy to have been effective on a much wider front than does the patient. (On the other hand it must be noted that both report the therapy to have been very successful both in terms of overall improvement, and in terms of changes since therapy began.) The patient cites three factors as having been helpful. The first is "being able to talk about my problems to someone willing to listen"; the second is "listening to the relaxation tape"; and the third is "realising that similar feelings to my own are experienced by other people too". Contrast these three factors with the therapist's four factors, which are as follows: firstly, "the opportunity to explore issues which had previously not been verbalised, in itself seemed to help her to find solutions to them"; secondly, "a belief on the part of the therapist, that she could change, countered her own pessimism

about the possibility of change, and seemed to make this possible for her"; thirdly, "in a way, I feel that therapy provided "permission" for her to rebel against a long-standing home situation, and to find ways of making her own feelings known to her husband"; and fourthly, "gaining some insight into her tendency to blame herself and to see that this was the cause of many problems". Unlike M.M., the therapist notes an unhelpful factor: "An initial emphasis on leaving the house and exposing herself to anxiety-provoking situations was eventually discarded, since other problems seemed more important".

It will be noted that in this end of therapy report there is again reference on the part of the therapist to the marital relationship which is not referred to at all by M.M., and in addition, the therapist notes the helpfulness of both his own interpretations and her growing awareness of responsibility for her life; neither of these being factors recognised at least overtly by the patient. Nevertheless, this was clearly an effective therapy through which the patient apparently gained in confidence and skill in handling everyday situations. As in previous case studies, the patient seems to have taken from the therapy sessions those events which she could use and benefit from (in this case the relaxation tapes, the opportunity to talk and the realisation of her similarity with others) and to have ignored other, possibly more threatening events (the discussion of the limitations of her marital relationship). Conversely, the therapist has emphasised his own role in the production of change; hence he makes reference to his interpretations and interventions. He also talks of the relatively profound impact that the therapy has had on the patient's psychological make-up in terms of her maturity and ability to accept responsibility for herself. Further, in the unhelpful factors, he notes a problem-solving activity which was ineffective, despite the fact that M.M. is primarily interested in problem solution. As in Case Studies one and two above, what can be seen here is that therapist and patient are both working hard to achieve change, and seem

to have been successful although at times their ends seem to be as different as their means.

Case Study 4, D.S.

This last case study is of particular interest because it is one of the few cases in the study which seems to have been to an extent a failure, although this judgement is based more on the sessional reports than on the end of therapy data. Here both participants saw the therapy overall to have been neither helpful nor unhelpful, and, interestingly, both reported that there had been some improvement in the patient during the time spent in therapy. It is difficult to conclude from the sessional reports, however, that the therapy had very much beneficial effect, and it is being included, therefore, as an example of a rather unhelpful therapy.

Both the theoretical orientation of the therapist and of this particular therapy, were psychoanalytic, and the therapist indicated at the beginning that he was only fairly hopeful that it would be successful. By contrast, the patient was initially at least very hopeful. The therapist expected the therapy to last for more than twenty sessions; in fact it lasted for twelve. The *patient was unsure about duration.*

It must be noted at this point that the story of the case is not always very easy to interpret, largely because of the patient's anger and disappointment in the therapist which manifests itself in the sessional reports. The therapist saw the patient as being more seriously disturbed than did the patient himself, and describes his problems in the following way: "Hostile dependent relationships with both parents, especially father. Denies both hostility and dependence but acts out both. Conflict likely to sabotage job". The patient, D.S., sees his problems in a rather different light: "The realisation that job satisfaction in a previous post was the only

thing for me in Hull, (no social life which is very important to me). Dilemma: job and social life away from the area or no job and exploiting other interests, (both seemingly not on-going solutions). The change of post caused a lot of strain as I felt I was not performing well... this I managed to amplify into the wider aspects of my life (ie., not performing in all aspects of what areas I felt important.) There's no-one better than you at getting yourself down - especially with nobody to take stock from time to time and put problems in perspective".

From these two accounts it can already be seen that the two are approaching the problem from very different vantage points; the therapist sees the problem in terms of the genesis of the difficulties, which are assumed to be psychodynamic in origin, and in terms of inadequate use of defence mechanisms; by contrast, the patient describes his immediate life dilemmas, concerning his unhappiness in his present life style. He also reveals his loneliness, and awareness that this is leading him into self-doubt and depression about himself. In particular, there did not seem to be any evidence of "denial" as diagnosed by the therapist, in this brief self description. Instead the patient seems to be openly revealing his dependency needs.

For the first three sessions, both participants provide reports of sessions that indicate that a certain amount of productive work is being done. However, by the fifth session, the patient's reports have turned into very confused diagrams and muddled accounts (muddled at least from the outsider's viewpoint), that appear to reflect his anger with the therapy, (although it is not possible to rule out an intention to muddle or sabotage the research, or to communicate with the researcher). Nevertheless, D.S continues to attend the sessions. Towards the end of therapy, his accounts have become more coherent, but no less frustrated. Throughout this, the therapist persists, apparently unaware of the degree of distress being experienced by D.S., or possibly accepting it as an inevitable by-product of the treatment process given the patient's

particular personality structure, and the therapist's theoretical orientation.

The accounts will now be presented in more detail. Session one is seen by both participants as information gathering, as follows: "Today's session was a general conversation about the background to the problems that I experienced.." (the patient); "A neutral session, information gathering..." (the therapist). The therapist also adds another factor: "Being listened to".

Session two is also a fairly calm session, in which both participants agree that they have been working out the approaches they will take in dealing with the therapeutic material. D.S.'s account is as follows: "Conveyance of my perception of myself via a simple model: Personality:- Effects of stimuli:- Effects of time/experience". His answer to question four is as follows: "I feel more confident in the analyst's (or is he my therapist?) perception of me, although he still tends to latch on to occasional words which turn out to have little or no relevance to the overall picture". The therapist responds as follows: "Developing a common language; him seeing himself as a machine in a central processor, only rarely operating at an emotional level. Brought us into greater understanding. Then patient related how important it was for him to be different, his own man, illustrated by account of holiday in Spain". The answer to question four is as follows: "Increased co-operation but still defences against disclosure operating, as shown by criticism of Dr. X. making judgement on him on too little data". Neither patient nor therapist saw this as a very helpful session overall, although D.S. saw the specific event of his description of himself to the therapist, as having been very helpful.

So far it would appear that both participants are agreed on the details of the therapy and have achieved some form of reasonable relationship. The next session is seen very differently by the two; the patient describes

his understanding of the subject matter of the session, which appears to have been (from his point of view) a discussion of his "performance" in life; the therapist on the other hand describes the patient's emerging psychopathology and psychodynamics. The accounts are not clear, but are perhaps revealing in their *confusion*: D.S.: "Application of over-reaching internal yardsticks to poor performance, catalyses deterioration *in performance* (vicious spiral downwards). What is the origin of yardsticks? Practicality of same?". The therapist: "Muted criticism of father emerging - not enough personal time for D.S., ie., critical, demanding academic achievement. A negative model. Dynamically this seems to underly his evolving the defence of distance and unemotionality".

In the fourth session, the patient sees as the most helpful event his attempt to explain to the therapist a view of himself. He does this by means of a diagram (not reproduced here), showing a figure perched up in the rigging of a ship, looking out, while another figure stands below on the deck of the ship. In explanation of the diagram, D.S.'s words are: "Problem: communication between the guy up in the crow's nest who has presumably been a bit of a skylight, and the real person "on the ground", getting out there and living the day-to-day existence. Solution: to attain a meeting of minds". The therapist also sees this to have been the most helpful event, although he rates the whole session as having been fairly unhelpful. His description is as follows: "For the elaboration of metaphors - two selves; a critical authority self up a mast head directing the worker (himself) down below, the whole being surrounded by fog. D.S. likes making models but today they were defensive. Some confrontation of this but little overt impact". Certainly the therapist has recognised that his analysis of the defensiveness of D.S.'s model, had little impact, although he has also recognised that making the model was important to D.S..

The next session is also portrayed by the patient by means of a complicated diagram. This shows a "black box" which the patient labels as being the "macro-model", and a series of smaller boxes which the patient labels the "exhaustive approach micro-model". His comment is: "Empirically fits observed data but doubtful extrapolative powers". It is interesting to consider what the patient is conveying through this communication. Data from future sessions suggests that the patient is both expressing frustration with his therapist, and parodying the research that he has agreed to participate in. Possibly he is also mocking himself to a degree. The therapist might see it in yet another way; his comments on this session (although not of course on the patient's report) are as follows: "Confrontation of his avoidance of having a model made of how he works as a person. Patient fears he will lose his individuality and spontaneity if a model/models were made. Reacts with displaced anger to this endeavour". His answer to question *four about additional important factors in the* session is as follows: "No session next week. Planned absence by myself. Hints of anger/disappointment over this".

It is at this point that both the usefulness and limitations of this particular method of data collection are demonstrated. The written report of the patient may indeed be "displaced anger", or they may be the sardonic humour of the parody, which seems an equally plausible interpretation. Reading previous reports, it is suggested that the patient does in fact find the making of models to be helpful, yet the therapist is here suggesting that he sees such an endeavour to be in some way likely to lead to a loss of spontaneity. What is going on in the communication processes between the two? It would at this juncture be particularly interesting to have some other observer of the therapeutic process, in order to give some dispassionate third opinion of the interaction. However, what can be observed is that the patient and the therapist are increasingly distant in their accounts of the session, and there is very little sense of enthusiasm or warmth between

them. This is in stark contrast to the other case studies noted elsewhere.

The sense that the patient is mocking himself, the therapist, and possibly the researcher, is also evident in D.S.'s report of session six. This report consists of a progression of words, describing material objects in pseudo-scientific jargon, (not reproduced here), accompanied by some rather incoherent speculations on the nature of "meaning" and "faith". Despite the fact that the language used is rather incoherent, nevertheless there is a sense that the patient is thinking about some important philosophical issues (albeit in a rather detached and yet immature way), which are of some concern to him. He then adds in answer to question four: "Nothing happened hence the stop-gap garbage above". The overall session was seen as neither helpful nor unhelpful. (It is important to note that the patient does not see the session as having been actively unhelpful.)

The account given by the therapist is very different. His account is as follows: "Useful description by the patient of his image of himself being "destitute" and "needy" a few months ago. Denied significance but ending session with the idea of the need for control. A theme to come back to, as area identified for further work." His answer to question four is: "Still fencing but a bit nearer getting through". This session and the event noted above are seen as fairly helpful by the therapist.

What is occurring in D.S.'s experience of therapy? There does not seem to be any sense of progress, although the patient is recording a number of thoughts and impressions which may or may not be the results of some intervention by the therapist. It could be that the therapist's interpretations are currently being resisted, but that their usefulness will become apparent to the patient in time during the therapy.

Moving on to the following session, the *notion* that the patient feels somewhat distant from his therapist is

conveyed by the language he uses: "I am told that people feel "alienated" or "distant" or that I am hard to "get to know" due to my predilection to erect barriers vis-a-vis others. Question is: how do you get to a responsive state? The truth is that I can selectively remove the barriers chameleon-fashion, to suit the situation/me. Having witnessed the effect of operating "barrier-free" and (indecipherable, S.P.L.) a suitable compromise... or is it?". The patient sees this session as having been neither helpful nor unhelpful.

The therapist again has a different perspective on the events of the session. "Discussion of his maintaining control in session. Openness depends on the intention of the other (learning/readjusting). D.S. agreeing that this is an area to work on. (Still very defensive)". The answer given to question four is: "Session started 15 minutes late. More sparring than usual in the first 15 minutes. Denied that was related to late start". As has been noted in previous case studies, the therapist has here made at least two self-referential comments, which might of course be expected, given his psychoanalytic orientation. It is not clear whether the patient is also referring to an event occurring between him and the therapist, when he says "I am told that... etc.", or whether he is reporting some event outside the therapy hour. However, it might be safe to conclude that he is indeed referring to an experience within the therapy given that he later says "The truth is... etc.". If this is so, then the therapeutic relationship is clearly not a very satisfactory one at present.

This is also suggested by the therapist's description of the next session, for which there is unfortunately no patient account. The therapist reports as follows: "Patient stressing that he needed the therapeutic relationship to be more equal, more of a two-way process in order to say more about himself. I interpreted that without that he feared getting into an exposed, critical relationship like he had with his father. (I hope by

clarifying the way in which past fears are projected into current relationship, he will be freed to be more open in this difficult, current relationship)". The therapist saw this as having been a very helpful event.

It may be clear from the above that the therapist is obviously trying to help his patient towards a healthier way of relating to others, and has a theoretical rationale for acting in the way that he did. However, subsequent reports (sessions eleven and twelve), as well as some of the end of therapy data) suggest that the patient was not able to use this interpretation very effectively. So, for all practical purposes, this interpretation was useless.

Session nine is seen by the patient as having been fairly helpful. He reports: "A general but useful discussion about behaviour aimed at meeting certain standards monitored by one's effect on others, i.e. self-perception versus the rare occasions when that perceived by others is given as feedback. A recent experience has shown that I was slightly off-target. Back to the drawing-board for slight modifications, and time to throw my copy of "Self and Others" (R.D.Laing) back into the 5p book pile at the local Oxfam shop". This same event is also noted by the therapist, although he adds a self-referential comment which was not noted by D.S.. The report is as follows: "Patient volunteered information about incident in which he had been accused of being "superior" and "stand-offish". Therapist gave similar feedback. Patient has described how he dislikes worked up emotional exchanges especially with father. A positive step as patient is now volunteering information and beginning to look at persona".

It is interesting to note that the participants both report progress when the patient is able to discuss something that he has brought to the session, from his life outside the session. This is in stark contrast to the subsequent session when two reports are available (session eleven). The patient's report, which is quite lengthy, is

as follows: "We played at "silly mind-games" today. I missed a couple of sessions for a number of reasons and prior to my explanations and apology, I was in receipt of a fairly strongly worded missive asking whether or not this indicated the potential termination of our "contract", ie., did I want to come and play on Mondays any more? This seemed an unfortunate indication of the therapist-patient relationship. As I abhor gratuitous use of authority in an autocratically imposed situation, we spent the session discussing this. I was amazed that by the end of the session we had managed to shift the apportioning of guilt from my shoulders to those of my Atlantic therapist:- (obviously into "self and others" not "others and self")". The answer to question four (about other important events in the session) is as follows: "I cannot see us getting anywhere unless I can feel that a) I am reasonably confident that what I describe to the analyst can be appreciated as a fairly accurate interpretation of the thoughts that initiated its communication; b) that some sort of dialogue exists, ie. comments/criticism/steering; such that a constructive approach can result from fractions of ideas/concepts in order that any ensuing self-revelations can be turned to advantage/self-change".

The therapist's account demonstrates very clearly the gap that has now opened up between them: "Examination of patient's attack to avoid looking at how weak he felt before Christmas and the reasons leading him to cancel the last session. Saw parallel between his defensive strategy and pattern with father and bosses. Still doesn't accept that he is defending". It is again important to note that the clash in understanding between therapist and patient does not mean that either is "wrong". It may be that the patient is indeed repeating with the therapist the unresolved patterns of defensiveness that occur his real life with significant others, and that he did indeed cancel the previous session for unconsciously defensive reasons. However this does not seem to be acceptable to the patient; indeed his request for some kind of more

equal relationship as noted by the therapist in session eight, has gone unheeded. If the therapist's framework is going to have any therapeutic impact, the relationship between the two must be based on the patient's experience of the therapist's concern for him, and a sense that the therapist is attempting to understand his view of the world. This unfortunately does not seem to be occurring in this case. If indeed he is behaving defensively, it seems unlikely that he will be prepared to abandon these defences unless he feels safe enough to do so, and the disparity in perceptions between the two indicate that this is unlikely to be the case.

As might have been predicted from the impasse reached in the previous session, the following session (number twelve) is in fact the last. (It might be worth recalling that the therapist had intended the therapy to last for more than twenty sessions.) The report by the patient is as follows: "Are we treading water or have we reached the other shore? Was I dipped in the river Styx - but unlike Achilles - feet first? The psychoanalytic phase has long been passed:- i) lack of self-confidence - overly savage self-criticism; ii) lack of purpose/self motivation - shortfall between actual/potential; iii) inability/involution to form deep communicative relationships; application of over-critical assessments of others too". The account given by the therapist continues with his attempt to interpret to the patient his defensiveness, as follows: "Feedback from therapist. Rejected core that he hides with denial and angry attack. Alarm at this being seen in therapy". The answer to question four is: "Discussion of what is his motivation for therapy. D.S. sees this as external insight and external techniques". Interestingly, both this session and this event are seen by the therapist as having been very helpful.

If indeed the patient does have a "rejected core" then it is not easy to avoid feeling that this "core" has yet again been rejected by the therapist, in the refusal to meet the patient's request for a more egalitarian and

human relationship, and the apparent insistence that the patient meet the therapist's demands for the conducting of the relationship. The point is not to apportion "blame", as this patient was undoubtedly a difficult person to work with, and indeed it does seem as if his defensive strategies were extremely difficult to penetrate. The point is that it didn't look that way from the patient's viewpoint; what he seems to have seen was a rather infuriating, impersonal therapist who was more interested in playing "mind games" than in understanding the patient, and helping him to find a way out of his dilemmas. The patient's view on this point is somewhat crucial, as it is after all usually him who decides whether to continue with therapy, as well as estimating how much of himself he dares to reveal in the therapy session.

The end of therapy reports provided by the patient are again fairly lengthy, but it seems worth quoting them in full to see whether the therapist's strategies make any more sense to the patient in retrospect. Two factors are cited by D.S. as having been helpful, and three unhelpful. (This is in contrast to most of the other cases in this study.) The first helpful factor is described as follows: "The discipline of having to try to rationalise/identify some of the mechanisms at work in one's own mind and how it may affect actions, emotions, relationships. From there to try and extrapolate to a more secure personality; however this can only be achieved to a certain extent as external factors and one's own developmental histories do impinge, limiting the overall path or options to this goal; hence a compromise or critical path analysis to this end must be adopted". The second helpful factor, rather like the first, is more like a description of how D.S. sees himself and his problems; it must be presumed, as it was given in answer to the question about helpful features of the therapy, that this is something he gained at least in part from the therapeutic experience. He writes as follows: "As the degeneration was gradual to start with and only rapid at the very end, the reverse process will take a long time; accepting and identifying

this reduces the frustration invoked by regular self-analysis, and helps to break the vicious circle".

It seems from these two factors, that D.S. has identified two distinct aspects of therapy which were helpful to him. The first is an acceptance that maybe he can't change everything because of external factors and his own history; the second is that the longstanding nature of his way of being in the world places a limit on the speed with which he can change things; this realisation leading to fewer feelings of frustration. It might be legitimate to label these two insights as personal/existential, and cognitive; they probably couldn't be seen as insight in the traditional psychoanalytic sense.

By contrast, the therapist's helpful factors as reported at the end of therapy are traditionally insight oriented in nature. They are not at all recognised, at least consciously, by the patient. They are as follows: "Realisation of his need to retain power by making other people uncomfortable and withholding himself. Pattern derived from family relationships, especially with father". The next helpful factor is seen by the therapist as: "Moments of insight into his dependent needs but quickly masked by denial and attack as a form of defence".

It is difficult to imagine how these two participants can have had such differing views of the most helpful events of the series of therapy sessions. The therapist, after all, was asked to indicate what were the most helpful events for the patient, not to say what he thought should have been the most helpful. It must therefore be assumed that he was answering in good faith and genuinely thought that the patient did "realise his need to retain power", and had some "moments of insight into his dependency needs". In fact it may be recalled that the patient did appear to have some insight into his need for others at the start of therapy (as was seen in his initial description of his difficulties). Nevertheless, it does seem fair to conclude that the patient did gain something

from therapy, even if it was not the aspects of therapy described by the therapist.

If we turn now to the unhelpful aspects of the therapy, both participants, ironically enough, are more agreed. D.S.'s views are as follows: "Very little feedback about my problems. Only on demand, eg., Q. "What is wrong with me?" A. "N....."." The second unhelpful factor is: "Very little self identification of analyst. One-sided relationship not leading to mutual trust. How can you begin to trust someone you don't know? How can you gauge analyst's views or personality if he provides no feedback, reactions or comments?". The third comment made by the patient is a discussion of some difficulties that have occurred regarding the patient's medication, and communication with the general practitioner, and are not of particular relevance here, so will not be discussed.

The unhelpful aspects of therapy seen by the therapist are as follows: "The contract was made when he was falling apart and was more open. Subsequently when he felt better, he back-tracked. Approaches to him by me aroused suspicion and fear which he denied". The second comment is: "He made much of the inequality of therapy, though I doubt that he would have done any better with co-counselling".

It might seem to an observer that this series of therapy sessions describe an interaction where the two participants acted almost in isolation of one another, except that there is of course some concordance between them from time to time. That is in itself not unusual (as has been seen in other case studies reported here); what is remarkable however is the lack of awareness on the therapist's part of the feelings expressed by the patient, and a lack of consciousness of how little the patient is able to use the therapeutic interaction. This is of considerable importance, as the therapist presumably thought that his interpretations were having some kind of useful impact, or failing that, were not actually

hindering other helpful aspects of therapy, such as the beneficial effects of simply having someone to talk to. Yet that is what seems to have happened. In other case studies it can be seen that self-referential comments by the therapist are not seen as being of great help by the patient; however the therapist seems to provide the patient with other opportunities to gain something from the therapy. In this case the patient is so concerned that he is unable to establish a personal or egalitarian relationship with the therapist, that little or no progress is made. Again it must be stressed that the therapist was not necessarily wrong in his understanding of the patient's psychodynamic structure; it is simply that the patient was not able to benefit from this understanding, probably because it did not make any sense to him and failed to meet his needs at the time of therapy.

These four case studies were included in order to give a clearer picture of the therapeutic interaction as it unfolded. The next chapter (chapter 8) will consider some of the methodological problems that were encountered during the completion of the research, before going on (in chapters 9 and 10) to discuss in any further detail the findings of the study, and their implications.

Chapter Eight

Methodological Considerations.

8.1) Introduction.

In this chapter the methodology used in the study will be examined in some detail. The main purpose of this discussion will be to evaluate the status of the information that has been provided by the study, and to consider to what extent any conclusions drawn from it can be generalised. The methodological issues to be considered will fall into a number of sections, each of which will be considered in turn. Firstly, (in section 8.2), there will be a discussion of the overall approach and some of the problems which are inextricably bound up with it, namely the acceptability of the accounts as useful and informative sources of data. Secondly, (in section 8.3), the procedures involved in the data analysis will be subjected to critical methodological analysis. Thirdly, (in section 8.4), there will be a discussion of the coding system used, and an examination of its reliability and validity as exposed by this particular study.

8.2) Accounts Methodology.

8.2.1) Subjective accounts: problems and limitations.

In discussing the question of assessing patient satisfaction through self-report, Lebow (1982) suggested that "neither blind dismissal nor blind faith in this method is appropriate" (p.255). Such also seems to be the case for the accounts produced in this study. There seems to be no doubt that some extremely interesting findings resulted from the method used. But how much do they actually tell us? Strupp, Chassan and Ewing (1970) suggested that one of the problems of any descriptive observation of therapeutic interaction is that there is really no way of being sure that the descriptions that we give of events are any more than "hazy projections", largely

because of the high level of inference that we are obliged to use. In other words, because we are dealing with a complex interaction, we are inevitably making very high-order inference judgements, and there is always the risk that our observations (or those of our subjects) are subject to a considerable degree of bias. The notion that patients are even more prone to bias than therapists (and are therefore particularly unreliable) has been raised (and rejected) in chapter 2, and will not be repeated here. Nevertheless, the issue of the meaning of each account to its author is an important one and has not been considered as yet.

8.2.2) Self-deception and meaning in the accounts.

No action occurs in a psychological or social vacuum, an axiom that applies as much to a psychological research study as to any other human interaction. Although a simple understanding of the request from the researcher to the subjects was to provide a straightforward account of their views of the therapeutic encounter, it is probably too simple to assume that this is all the subjects actually did, if only because people are always prone to some degree of self-deception. Tully (1981) in his study of the accounts of transsexuals, suggests that any individual is always trying to achieve something by his account, such as legitimacy, a reduction in feelings of incongruence, social desirability and so on. In addition, Smail (1978) points out that people are almost always self-deceptive, so that any account of behaviour must be subject to negotiation before being accepted at face value. Smail (1984) also suggests that self-deception is "the characteristic mode of existence in this society", and that it is in effect impossible for individuals to report accurately on their own behaviour, if only for the reason that the part of the self that is observing itself, is unable to detach itself from itself, in order to be able to observe: "the eye cannot look directly at itself, as it were", (Smail, 1984, p.99). Such points are also made by Plummer (1983) and echo the concerns of Shotter (1981),

and Harre (1979) that to ask an individual to describe or account for his or her behaviour invites that individual to make sense of events in a way that is coherent, even though those events may not be coherent at all. The implication of the work of social psychologists such as Tedeschi and Reiss (1981) is that this distorted accounting may not be done maliciously or even consciously, but is an inevitable aspect of the process of interpersonal impression management. This problem of unintended deception may well apply even more to the therapists in the study, many of whom were personal friends and colleagues of the researcher, than to the patients, who were largely unknown to the researcher, and hence had (arguably) less to gain or lose by the impression they made. The argument of Smail (1984), concerning the ubiquitous nature of self-deception and the unwillingness (and inability) of individuals to examine their own conduct with honesty, might suggest that all of these accounts have to be treated with considerable suspicion.

In summary, then, it probably has to be accepted that the accounts of participants cannot be seen as straightforward, and probably do serve some function for their authors, although these functions are undoubtedly extremely varied.

8.2.3) Unintended effects of empirical procedure.

Simply asking subjects to complete questionnaires after each therapy session means that the each therapy was not "typical"; furthermore the procedure itself may have had some unintended therapeutic or counter-therapeutic effects. Indeed, some therapists commented during the period of data collection that it was enormously difficult and challenging to have to write out the helpful factors after each session, although they also felt that it actually helped them to understand what was going on. Some patients also commented on their H.A.T. forms that the task was in itself helpful; this is of course consistent with Meichenbaum's (1972) cognitive therapy, which

involves self-talk and self-reports as a deliberate therapeutic strategy; and also with Ryle's (1983) suggestion that written communications can be enormously useful therapeutic tools, in certain cases, allowing patients to think out aspects of their lives on paper. Other patients may well have been using at least some of their reports to express feelings (both negative and positive) about the therapist. This seemed to have happened in case study four, (included in chapter 7 above). In addition, one other patient appended direct messages to the researcher in his reports, appealing for some other form of help. These points need to be born in mind when assessing the extent to which the reports of the sessions can be seen as acceptable representations of what usually happens in therapy.

8.2.4) Honesty in the accounts and the "halo" effect.

The question of overt honesty also arises. Allport (1942) in his discussion of the use of personal documents, cautions against the problem of reader deception as well as self-deception, and advises caution in reading documents that seem to be clearly egotistical or confessional. However, Lipkin (1948) suggested that some fairly simple precautions will ensure the honesty of subjects, such as promising and providing complete confidentiality, and stressing the need for frankness. In addition, Orlinsky sky and Howard (1967) reported from their "Good Therapy Hour" study that "there is also evidence that the procedure of repeated testing tends to reduce defensive responding" (p.628); and as stated above in section 2.3.1, Elliott (1983) wrote that as far as he could see, subjects were honest and avoided fabrication. Certainly my own close reading of all of the accounts did not show up any obvious or conscious attempt to invent, exaggerate or distort the evidence.

It must also be noted that patients were slightly more likely to be critical about the therapists' efforts than were the therapists themselves, although some of the

therapists' reports included desperate confessions of insecurity and doubt. Further, the number of critical and unhelpful factors noted by patients, it will be recalled, exceeded the number noted by therapists. However, the overall number of negative events were very small compared with the number of positive events (63 versus 931). To what extent could this have been due to a "halo" effect, as noted by Hathaway (1948)? In other words, as the majority of the patients were improving, was this fact more responsible for the positive nature of most of the comments than any particular significant event? It is not possible to rule out this factor with certainty, although as the central question of the research concerns the subjective perceptions of participants concerning the relative degrees of helpfulness of a variety of events, possibly this question is not of fundamental importance.

8.2.5) Memory problems and emotional distortion.

A number of other distortions, almost unavoidably bound up with the method of personal reports, need also to be taken into account in interpreting the results of this study. The first is the possibility that deficits in memory led to distortion in the reports. As Kiesler (1973) points out, the human recorder of events is fallible: errors of omission and commission abound. Droge (1983) found evidence, in a study of helpful factors in an epilepsy self-help group, to suggest that patients "misattribute both the content and source" of what was considered to be the most helpful event; equally a study by Xenakis, Hoyt, Marmar and Horowitz (1983) concluded that therapists are not very accurate in their self-reports of what they did during a therapy hour. Similar results have been obtained by Chevron and Rounsaville (1983). On the other hand, a study by Meyer, Borgatta and Fanshel (1964) suggested that there was a close correspondence between what a therapist said happened, and did actually happen. (These points will be considered again in chapter 9.) In the present study, the subjects were asked to write down their accounts at some point in the day following the

session; there is of course no guarantee that subjects actually did do this. Even if they did, there is no way of ensuring that the intervening day did not result in a significant loss of recall. The only way of avoiding this problem would have been to insist that subjects should write down their accounts as soon as a session ended; however it was felt that this would lead to yet another distorting factor: the overpowering influence of the emotional impact of the session. The design of the study was specifically chosen to exclude the likelihood that unreflected or undigested affect only was sampled. However there was no way of ensuring that the delicate balance between memory loss and distance from immediate emotional reaction, was actually achieved. In my personal judgement of the accounts, it was; at least in the majority of cases very few reports showed evidence of either an excess of undigested emotion or a complete loss of memory. Of course the differences documented in chapter 6 between the therapist and patient views, and between the sessional data and the end of therapy data, do not provide evidence on either of these points, because the difference is, as will be argued in chapter 9, more likely to have resulted from a different perception of the salience of different aspects of the therapy than from a simple methodological issue. However, neither of these possible distortions can be excluded with complete confidence, (see also section 8.2.6).

8.2.6) Intellectual limitations and responsibility.

An additional problem in the use of elicited accounts is that the patient may not have had the language or the skills of discrimination to be able to act as an effective informant. Mayer and Timms wrote that, in their study: "a large percentage of people who visited psychiatrists (and benefited) could give no indication of a specific way in which therapy had helped them" (Mayer and Timms, 1970, p.323). Again, this point seems to be answerable only by empirical test. There does not seem in this study at least, to have been much evidence of a lack of comment

from at least some of the patients although there were more events noted overall by therapists than patients. It remains an open question whether some patients were unable to verbalise their true opinions. Of course there is also the issue of whether the difference noted between therapists and patients was caused by a lack of insight on the patients' behalf. This will be discussed further in chapter 9; suffice it for now to say that the evidence of the reports of the patients does not support the notion that they were unable or unwilling to present their own views, or in most cases, were unable to do so. It is of course not being claimed that either the therapist or the patient is "right" in any fundamental sense about the events of the therapy, so possibly the lack of intellectual skill of some of the patient respondents *is not* a problem of substance.

However, a note of caution must still be struck, as follows. Possibly the most fundamental criticism of the study would be that the accounts provided were simply meaningless; chapter 2 has hopefully rejected this hypothesis. A somewhat milder criticism, but one which could be equally problematic for at least some of the sections of the thesis, is that any comparison between reports of therapists and patients would be pointless because the two groups of respondents occupy different and fundamentally distinct structural positions; this point has been made by Pilgrim (1984, personal communication). Pilgrim suggests that just as a parent and a child both share a relationship and hence have equal but different experiences of the interaction, yet with the mother alone having the responsibility for the interaction; so also the therapist alone has the structural responsibility for directing the therapeutic encounter, although both participants experience it. This in itself, Pilgrim suggests, can account for the differences in the reports from the two. It is my view that this is a valid point although I am not convinced that it renders the exercise fruitless, if only because it highlights the difference in perspective, and illuminates the consequences of those different

structural positions. As Lebow writes, in defending the use of studies which look at patient satisfaction: "In part, treatments must be judged by whether consumers obtained what they wanted and were satisfied with their experience, just as evaluation of other services is determined by such considerations" (p.255). Nevertheless, this point, which will also be raised again in chapter 9, needs to be taken account of in the interpretation of the results.

8.2.7) Summary of problems involved in the accounts methodology.

The points raised above concerning self-deception, memory distortions, emotional over-reaction and the underlying meaning of the accounts to the subjects, all signal the need for caution in the interpretation of the results of the study. They also emphasise the need to reiterate the point that there is no claim being made that the events seen as helpful, actually were helpful in any absolute sense. It may be recalled that question two (in section 5.2), to be answered by this research study, was whether an instructive, informative and valuable picture of the therapeutic interaction could be gained from subjective session by session reports of therapy participants. It is my belief, based on the evidence presented in chapters 6 and 7, that it can.

8.3) Methodological Issues.

In this section there will be a discussion of a series of issues arising from the precise methodology used in data collection and in the analysis of the results. First, however, there will be a brief consideration of the overall methodology used.

8.3.1) Uniformity myths.

The attempt to use patients' and therapists' accounts in both nomothetic and ideographic ways (as illustrated in chapters 6 and 7 respectively) may have been successful in

avoiding at least some of the limitations of each method used separately. Allport (1942) particularly welcomed this approach in the use of personal documents, and pointed out how this combination can lead, in science, to some useful insights. However, as he remarked: "What for the nomothetist is hard to contemplate is the very real possibility that no two lives are alike in their motivational processes" (p.57). Indeed, the "uniformity" myths noted by Kiesler (1966) certainly apply to the nomothetic analyses carried out in this study; possibly some extremely interesting differences between the factors found helpful by subjects would have emerged if the sample had been more precisely specified. In their careful study of therapeutic effectiveness, Strupp and Hadley (1979) comment that: "We became impressed with the fact that group comparisons obscure the very phenomena that must be understood in psychotherapy research and that constitute its essence, namely, the particular combinations of patient and therapist variables that give rise to a particular relationship and to a particular therapeutic outcome" (Strupp and Hadley, 1979, p.1135).

The mixture of patients, problems and therapies is definitely a serious limitation of this study. Beutler (1979) suggested that a way out of the dilemma that no one therapy is more effective than another for heterogeneous groups of patients, is that specific therapies are needed for specific problems with specific types of patients, having specific types of personality profiles; the same point undoubtedly applies to research. Looking at all the types of therapy together in this particular study may have resulted in a loss of meaning; Beutler found some evidence for this as follows: "Insight therapy appears to be superior to behaviour therapy among highly reactive patients, whereas the opposite relationship seems to hold among less reactive patients" (p.894). It may well be that some distinctions, for example between patients receiving psychodynamically oriented therapies and those receiving behavioural therapies, should have been made; this was unfortunately impossible because of the small numbers of

patients in each of these categories. In addition the majority of therapists claimed to be using an "eclectic" approach. As Garfield and Kurtz (1977) have said, it is not clear exactly what this means, since it may imply a vast array of techniques some of which may be having specific effects, and others of which may be having no effect at all. Further, a large number of different therapeutic factors may co-exist within the eclectic therapist's practice.

All of the above points must be taken into account in interpreting the results from the nomothetical aspects of the study. However, possibly it is appropriate here to refer to the defence made by Murray (1956) in his thought-provoking study of psychotherapy process: "The sample is heterogeneous with respect to the length of therapy, experience of the therapist, and theoretical experience of the therapist. The patients were all neurotic but had various kinds of complaints and character structures. However, the cases were all alike in that each consisted of an interaction of two people, one of whom came to the other for psychotherapeutic help." (p.16). This is clearly also the case in this study, which is not attempting to be more than an indication of the perceptions of patients and therapists, working with a number of different problems, using a variety of types of psychological therapy.

The method of data analysis used also carries with it some questionable uniformity assumptions. As was pointed out in chapter 5, the content analysis procedure used in the coding of the data, was in the pragmatic mode. The problem with both the pragmatic and the classical mode of content analysis is that it presumes that quantity implies importance; yet this is by no means necessarily so. The inclusion of four lengthy case studies in chapter 7 was an attempt to mitigate at least some of the questionable aspects of this assumption, as well as to deal with a number of additional problems. Although it can allow for some extremely interesting and informative conclusions to be drawn, quantification of therapeutic interaction

inevitably leads to loss of detail. As Sargent, Coyne, Wallerstein and Holtzman (1967) have pointed out, the statistical approach is useful, but it does have limitations: namely the risk it carries of squashing informative individual differences into a composite mean which obliterates at least some lawful relationships. As Allport (1942) said: "lawfulness need not be synonymous with frequency of occurrence in a population" (p.64). However, it is my view that the statistical procedures used in this research study do not seem to have obliterated too many individual differences to any substantial degree, as can be seen by the similarity of the implications to be drawn from the results presented in chapter 6, to those drawn from the case studies presented in chapter 7. Nevertheless, there is still the possibility that some as yet undiscovered patterns of responding lie hidden in some of the case histories; equally some extremely important but infrequently occurring factors may have been ignored in the analyses, simply because of their rarity.

8.3.2) Outcome.

Section 5.5.2 considered the question of the measure of outcome employed in the study; it was stated at that point that the measures used were only to be seen as an indication of the helpfulness of therapy, largely because it was recognised that the question of a reliable and valid measure of outcome was beyond the scope of this particular study. The findings reported in chapter 6 concerning the outcome of therapy must therefore be interpreted in this light. Of more interest, of course, was the "mini-outcome" question posed by the session-by-session evaluations. Luborsky et al (1980) claimed that sessions or fragments of sessions could not predict outcome; however recent work by Stiles and Snow (1984) suggests that impact is a useful measure of the immediate effects of therapy. They propose that impact is best seen as an intermediary between process measures and outcome measures, and that it is indeed meaningful to correlate impact measures with outcome. This was done in this study,

although no reliable long-term measures of outcome were available. (As will be outlined in chapter 10, a number of colleagues and I are currently collecting data which will allow further examination of the relationship between process, impact and outcome). The question of outcome in psychological therapy is, of course, a vexed one; in different ways both Frank (1975) and Strupp (1981) have suggested that we ask the wrong questions about outcome in psychological therapy research, since "cure" is no more complete in psychological therapy than it is in physical medicine. Frank suggested that five or ten year follow-up studies may not be appropriate for the type of problems that most mildly disturbed patients bring to therapy, any more than such studies would be appropriate for the common cold. Hence, it might be argued, the study of "impact" might actually be of more direct relevance to psychological therapy research, than long term studies. This remains a debatable point.

Another issue which needs consideration is the extent to which participants were accurate in attributing success in therapy to the endeavours of both or either of them in the therapy itself. Of course many events were taking place in the lives of the participants which may have had considerable impact on the outcome of the therapy; this is indeed the implication of the work of Cross and Sheehan, (1981). Just because the patient was in therapy does not mean that it was the therapeutic relationship which caused the improvement; any change which took place could of course have been coincidental or complementary. Again, this calls into question the validity of a number of assumptions made in this study, as indeed with much psychological therapy research.

8.3.3) Representativeness of sample.

This question will be dealt with in two parts; the first will concern the representativeness of the patient sample, and the second, that of the therapist sample. Firstly, as was pointed out at the start of both chapters

6 and 7, no claim can be made that the subjects used in this study are representative of all patients in receipt of psychological therapy, largely because no thorough attempt could be made to control for the selection of patients by the therapists. The fact that most of the patients were well satisfied with their therapies may mean that the sample was slightly biased towards successful cases. In addition, it must be recalled that there were one or two significant demographic (although no attitudinal) differences between completers and dropouts. However, the differences were only very slight, which seems to be a fairly consistent finding in psychological therapy research. A review of a number of studies of dropouts carried by Brandt (1965) concluded that no reliable variable distinguished dropouts from completers, although Saltzman et al. (1976) suggested that patient affect and respect, as well as therapist involvement, distinguished between the two.

Leaving aside the question of the dropouts, the distribution of the responses from the sample remained remarkably stable; that is, the average number of reports missing from each subject did not vary too widely. Even more remarkably, there was a 95% response rate for the final end-of-therapy questionnaire, which had to be returned by post. This is most unusual. The modal response rate for postal questionnaires in psychiatric research studies is, according to Sydiaha, Stewart and Lafave (1968), approximately 33%. In the previous study which I carried out concerning helpful aspects of therapy (Llewelyn and Hume, 1979) a response rate of 76% was achieved. Clearly the response rate in this study was exceptionally good, which must encourage confidence in the value of the data produced.

It will have been noted that no distinction was made in the presentation of the results between males and females, or according to age, social class or marital status. This omission was deliberate, and was based on a comprehensive and thorough review of relevant evidence

from a large number of studies carried out by Lambert (1979). This review suggested that "there does not appear to be a trend for age, race or sex to be consistently related to therapy outcome" (p.16). Equally, no comprehensive and reliable effect of any of these variables can be detected on therapy process. A number of studies have implicated some relationship between sex of therapist and outcome (for example, Howard, Orlinsky and Hill 1970, and Kirshner, 1978); however this was not considered to be within the remit of this study and was not therefore included in the present analyses.

In addition, no distinctions were drawn within the sample between patients with different diagnostic labels. This was done for a variety of reasons. One reason was quite simply pragmatic; because of the difficulty involved in obtaining subjects, it was thought to be unlikely that a large enough sample of patients with a particular presenting problem could be obtained in a reasonable period of time. The constitution of the sample bears this out. Another reason for obtaining a heterogeneous sample of patients was that, in practice, the labels given to patients appear to have relatively little impact on the nature of the therapeutic interaction. Orlinsky and Howard (1978) pointed out that therapists tend to act towards patients on a pragmatic level, rather than according to strict diagnostic categories. This is also the implication of the work of Doherty (1971) and Crowder (1972) concerning the interpersonal behaviour of therapists and patients.

Secondly, the representativeness of the therapist sample needs to be considered. Again, as stated above, there was no attempt to control for the approaches used by the therapists, nor to select a "typical" group of therapists, except insofar as they were all the available and co-operative therapists within reach of the researcher! This clearly limits the generalisability of the findings, but probably no more so than many similar research studies. Of possibly greater consequence, however, for the

interpretation of the data collected, was the fact that of the nineteen therapists, some contributed one patient, some contributed two and some contributed three; (the figures are 17.5%, 30%, and 52.5% respectively). However, this was also the case in the major and influential "Good Therapy Hour" study of Orlinsky and Howard (1967). Although this point possibly calls into question the independence of some of the measures used in the study, it was defended by Orlinsky and Howard who reported that they found as much variation between the cases of one therapist as between the cases of different therapists. A similar problem, of there being more patients than therapists in the sample, is likely to occur in most research studies of this type; the issue is raised in the study by Saltzman, Luetgert, Roth, Creaser and Howard, (1976) referred to elsewhere in this thesis. Although it was not possible to examine this in detail in this study, it was also my impression that there was considerable variation between the cases of any one therapist. But because of this, care was taken only to use statistical procedures which were non-parametric, or to ensure homogeneity of variance of the sample before analysis.

Equally problematic for some of the statistical questions raised in the presentation of the results, is the variation of the number of sessions across therapies; as may be recalled the mean number of sessions was just under ten, with a range from one case of three and one case of four, to three cases of eighteen or more sessions. The possibility that therapeutic factors operate differently according to the length of therapy, was raised by Horn-George and Anchor (1982), as mentioned in chapters 2 and 3. They found that there was a higher degree of congruence between therapists and patients with longer term therapies than with shorter term therapies. Although this was not examined systematically in the current study, (because of the small number of patients whose therapies were significantly different from the mean), there was no evidence on inspection that congruence was higher (or lower) in the longer term therapies. However, this possibility (like

the possibility that distinguishing between different theoretical orientations might lead to different results), cannot be entirely ruled out.

The problem created by the different number of events provided by different therapists and patients, was, as described in section 6.6.1, dealt with by scoring each event as a proportion of the total numbers of events per respondent. Hence if one patient reported two Insight events out of a total number of four events, he or she received the same score in the Insight category as another patient who reported six Insight events out of a total number of twelve events. This was clearly more meaningful than simply adding up the total number of events in each category and comparing them; nevertheless it still remains an unexplored and almost unexplorable assumption (implicit in both the classical and pragmatic modes of content analysis) that events can be added together in a quantitative way. The finding that there was a very clear relationship between the frequency with which certain types of events were reported, and their ratings (as detailed in chapter 6) does, however, provide some limited evidence for the validity of this assumption.

8.4) The coding system.

In this section there will be an examination of the reliability and validity of the Elliott Therapeutic Impact Content Analysis system. In this discussion, reliability will be taken (following Kiesler, 1973) to refer to the extent to which the coding is carried out consistently by two independent coders; and validity (also following Kiesler, 1973) will be taken to refer to the ability of the system to incorporate all of the questions that it claims to incorporate, in a meaningful way.

As was stated in section 4.3.1, this system was originally based on responses from subjects from an analogue counselling study, and as such, did not present much data concerning validity; nor did it have much clinical evidence of reliability, since the subsequent study using

the system was based on brief one-session therapies. Further, as Elliott has pointed out (1983, personal communication), the number of events involved in the original content analysis were much smaller than those used in this study. Consequently, one of the questions to be answered by this research study (as indicated in section 5.2) was whether the Elliott system is a valid and reliable way of looking at sessional data; in other words, can this study provide both the validation of this particular content analysis system, in this particular context, and also, can it provide good reliability data?

8.4.1) Reliability.

The results of the coding procedure presented in Tables 4-9 in chapter 6 show that the system was reliable, although some categories (notably Problem Solution and Reassurance/Relief), were more reliable than others (notably Misperception and Negative Therapist Reaction). It is also important to remark that, overall, the helpful events system was much more reliable than the unhelpful events system. This of course independently confirms the need for revision of this part of the system noted by Elliott, (1983). However, the choice of this system in the present study was vindicated, which demonstrates the importance for new investigators in the field of psychological therapy process research not to ignore all previous work in the field and devise yet another coding system, but rather to work with existing systems, as has been done here. The high inter-rater reliability, given the high-order inferences needed in order to code the data, is excellent, and suggests that the scales possess unidimensionality. This is particularly interesting, given the fact that in the original administration of the system, coders were allowed to use multiple classification.

Incidentally, one other positive aspect of this research project has been to provide independent British replication of the reliability of this system, which was of course originally developed in the USA. As Shapiro,

Barkham and Irving (1984) point out, this is particularly important given past difficulties encountered in using American scales reliably, in the British context.

8.4.2) Validity.

Kiesler (1973) suggests that a content analysis system should possess both face validity and construct validity; in other words, it must appear to make sense to clinicians, and measure what it claims to measure. The only way to consider this issue in the present context is by empirical test; in other words, to look at the system and see whether it does possess these indices of validity. It is my opinion (and that of the two trained coders, see section 8.4.3) that it does. Kiesler also points out that the system should be parsimonious, yet capable of incorporating all it purports to measure. Certainly the coders had relatively little difficulty in using the system; only 8.9% of events were judged by the coders to be "unclassifyable", which compares favourably with 26% in the system reported in the study by Berzon et al (1963), and 12% in the system used by Bloch et al (1979). (In a recent paper, Elliott (1984) has reported that 95% of events can be sorted by this system.)

It might also be interesting to note that Elliott, (1983), in discussing methodological questions concerning Interpersonal Process Recall (which in many ways involves similar assumptions to those made in this study), talks of the various "threats to validity" which must be faced before any such system or method can be accepted. Such "threats" include the questions already considered in section 8.2, such as deception, forgetting, the interference of unconscious processes, fabrication and so on. He concludes that there is no simple answer to the question of whether I.P.R. is valid: "each threat should be examined carefully in order to make sure that it is being minimised and does not exceed acceptable levels in a given situation" (p.28). Possibly the same applies to the use of the Therapeutic Impact System. It is hoped that section

8.2 dealt with these threats in adequate detail. It is accepted, however, that no definitive answer can be given to the question "is the system valid?", although it is being proposed here that it is an interesting and informative way of gathering information about psychological therapy process.

8.4.3) Evaluation of coding system by coders.

In line with the underlying philosophy of this thesis, it was my opinion that some of these issues might well be illuminated by using the views of the two individuals, who, having read all of the accounts in detail, had a close knowledge of the workings of the system. Following completion of the coding, therefore, I asked them to record their experience of the use of the system. They made a number of extremely interesting points, some of which will now be described.

Firstly, they both commented that the examples given for the categories were not very helpful, and even the category titles did not fit very well with the descriptions of the events given in the manual. It was these descriptions that they used in their codings, rather than the "bald" category titles. They also commented that their joint discussions were extremely useful in increasing their skill in coding, as well as in developing their understanding of the system.

Secondly, both the coders were a little unhappy about some of the distinctions they were being asked to draw (although the reliability data shows that they were drawing them very accurately). Overall, they felt that some categories were much easier to code than others; for example Problem Solution (category 4) was straightforward when compared with Problem Clarification (category 2). In particular, they felt that Reassurance/Relief (category 7) was almost inevitably present when any of the other events took place, quite simply because the patient felt better when any type of helpful event took place; hence they only used it when nothing more specific was implied, or where

the experience of relief was clearly primary. They also noted that there was often a confusion between Insight (category 1) and Clarification (category 2), as the one often implied the other. The "rule" that they devised to deal with this was to code according to initial impact. In addition they had to draw a clear distinction between affective and cognitive insight in allocating events to category 3 (Affective Awareness) and category 1 (Insight). Lastly, they commented that Personal Contact (category 8) and Involvement (category 5) were very similar: the former referring to the relationship of the patient to the therapist, and the latter, to the therapy.

Thirdly, the coders felt that the system failed to take account of the different meanings of the events at different times of the therapy; for example, insight for one patient might occur both at the beginning and end of therapy, but have completely different consequences and implications on the two occasions. In this connection both raters pointed out that they were often using their own experiences in order to make sense of what the patients and therapists had written on the cards; in particular, the coders were attracted to the notion of a "cyclical" view of therapy as they noticed patterns of responding recurring through the cases.

Fourthly, the coders reported that they often had either to to rely on the conventional rules of English speech to make their codings, or to expand what was reported in order to make sense of what was said. Thus they often had to rely on what was implied, rather than on what was clearly stated. For example, the term "we did..." as opposed to "I did..." was taken by them to imply mutuality, and the expression "relaxation" was taken to imply "during the session we did relaxation which was helpful". However, it was often on the occasions where a degree of interpretation by the coders was needed, that the disputes between them would occur.

Lastly, the coders remarked that although the system

was fairly all-encompassing, there were still times when events could not be classified very comfortably in any of the categories, and hence some of the more subtle distinctions that might have been made, could not be made. They did agree, however, that a larger system which could encorporate nuances of interaction would then have become unwieldy and hence unreliable.

8.4.4) Summary of discussion of the coding system.

The results presented in chapter 6 of this thesis stand or fall on the coding system. The findings reported are meaningful only if the categories used are meaningful, which is why so much time and space was initially spent (in chapter 5) in discussion of the selection of the system, and why so much of this chapter has been devoted to discussing the validity and relability of the system. It is to be concluded that, with one or two reservations, the system is reliable and valid; hence the results can be considered to be meaningful, hence question one from in section 5.2 is answered. This is not of course to deny the points raised in sections 8.2 and 8.3 of this chapter, concerning the overall acceptability of the accounts methodology, or concerning the problems associated with some of the methodological details and analyses performed. With these points in mind, however, it is now appropriate to move on to a discussion of the results.

Chapter Nine

Discussion of Results.

9.1) Introduction.

Since this was essentially an exploratory research study, a large number of interesting issues have been raised by the accounts collected from the therapists and patients who acted as research subjects in the study. Just as it was not possible to examine all aspects of the participants' experience in the analysis of the results, so it will not be possible to consider all of the implications of the results in this chapter; inevitably, I will have to be selective. The answers to the nine questions raised in the study have been presented in detail in chapters 6 and 7; it would be repetitive to reproduce them here. In this chapter, therefore, a number of the more interesting aspects of the results obtained will be discussed, both in terms of the contribution which they may make to an understanding to the experience of psychological therapy, and in terms of their contribution to some promising theoretical formulations concerning the process of psychological change. Firstly, the discussion will (in section 9.2) concentrate on the different pictures of the therapeutic relationship presented by the accounts of the two groups of participants; and secondly (in section 9.3), the discussion will concern the implications of this discussion for our understanding of therapeutic factors and the therapeutic relationship, as originally outlined in chapter 3. Thirdly (in section 9.4), the discussion will consider the significance of the difference in viewpoint between therapists and patients, and the chapter will conclude (in section 9.5) by considering the contribution that the results obtained by this particular research methodology might have for our understanding of the process of psychological change in general.

9.2) Therapy: the participants' view.

9.2.1) Picture of the therapeutic relationship as revealed by patients and therapists.

The vast majority of the patients included in this research study felt that they had benefited from their therapy. Their therapists, on the whole, agreed with them. Yet they disagreed about some aspects of the mechanisms for that improvement. Experiencing helpful events from the viewpoint of the patients seemed to be a much "simpler" process than from the therapists' viewpoint; during the period of therapy the patients valued the reassurance and relief that their therapies provided, and in retrospect, valued the problem-solving aspects of the therapy. By contrast, therapists emphasised the cognitive and affective insight that they assumed that the patients had developed through having experienced therapy, both during and after the conclusion of therapy. These viewpoints were different from each other at a level which far exceeded chance. On the other hand, other aspects of the therapeutic interaction were perceived in a similar way, for example, therapists and patients were agreed on the relative infrequency of Involvement as a helpful event, and their estimations of the effectiveness of therapy were also highly correlated. In this chapter it will be argued that these differences and similarities arose because the two sets of participants were making sense of their experiences in different, although related ways. The significance of these differences will then be discussed in section 9.4 below. For the moment, however, I shall consider the experience of patients and therapists, each in turn.

9.2.2) The patients' experience.

The vast majority of patients included in this study were not seriously disturbed; they had an acceptably clear idea of the reasons for seeking therapy, and they appeared to be reasonably able to give a coherent account of their experiences (although of course this is not to say that they were "accurate" in their self-perceptions). While it

is obvious that the patients studied here were all individuals with different goals and priorities, some generalisations can nevertheless be drawn from the responses of the group of patients as a whole. Those aspects seen as most helpful were the presence of a caring, concerned helper, who was able when required to listen and give reassurance; he or she was also able to help in the process of reaching a solution to the problems which the patient brought to therapy. To only a limited extent, the therapist was also seen as helpful when he or she could assist the patient to gain insight. Positive outcome was related to the patients' perception that they had experienced problem solving events, and conversely, the unhelpful aspects of therapy from the patients' viewpoint included disappointment in the therapy and therapist. Material from the extended case studies suggested that patients felt frustrated and disappointed when therapists either refused to enter into open dialogue with them (as in case study 4), or when the therapists did not assist directly in the solution of problems (possibly because the therapists were occupied in attempting to provide insight for their patients).

It is perhaps worth recalling at this point that the emphasis placed by patients on problem solving events, does not imply that the patient was passively sitting and waiting for the therapist to solve his or her problems, although it can be assumed that therapists were involved in the process. In Elliott's Therapeutic Impact Content Analysis system, Problem Solution refers to problem solving efforts which move the patient towards a practical plan of action outside the therapy situation; the patient is seen as learning how to cope with a situation in his or her real life.

The picture given by patients of therapies in which these helpful events occurred was, therefore, not a passive one, but rather, an active one, in which both participants were working out solutions to problems. This problem-solving activity was seen to occur within the

context of a relationship which was personal and encouraging. To put it very simply, the patients in this study seemed to report as helpful, those factors which might be found in any caring relationship, where one person is trying to understand, reassure and encourage the other, as well as to work out solutions to problems. What consequences do these findings have for our understanding of therapy as experienced by patients?

The first point of importance to note is that those factors which were reported by patients to be helpful in this study are remarkably consistent with those reported in numerous other case histories, empirical studies, and autobiographical accounts, which have adopted the perspective of the patient; (for example, Strupp, Wallach and Wogan, 1964; Worth, 1969; Sloane et al, 1975; Saccuzo, 1978; Llewelyn and Hume, 1979; Cooley and Lajoy, 1980; Hunt, 1984); although there were some minor differences from others, (for example, Hill, Carter and O'Farrell, 1983; Elliott, 1984). As was pointed out in chapters 5 and 8 above, the research strategy employed in this study (that is, asking participants for their views on helpful events almost immediately after therapy sessions), was designed to avoid the possible danger that respondents might give general unspecified relationship-type factors as having been therapeutic because of memory loss; however, even using this strategy, the "non-technical" aspects of the helping relationship were seen by patients as primary. (The term "non-technical" is being used here simply to reflect the notion that the reassurance and the relief of having someone to talk to, is an aspect of the helping procedure which is less likely to be the result of the therapist's professional training, compared with other aspects of the therapy process, such as the discovery of new parts of the self, ie., insight, or the experience of previously warded-off emotions, ie., affective awareness. It seems likely that these latter aspects of the therapist's activity are likely to have been encouraged by training or study). The fact that this finding is consistent with the picture of therapy provided by many of

the autobiographical accounts reviewed in chapter 2, should provide support for the present results, as well as acting as some form of validation for those accounts. Whatever the status that is accorded to any of these subjective accounts from patients, it does seems important to recognise that the factors highlighted above are those which patients repeatedly report as having been salient in their experience of therapy. This recognition is especially important as such factors tend not to be the focus of therapeutic training or theory. (This issue will be discussed in greater detail in chapter 10.)

Another notable finding obtained through these accounts of the patients' experience, was the extent to which patients made good use of a number of different events occurring both in and outside therapy, in their attempt to come to grips with their problems. This they appeared to do in a way that was well beyond the control, recall, or understanding of the therapist. The patient reported in case study 1, for example, used his relaxation skills in ways that were never apparently discussed with the therapist; and the patient in case study 2, applied her understanding of herself to situations which did not appear to have concerned her therapist, (although this is not to say that, in either case, the therapist would not have welcomed these applications. I am merely making the point that the therapist may well not have intended them directly, or even known about them). In a similar vein, Droge (1983), in his study of the effectiveness of epilepsy self-help groups, reported on one particular occasion that the most helpful event noted by one member (being advised to consult the Social Security), never actually occurred according to a tape recording of the session; what "actually" happened was that another member of the group was advised to seek some guidance about employment facilities. Clearly the patient interpreted this event in a way that was important for himself, although not available for outside confirmation. Parry (personal communication, 1984) also noted that one of her patients (using the same data collection method described

in this research, in a study which is currently being carried out on my behalf, to be reported elsewhere), recently reported that the most helpful event in his session with her, was being advised to give up smoking; despite the therapist (a smoker) having no recall of advising this. In another field, that of interpersonal communication, Knapp, Stohl and Reardon (1981) found that most "normal" individuals report having certain "mottos" or memorable messages which they remember being given to them by significant others; these messages, often cliches such as "If you don't succeed, try, try and try again", or "Life is all about learning from your mistakes", are frequently completely forgotten by the significant other despite the importance they continue to have for the recipient.

All of this seems to suggest that patients, like most other humans, are, in therapy, actively trying to make use of their experiences in order to achieve their goals and make sense of what happens to them. Cross, Sheehan and Khan (1980) in their discussion of the relative importance of the primary and secondary variables in therapy, pointed out that friendship patterns frequently change during, or shortly after the termination of therapy; given the importance of friends in providing "alternative counsel", it may indeed be the case that one of the significant impacts of therapy is, in fact, its ability to catalyse other, possibly more important experiences in the life of the patient. It is not of course surprising if the therapist does not have access to this information. But it is important for the therapist to remember that the patient has numerous experiences outside the single therapy hour every week. It is probably a professional arrogance of therapists to assume that patients come for therapy either ignorant of numerous psychological principles which affect their interactions, (Smail, 1978), or unable to benefit from experiences outside therapy.

One of the repeated cries of anguish from psychotherapy researchers (for example, Auerbach, Greenberg and

Howard, 1984) is that many of the research results which are obtained are disappointing (that is, significant differences between groups are not found, or correlations obtained are low); invalid, (that is, the results obtained can often be ascribed to error variance or chance); or unimportant, (that is, the crucial aspects of the interaction do not seem to have been touched by the research). This may be because much existing research does not seem to focus on the most crucial aspects of psychotherapy process, which quite possibly do not occur in the presence of the therapist, or in something the therapist does to the patient within the session. It may well be that an important aspect of this difficulty is a lack of recognition of all of the factors which occur outside therapy, over which the individual therapist has no control, as well as an inability of the therapy researchers to recognise the importance of the contribution of the patient him or herself to the process of therapy. This theme will be returned to in section 9.5.

A number of additional aspects concerning the patients' experience of therapy were of interest; however only one more will be mentioned here for reasons of space. This is the finding that patients frequently referred to the value of realising that they were not unique and that others had also felt the same way. One patient expressed this as follows: "Felt my therapist understood and instilled confidence. I didn't feel such a freak to know many more people suffered similar problems." Often an event such as this one was reported to have occurred very early on in the series of sessions. It appears that the patient's realisation that he or she is not unique, comes in part from the experience of the relationship with the therapist, and in part from the verbal reassurance which the therapist seems to be able to give them *about* other people also feeling the same way. It may be that it is the experience of relief at not being "abnormal", that allows patients to be much more accepting of themselves, which in turn seems to be a prerequisite for further psychological change. Therefore it may be that this type

of event is an important step in building the patient's confidence, allowing him or her develop a therapeutic relationship with the therapist, which in turn can lead to positive psychological change.

9.2.3) The therapists' experience.

The view of the helpful aspects of therapy as seen by the therapists, is rather different from that held by the patients. Therapists overwhelmingly reported that insight, either affective or cognitive, was crucial to the patients. (The nature of insight is discussed further in section 9.4.3.) They did not place so much importance on the more "straightforward" aspects of helping, such as providing a sympathetic ear, or giving advice. What does this tell us about therapy as experienced by therapists?

Before attempting to answer this question, it seems appropriate to consider the nature of the information that the therapists' accounts have provided. There is no evidence in this research study concerning what occurred in therapy in any "objective" sense. What there is, however, is a series of accounts of the ways in which a fairly diverse group of therapists described the effective aspects of their encounters with their patients. This picture of the therapists' experience is, in itself, quite informative, especially as, until recently, very little research had been carried out concerning the therapist's direct and personal experience of carrying out therapy. As long ago as 1938, Thompson wrote that: "If one knew practical psychoanalytic experience only from the papers printed, one might be tempted to assume that the analyst as a person does not exist... " (Thompson, 1938, p.205). Yet there is still a paucity of work on the therapist's experience of therapy; in 1967, for instance, Orlinsky and Howard suggested that "systematic research on the therapists' experience should help to clarify the still apparently intuitive connection between the therapists' working theory of personality, and its clinical data base" (p.3). Very little such work has been done. Although it

may initially be assumed that the theories used by therapists, actually inform their beliefs about what was in fact effective in therapy, there is no clear evidence that this is the case. One very interesting way of examining this issue has been by the use of I.P.R. with therapists, (as carried out by Elliott, 1984, and outlined in section 2.3.1), which may in time clarify the intentions and reasoning which lie behind therapists' interventions. The present study has also indicated something of the thought processes of therapists as they conducted therapy, as well as highlighting their views on the crucial aspects of therapy process, although it is of course not possible to conclude anything about what really helped.

Turning now to the accounts, one of the most obvious aspects to strike the observer is the self-reported confusion and uncertainty of many of the reports provided by therapists. For example, a report provided by the therapist in one moderately successful case read as follows: "Very difficult today. J. settling down to recognise how all-pervasive her depression has been and how much her coping behaviour has been a facade to cover her true feelings. I'm not sure! Maybe accepting present feelings and able to stay with them, whereas previously she was always bobbing around from one topic to another. I'm not at all clear". At the conclusion of therapy, this therapist reported the following unhelpful aspects of therapy: "My difficulties drawing things back together again. I am sure that I have not been at my best in this therapy, but to be more specific is difficult".

Yet despite (or possibly because of) their confusion, most of the therapists were obviously trying to make sense of the interaction with the aid of some very specific theoretical tools. It must be recalled at this point that the majority of therapists reported themselves to be eclectic in their therapeutic orientation, and furthermore, to have carried out eclectic therapy. It might have been anticipated, therefore, that no particular theoretical tool would predominate in their accounts of their

actions. Nevertheless, most of the therapists were clearly making use of one particular set of theoretical constructs with which to organise their therapeutic interventions; namely interpretation, presumably designed to bring about insight. Despite the absence of a large number of therapists who identified themselves as psychodynamic, these interpretations often seemed to be transference-oriented; (cases 1, 2 and 4 provide clear examples of this). Recent work by Leiman (1983) has suggested that therapists can be seen to operate on at least three levels of conceptual complexity, two of which are largely inaccessible to the patient. The first, he suggests, is "everyday" language; the second, implicit theoretical concepts; and the third, explicit concepts tied to some established theoretical tradition. Most of the therapists in the present study appeared to be operating on the second level, (without any apparent understanding that this is a level to which the patients were probably not privy), and on many occasions they also appeared to use third level concepts. As Leiman comments: "Any interpretation requires that the therapist reorganises the actual data by using theoretical generalisations. This restructuring by theoretical generalisation is, of course, bound to the particular theoretical tradition in use." Leiman, 1983, p.9). Yet most of the therapists did not appear to possess an adequate or coherent grasp of the model by which they were trying to structure their interventions. This may account in part for their confusion. (On the other hand, it might also be objected that therapists simply could not express their intentions and reasoning within the limited constraints of the questionnaire used in the study. This is an argument which cannot be entirely ruled out, although the fact that at least a small number of the therapists, (notably the behaviourally oriented and the psychodynamically oriented therapists), did manage to be able to convey adequately their underlying theoretical rationale within the questionnaire format, rather weakens this point.)

The use of some theoretically derived concepts by the therapist is of course understandable; such concepts can

perhaps be seen as the strategies by which the therapist can make sense of a situation (one where he or she is supposed to be acting as a qualified professional), in which "everyday" or non-technical aspects of therapy, may have seemed inappropriate. In other words, the therapist may have felt that the use of "everyday" helping strategies, such as the provision of reassurance and problem solving, was not the "right" kind of intervention from a trained person, and therefore conceptualised the helpful aspects of the interaction in professional terms. (Nevertheless, it must be recalled that the question which was asked of therapists, concerned the helpfulness of events occurring in therapy, for the patient, not for the therapist.) The type of strategy most commonly adopted by the therapists in this study, in assuming that insight was the most helpful type of event occurring in therapy, seems therefore to imply that therapists required a model with which to make sense of the therapy situation, which was relatively sophisticated and "technical". Furthermore, it seems probable that these strategies did not rely very heavily on feedback from the way in which the patient was making use of the therapy, in that patients (at least according to their written accounts) did not appear to respond to all, or even most, of these strategies. The fact that many of the eclectic therapists were using transference-like interpretations, apparently designed to bring about insight, also suggests that the most easily available model open for adoption by the eclectically oriented therapist, was a "weak" version of the psychodynamic. Perhaps this is because this particular choice of strategy was the most productive in allowing many of the therapists to make sense of their roles as therapists, (although it did not appear to be of so much use to the patients).

A number of other aspects of the therapists' experience were also worthy of note, of which only two will be discussed here. The first concerns the unhelpful aspects of therapy as noted by therapists. It is perhaps commendable that therapists were quite well aware of some of

their own shortcomings in therapy. Particularly after the end of therapy they seemed able to pin-point errors of both commission and omission, although it is notable that they were more likely to mention the former than the latter. In other words, they were more aware of having had a negative reaction towards the patient, and of having misdirected the patient, than of having disappointed him or her. (Conversely, patients were more likely to report having been disappointed.) It is interesting to note that Auerbach and Luborsky (1968) also found that poor therapy hours were characterised by the therapist imposing his or her concerns onto the patient, when the therapist was not aware of the needs of the patient. Case study 4 provides a clear example of the imposition of the therapist's concerns, in the shape of his theoretical framework, onto the patient.

It seems likely that this tendency to accept the responsibility for the negative aspects of the encounter, parallels the therapists' tendency to accept responsibility for the positive aspects; the emphasis again is on what the therapist did, or experienced, and not on what the patient did or experienced. Related to this point was the finding that many of the helpful events which were provided by therapists were identified as Insight events, and were transference-like interpretations, again referring to the therapist's self. For example, one therapist in a therapy which was clearly successful gave the following as the most helpful event: "My pleasure at (the patient's) success and improvement". In this and other cases, it was obviously difficult for therapists to conceptualise important aspects of therapy process (either negative or positive) which did not involve themselves in any way. (It might be interesting to note at this point that the tendency to over-attribute responsibility to the self, in ambiguous circumstances, is a phenomenon well-known to social psychologists who are interested in Attribution Theory. There it is known as the "Personalisation" error.) A similar point has been made by Fransella (1983) who suggests that therapists are perhaps mistaken in their

assumption that their relationships with patients are central; she reports that she finds that patients are actually far more interested in solving their current problems than in worrying about the meaning of their relationships with her.

The last point of interest to be discussed here concerning the picture of the therapeutic interaction from the therapists' perspective, concerns the positive aspects of the encounter. It was clear that many of the therapists enjoyed their work and felt enthusiastic about the progress of their patients. There is considerable evidence elsewhere (for example, Orlinsky and Howard, 1977; Ferguson and Carney, 1970), that good outcome is related to an interested and accepting attitude on the part of the therapist; this was clearly demonstrated in case study 2, but was also evident in the results of the content analysis of all of the therapists' responses, (as shown in Table 19) where poor outcome was negatively related to the amount of reassurance and relief that the therapist reported him or herself as having been able to provide. It might be worth recalling at this point that in the content analysis system, Reassurance/Relief was defined to include factors such as "the enhancement of feelings of self-worth" and "hopefulness". Clearly a therapist who is feeling negative towards the patient will not be very convincing in providing the context in which such events can take place.

Also important in the reports of both therapists and patients was the personal contact between therapist and patient; in Elliott's system this referred to the experience of the therapist as a fellow human being, "perhaps one who has also struggled with the issues the client struggles with ". The fact that this type of event was the second most frequently reported event by therapists, after the conclusion of therapy, implies a picture of the therapeutic experience in which the therapist is hardly passive or uninvolved. Interestingly, Orlinsky and Howard (1967) in their portrayal of the "good therapy hour" described

the effective therapy session as one in which the therapist is involved "in the style of a peer"; neither the psychodynamic neutral screen nor the non-directive approach seems to be as effective. To the extent that therapists recognised the importance of this, they were agreed with by their patients.

To summarise this section on the views of the therapy experience from the perspectives of patients and therapists, it was observed that patients, as a group, tended to highlight aspects of the therapy process which were relatively straightforward, and centered on their immediate, and short term needs and goals. The experience and gains of therapy were usually well integrated into the rest of their lives. Therapists, on the other hand, tended to organise their experience of therapy using a number of theoretically derived tools, and often seemed to perceive themselves and their relationship with the patient, as a focus for the therapy.

9.3) Therapeutic Factors.

9.3.1) Importance of therapeutic factors as revealed by the study.

It may be recalled from the research reviewed in chapter 3 that a therapeutic factor was understood to be a process occurring in therapy which contributes to the patient's improvement. In the following discussion it is assumed that the helpful events isolated by participants were indicative of the therapeutic factors which were operative in the patients' therapy. The events (and hence operative therapeutic factors) which were seen to be most helpful by all participants (despite the existence of differences between them concerning the relative importance of these factors), were: Reassurance/Relief, Problem Solution, Insight and Personal Contact. The findings of the study thus indicate some similarities with factors isolated by other studies, and some differences. As was noted previously, a series of lists of therapeutic factors have been produced during the past decade, in an attempt

to gain a comprehensive picture of the successful therapeutic encounter. These lists will not be repeated here, but it might be interesting to note in passing that there was little evidence in this study for the importance of some factors included in other lists of therapeutic factors, for example, identification, (Marmor, 1971); while there was considerable similarity with others, especially those which conceptualise therapy as an interactive process, as for example Strupp, (1977), and Kiesler, (1979). So what picture does the present study give of effective therapeutic action?

To put it very simply, in this study the successful therapy hour would seem to be one in which the patient had as much space as possible to work out solutions to his or her problems, in the context of an emotionally secure relationship. Reassurance and Personal Contact seemed to be a prerequisite for any further therapeutic endeavour; its absence (as in case study 4) proved fatal for the therapy. What then appeared to be therapeutic varied; clearly it consisted in part of the gaining of insight into the problem, and in large part, of problem solution. Sometimes this seemed to include the direct giving of advice, and the active participation by the therapist in devising answers to problems. Sometimes it involved simply listening to and reassuring the patient, while he or she worked on solutions to problems.

It might be interesting at this point to note how the results obtained in this study relate to the work on non-specific factors reviewed in chapter 3. In some ways the conclusions from the two areas of work are very similar (that is, that the crucial aspects of the therapeutic encounter from the patients' viewpoint are not those specified by any particular theoretical stance); however in other ways the implications are somewhat different. Hence the present results, contrary to the work on non-specific factors, suggest that the therapists' theory, or way of making sense of the relationship, may in fact be important for the therapy to proceed, even if the precise

nature of that theory is not of the greatest importance at least from the patients' viewpoint. It will be suggested in section 9.5.1 that the therapist's way of sense-making, usually encapsulated in theoretical terms, is crucial for therapy, even if only as a challenge to the patient. Thus a variety of therapeutic factors, which may be based on some theoretical rationale, do seem to have some importance over and above non-specific factors. (Of course I am not attempting to rule out the possibility that some ways of "making sense" are better than others in that they are more productive, have a wider range of convenience, and so on. I am simply suggesting that this may be of much greater concern to the therapist than to the patient.)

9.3.2) Direct intervention and advice as a therapeutic factor.

Since direct involvement in solving problems or even giving advice, runs counter to the set of therapeutic principles espoused by many conventionally trained psychotherapists, and because it is not often thought of as an important therapeutic factor, (although of course it is no stranger to behaviourally oriented therapists, or lay helpers), some time will now be spent on discussing active therapist intervention as a therapeutic factor, and examining how it could relate to the other aspect of effective therapy suggested by this research; namely the process of sense-making by the patient. Incidentally, it is not being suggested that direct involvement or problem solution through advice giving is the most important therapeutic factor to emerge from the reports; merely that it is an interesting one, which is not normally discussed much by psychotherapy researchers. It might be speculated that there is in fact a systematic prejudice against the recognition of this factor, as to many therapists, it does not seem to be the "right" way to proceed. Research strategies which do not include the views of patients, obviously perpetuate this prejudice.

There are a number of different ways in which a

therapist may be actively involved in the process of problem solving in therapy. One way is through the giving of advice. The challenging study by Strupp and Hadley (1979) found that the successful but untrained therapists in their study freely gave advice in a way that shocks most professionals, although their patients clearly came to no harm. In similar vein, Aveline (1979) argues that it is important to respond to the needs of the patient: "Giving advice, setting tasks and intervening is seen by purists as stultifying to others' striving for maturity, but may be the correct thing to do when the other is bemused by options and needs to act, or is about to fail himself in a tragic, self-limiting way" (Aveline, 1979, p.274). The study by Murphy, Cramer and Lillie (1984) also suggested that patients valued being given advice. However, the evidence elsewhere on this question appears to be mixed; Hoyt (1980) for example, found that it was in poor sessions that therapists gave lots of advice to patients, and the attempt to impose the therapists' concerns has also be found to be linked with poor therapy hours, (as already suggested above, Orlinsky and Howard, 1967).

Perhaps the key issue is therefore whether or not the advice or active intervention in question is appropriate for the patient at any given moment. Strupp (1980) pointed out the importance of the ability of the patient to "use" the approach taken by the therapist; clearly a factor is only therapeutic if the patient can make use of it, in the sense of being able to see how it applies to his or her present concerns. It may be, therefore, that the advice given to patients is only useful if it seems in some way to be applicable by them, and it is applicable only when it makes sense to them. This is likely to be the case even if the advice or direct intervention is not used in precisely the way it was intended by the therapist. Indeed, the fact that advice is <u>given</u>, does not mean that it is <u>taken</u> by the patient in the way that it was intended; nor need the acceptance of the value of advice be seen as abrogation of responsibility by the patient. In

a sense, the seeking of advice could be seen as a way of gaining "information" on which to act, occurring when the patient is seeking to reduce uncertainty. But that advice will only be taken if it makes sense to the patient; in other words, if the patient is able to see how the advice fits into his or her own way of seeing the world.

Of course, the notion that active intervention is not after all such a bad thing, runs counter to many of the core beliefs of a number of different therapeutic schools, despite being identified as positive by a number of studies taking the patients' perspective. It is interesting to note that a key aspect of more direct intervention is the way in which such interventions involve approaching directly the concerns of the patient. This may be seen as paradoxical because the claims of schools such as the Rogerian are that the absence of overt direction ensures that it is only the patient's concerns which direct the therapy. Yet such interventions may be what "makes sense" to the patient, and also demonstrate that the therapist is listening, trying to help, has resources which may be useful, and so on. Indeed, the picture of the good therapeutic relationship implied by the current research study is largely consistent with that provided by Strupp, Fox and Lessler some years ago, as follows: "The composite image of "the good therapist" drawn by our respondents is thus of a keenly attentive, interested, benign and concerned listener; a friend who is warm and natural, is not averse to giving direct advice, who speaks one's language, makes sense, and rarely arouses intense anger." (Strupp, Fox and Lessler, 1969, p.117). In fact, this does seem to describe very well the picture of the "good" and "useful" therapist as seen by the patients in this study.

Incidentally, an essential argument in favour of examining the views of patients in therapy is that patients' accounts can provide a relatively direct measure of which interventions are useful to the patient at any particular time. If the ability to apply an intervention, or make use of a therapeutic factor, is at least in part

determined by the patient's perception of the relevance of that factor, it probably follows that patients, rather than therapists, are in the best position to judge its effectiveness. Obviously, many events occur during the one hour of a typical therapy session, and the patient is therefore inevitably in the position of having to pay more attention to some aspects of the interaction than others, and hence to "select" from the wide range of diverse interventions and exchanges which may take place, those particular comments, pieces of advice or questions which seem most salient to him or her. It may also be, therefore, that it is a therapy which provides a fairly wide range of therapeutic experiences that has the most chance of meeting the patients' need to find something that they can apply to their own problems.

9.3.3) Involvement as a therapeutic factor.

A number of other points could be made concerning the therapeutic factors which have been indicated by the results of this study. However, it is perhaps worth noting that some factors were surprisingly infrequently seen as helpful, such as Involvement. This was defined, according to the Elliott system, as the strengthening of the alliance between therapist and patient, or the increasing commitment of the patient to therapy. It is difficult to know how to interpret this result, except to say that it may again reflect the fact that, in brief therapies such as the ones studied here, the involvement of patients in therapy is of less importance than their involvement in learning to cope more effectively with life outside therapy.

9.4) The Rashomon phenomenon revisited.

The points raised in the two previous sections lead directly to the question of the relationship between the views of participants. There is, it seems, some evidence in this study for the "Rashomon" phenomenon (as described in chapter 2), although this study has perhaps shed some light on the extent and limits of the phenomenon. The

differences in perspective do not seem to be global; rather they depend upon both the helpful factor in question, and to an extent, upon outcome. In other words, therapists and patients were agreed on the importance of some factors, and not on others, and agreement was somewhat higher when the relationship was better although similarity in perspective did not appear to be crucial for improvement to occur. Two important consequences follow from this: firstly concerning our understanding of the process which leads to positive outcome, and secondly, concerning our understanding of the process of psychological change.

9.4.1) The Rashomon phenomenon and outcome.

Table 20 indicates that where outcome was positive, there seemed to be somewhat fewer differences between the views of therapists and patients, than when outcome was poor. This is perhaps not an entirely unexpected result. However, what does at least on the surface seem surprising is the extent of the differences that still existed between therapists and patients even where the outcome was very positive. In fact, the number of differences that were found between the two extreme outcome groups was not great. Individual case histories (including those in chapter 7) showed that improvement often occurred despite major differences in perception. This seems to suggest that while a degree of concordance was helpful, it was not crucial. Possibly it was important for therapists and patients to have at least some shared perceptions of the process for effective therapy to take place, although a very similar perception was not essential for change to occur, and some differences were certainly not harmful.

The present results are therefore reasonably consistent with those obtained by a number of other studies concerned with therapists' and patients' perceptions; for example the studies by Schonfield et al (1969), who found that patients reported themselves to be most improved when therapists and patients were closest in agreement

regarding appropriate therapeutic behaviour, although not necessarily values; and Schwartz and Bernard, (1981), who reported that the degree of consensus in effective therapy was high, although it varied according to the stage of therapy, (a question which was not examined in this study). Kaschlak (1978) found significant correlations between therapist and patient views concerning outcome, but not concerning process; however he did not relate these two levels of agreement to each other.

The relationship of shared perceptions to outcome is therefore clearly neither linear nor straightforward; it does not seem to be the case that the more the two groups of participants see therapy in a precisely similar way, the more likely the patient is to improve. This counter-intuitive finding, that difference of viewpoint does not appear to lead directly to negative outcome, may in fact suggest one of the ways in which therapy is effective; that is, that the contrast between therapists' and patient's viewpoints, given a supportive relationship, may in itself be conducive to therapeutic change. This point will be considered in more depth in section 9.5.2, although it will obviously be necessary at this point to suggest ways in which such a process could operate.

9.4.2) Sense-making by the participants.

It is to be argued in the remainder of this section that the differences and similarities in perception found in this study were not merely an artifact of the research design, but may represent a "real" difference in perspective which has some import for theories of psychological change. This is not to ignore the importance of the points made in chapter 8 concerning the limitations of the present study; indeed it is important that the present results are not seen as *"proving" this argument.* At present, all I am attempting to do is to make sense of the results which were found in as plausible a way as possible. The implication of the findings of the study is that one of the possible sources of variance in trying to

account for therapeutic process is that concerned with the different ways in which individuals account for, or make sense of, their experiences in particular and idiosyncratic ways. It seems important therefore to spend some time considering what exactly is meant by "making sense" in the therapeutic context.

It is perhaps a basic axiom of much present day psychology to say that any individual in any given situation is always in the process of trying to understand and cope adaptively with that situation (see for example Kelly, 1955; Piaget, 1954; Hampson, 1982; and much of the recent work in the information processing paradigm). In other words, the individual is always trying to discover patterns of meaning from the assorted stimuli which confront him or her; this meaning is necessary for the individual to be able to act effectively in the world. This attempt to discover and construct meaning is essentially a creative process, whereby the individual uses and adapts his or her existing framework of understanding to make sense of each new situation; however it is important to note that there is always the potential for the individual to devise new ways of making sense of the stimuli. Therapy is no different. Obviously, patients and therapists bring with them to the therapy situation the resources that they have relied on in the past, which are then used in trying to deal with the current situation. But it will also be obvious that all therapists and patients have different resources on which to draw; besides their own life experiences, therapists have experience of previous patients, and the conceptual analyses that they have learned during the course of their training. Patients, on the other hand, excepting those patients who are themselves therapists or who have read widely in the area, must rely primarily on their own life experiences, and their friends, in order to make sense of what is happening. Hence the resources that they bring with them to help them to understand and adapt to the therapy situation are different.

Having accepted this, it is also important to note from previous studies (for example, Buckley, Karasu and Charles, 1981, and the numerous personal accounts of therapy reviewed in chapter 2), that therapists, when themselves patients, also tend to see as helpful those aspects of therapy which are comprehensible using "everyday" experience, not "professional" experience. It may be, therefore, that there is something about the "professional" way of making sense of the therapeutic encounter, which is in fact less helpful or salient to the patient. This could be because the "professional" way of understanding the process is simply unavailable to patients, as might be suggested by the work of Leiman (1983), described in section 9.2.3. However, Leiman's ideas cannot explain the findings obtained from therapists as patients. Alternatively it could simply be that those issues which concern the therapist, are of less importance for the patient. In other words, the patient may not be able to make use of those aspects of the therapeutic situation which are indicated by professional training, because they do not appear to be of much help to the patient in the task of making sense of the situation, or putting that sense into action, ie., acting in the real world outside therapy.

In order to clarify these issues, it might be advisable to look more closely at one of the therapeutic factors which most clearly distinguishes the two perspectives, that is, insight.

9.4.3) Differences in perspective: the case of insight.

The most obvious example of a distinction between the perspectives unearthed by this research study, was that of the view taken by participants of insight. According to the Therapeutic Impact Content Analysis System used in this study, cognitive insight is defined as the patient realising new connections and seeing something new about the self; and affective insight is seen as reducing blocks

to the experience of previously warded-off and uncomfortable thoughts and feelings. Both affective and cognitive insight are generally assumed by many psychodynamically oriented theoreticians (for example, Wallerstein, 1983, and Claiborn, 1982) to be the central therapeutic agents in psychological change. In a recent paper, Wallerstein quotes the view of Blum (1979), that: "Interpretation leading to insight is the specific and most powerful agent of the psychoanalytic curative process... Insight may be stated to be a-sine-qua non of psychoanalysis." (Wallerstein, 1983, p.34). Obviously this point applies particularly to psychodynamic approaches; nevertheless the fact that over 37.9% of therapist responses obtained in this study fell into the category of either cognitive or affective insight implies that the belief in the importance of insight was fairly widespread. Yet instances of either cognitive or emotional insight were not seen to be centrally helpful on more than a small number of occasions by the recipients of therapy. (It may be recalled from Table 17a, that although Affective Awareness events were not seen to occur very often by therapists, when they did, they were given the highest ratings of all of the categories of event. Conversely, patients rated Affective Awareness events lowest in helpfulness of all categories of event.)

The case histories demonstrate the way in which the carefully worked out interpretations of the therapist (which were presumably designed to bring about insight) often seemed to fall on apparently deaf ears, or at least, did not appear to have any major impact on the patients in terms of their self-reports. Of course it could be argued that the patients were indeed gaining insight; it is simply that they were not aware of it or saw it as less significant; in other words, they did not have insight into the fact that they had insight. As was pointed out in chapter 8 above, the assumption cannot be made that anyone, let alone a patient or a therapist involved in a therapeutic relationship, is able to give an unbiased or accurate account of their own actions; there is no way

that the views of patients on this matter can be seen as other than subjective opinions which may have been given with particular but unknown purposes and intentions. (The same qualification can, of course, also be made with respect to therapists.) However, what can be said is that the patients do not appear (for whatever reason) to have reported registering the impact of insight events as often as other events, or as often as the therapists' reports suggested they should have. How can this be explained?

Possibly one of the simplest ways to account for the differences is to suggest that the patients and therapists were "really" talking about the same thing; it is simply a question of the words used. Thus it could be argued, for example, that when one patient described as the most helpful event: "Working out how to cope with my mother's nagging when she visits next week", it is the same thing as the therapist's report that the significant event was: "Understanding how she is repeating with me the hostile feelings that she has towards her mother". (These events were seen by coders as Problem Solution and Insight, respectively.) Yet examination of the codings given on the Elliott Therapeutic Impact Content Analysis System do not substantiate this argument. Inspection of Tables 7 and 8, as well as the subjective reports of the coders (see section 8.4.3) suggest that there was relatively little difficulty for the coders in distinguishing Insight events from Reassurance/Relief or Problem Solution events. Nor did patients have any difficulty in describing Insight events; such events did occur, and patients did appear to be able to describe them quite adequately. It could of course be suggested that insight leads to problem solution, and that patients were simply unable to perceive the process. However, even if this is the case, it is clear that patients were more concerned with the results of the procedure (ie., problem solution) than with the process by which it occurred (which may or may not be through insight).

It could also of course be argued that, even after the conclusion of therapy, enough time had not elapsed for the patient to realise what exactly it was that he or she had gained from therapy, so that patients were responding to short-term considerations only (assuming of course that problem solution is a more of a short-term gain of therapy, than insight). This cannot of course be ruled out. However, many of the results from the other autobiographical accounts and empirical studies mentioned in previous chapters, which were consistent with the present results, were obtained a considerable time after the period of therapy had elapsed. This rather weakens the suggestion that, in time, the patients would realise that they had indeed gained insight. Furthermore, the finding that patients were even less likely to report Insight events, after the end of therapy than during therapy, weakens this idea even more. However, only a study with provision for some long-term follow-up, can answer this question satisfactorily.

Yet another way of attempting to explain the discrepancy would be that the patients were unwilling to describe the discovery of something new about themselves because it might suggest that they were stupid or very misguided before therapy took place. Again, the fact that patients did describe Insight events on at least a number of occasions rather undermines this suggestion, as does the impression of enjoyment (rather than shame or embarrassment), that is gained when the patient did describe gaining insight. More serious is the objection that it is not possible to accept at face value any individual's account of his or her behaviour on the grounds that there are simply too many aspects of "reality" which it is convenient for him or her not to know about, let alone for the "other", in the person of the therapist, to know about. While there is undoubtedly considerable force behind this argument, it is nevertheless of some interest to know the nature of the differences between the partial accounts of "reality" given by the two groups of participants, whatever the status we give to those partial

accounts.

Perhaps one of the most plausible ways of accounting for these results, however, is to accept that they are indeed a reflection of a "real" difference in the salience which was accorded by patients and therapists to the gaining of insight. It may simply be that patients, as a group, were less interested in self-knowledge than in solving problems and feeling better, on a short-term basis. Therapists, as a group, may have been able to perceive more clearly the advantages of helping the patients to understand why the problems arose in the first place, so as to prevent their recurrence in the long term. (This is not of course either to condone or condemn patients or therapists for their views.) It seems to be simply that, according to these results, patients wanted to solve their problems and to feel better. Insight was a less important consideration. Alternatively, patients may have been less interested in process than in outcome; as has already been suggested, some form of insight may have occurred to these patients but it had little significance in comparison with the solution of their problems.

9.4.4) Consequences of the Rashomon phenomenon for an understanding of the place of insight.

In the field of psychiatry and social work, it has for a long time been recognised that patients and therapists may have different goals (for example, Fitzgibbon, Cutler and Cohen, 1971, Mayer and Timms, 1970); it has also been recognised in psychotherapy that patients and therapists may have different core beliefs and values, (Bergin, 1980). The present research study suggests that the aspects of therapy which are most salient to the patient may not be those which are expected by the therapist to be the most salient. How does this implication relate to current theories about the place of insight in psychological therapy?

Interestingly enough, a number of psychodynamically oriented writers now appear to be suggesting a relatively

lower status for insight in the therapy relationship than previously. It could perhaps be that some researchers are heeding the suggestion made many years ago by Alexander and French, that: "the role of insight is over-rated." (Alexander and French, 1946, quoted in Wallerstein, 1983, p.37). Mollon has recently written: "The primary function of psychotherapy is the facilitation of intrapsychic communication rather than the achievement of insight per se ... this intrapsychic communication is catalysed by the interpersonal communication between the therapist and patient." (Mollon, 1979, p.60). In the same vein, Winnicott (1971) commented that "Psychotherapy is not making clever and apt interpretations; by and large it is a long-term giving the patient back what the patient brings." (quoted in Pedder, 1979, p.117). This view of the place of insight implies of course that it will be effective when it occurs in the context of a good interpersonal therapeutic relationship, in which the patient is an active participant, not simply a recipient of wisdom. There is elsewhere some additional evidence for this; Tovian (1977) reported that patients who saw themselves as responsible for progress in therapy sessions were more likely to obtain more positive outcomes than those who simply sat waiting for the therapists' input.

Of even more interest to an understanding of the process whereby change is achieved is the implication in Winnicott's words (above) that effective therapy concerns working with the "material" brought by the patient to therapy; in other words with the resources and sense that the patient has already been able to make of the world. This is clearly consistent with the results of the present study, and implies the need for the therapist to accept at least as a starting point the way in which the patient may be able to use the therapeutic situation, rather than imposing his or her own view of what the therapy should be about, or interpretation of events, onto the patient. This acceptance of the patient's world view may be an important part of effective therapy.

On the other hand, some recent research has indicated that the frequent use of interpretations is in fact linked to good outcome. Claiborn (1982), Dorn (1984), and Marziali (1984) have all suggested that transference interpretations are correlated with positive outcome in brief psychotherapy, although Marziali adds that "relationship factors", concerned with the therapeutic alliance, can't be ruled out. The lack of a relationship in the present study, between outcome and either the therapists' or the patients' perceptions of the frequency of insight as a helpful factor, perhaps suggests that the participants' perception of frequency, at least, is not crucial, (see Table 19). However, in Elliott's coding system, the number of events coded as Insight is obviously neither a direct measure of the frequency of interpretations, nor an objective measure of the importance of interpretation, so that the results of this study cannot be seen to have direct relevance to questions about the effectiveness of a high level of interpretations. In addition, the type of therapy and type of patients is rather different in the two sets of studies. Nevertheless, it might be fair to conclude that these results do not appear to provide direct support for the work of Marziali, Claiborn and others.

9.4.5) Consequences for the Rashomon phenomenon for an understanding of therapy.

As was outlined in previous chapters, until relatively recently probably the most widely accepted view of the therapeutic process held both by clinicians and researchers was mechanical: the therapist did something to the patient who was more or less a passive recipient of the technique, with results which were assumed to be uniform irrespective of the problems presented or the personalities involved. Success therefore depended more on the skill and technique of the therapist than on any action or even characteristic of the patient. (This view is still widespread, albeit in a somewhat modified form; see for example Marziali, 1984). In time, more complex

formulations were by necessity evolved to explain the repeated failure of any variables to explain more than a very small percentage of the variance occurring in either outcome or process. Therapy began to be seen by some researchers as an interaction between two participants, who were said to be in "a social influence situation in which the patient's relationship to the therapist is the primary vehicle for therapeutic change" (Kelman, 1963, p.399). Dorn (1984) has described therapy as a two-way process of influence, and Saltzman et al (1975) consider the therapeutic process to be a function of interaction and mutual influence, in which it is meaningless to locate the responsibility for therapeutic change within the behaviour or characteristics of either the therapist or patient alone. Indeed, one of the consequences of this newly developed conceptualisation of the therapeutic interaction is that it means that the understanding of both parties in the process have to be considered; simply knowing about the constructs (or theories) used by one of the parties involved is clearly insufficient. This position has also been advanced by Lee (1984), who pointed out that the process of getting to know a patient is rather like getting to know another culture, such that a therapist should not assume "that the categories used to make sense out of his or her experience are applicable to all people ..." (p.593), any more than we should impose our own cultural assumptions onto another culture if we really want to understand how that culture works. This is partly because our own assumptions may actually hinder us in making any sense of that other culture. In other words, if the notion of therapy as interaction is to be accepted, the importance of multiple perspectives (or the Rashomon phenomenon), must also be accepted. (This is not to say that the perspectives are of equal "value", but simply to assert that there clearly are different perspectives that need consideration if therapy is to be seen as an interaction.)

To summarise this section on the differences in perspective between therapists and patients, it can be

concluded that the Rashomon phenomenon exists, and may point to an important distinction in the goals and needs of the two groups of participants in therapy. Awareness of these differences could have important consequences both for our thinking about the process of psychological change, and for the actions of therapists. These points will be discussed in the last section of this chapter.

9.5) Implications.

The remainder of this chapter is devoted to an examination of some of the implications of the results of the study, and draws on both the evidence presented, and on my subjective understanding of the findings. No claim is being made that I have "evidence" for the model to be suggested in section 9.5.2, merely that it seems to me to be an interesting and promising way of making sense of the findings.

9.5.1) Implications for understanding the process of psychological change.

One of the most interesting aspects of the results obtained by this study are the implications which they have for our understanding of the processes by which one person can be helpful to another. How is it that the therapist does succeed in contributing to psychological change? In this section of the discussion of the results of this study, there will be an examination of the contribution that the results can make to our view of this process.

As has been shown above, there is in this study the suggestion that the therapist's ability to provide a relationship in which the patient (with some help) can seek solutions to problems, is one of the keys to effective helping. The helper does not have to be seen by the patient to have provided an excessive number of insight oriented events (although some seem to be helpful); rather a personal, encouraging and problem oriented approach (at least as seen by the patients) seems to be indicated. The

picture of the therapist portrayed by this list of characteristics is not therefore that much different from that of a close, concerned friend, although the friend in question might be a singularly skillful and perceptive one. In addition, the process seems to be essentially interactive rather than passive on the part of both therapist and patient. Hence one way of looking at the effective therapist is to see him or her as a "real" person in the patient's life, who is providing the patient with a number of novel ideas and experiences which the patient can apply in a variety of ways.

From the perceptions of the patients in this study, it would appear that a therapist who is more than either a paragon of warmth and empathy, or a source of interpretations, would be most likely to be able to catalyse helpful events, and least likely to be disappointing. This is consistent with the findings of Orlinsky and Howard (1967), who found that "bad" therapy hours were characterised by therapists who adopted a passive and neutral stance. The passive therapist cannot be said to be providing the patient with very much to work with, (although of course it has traditionally been argued that this is therapeutic in itself); nor would he or she be genuinely interacting with the patient. An active, involved therapist does seem to be preferred by patients, possibly because there is more "happening" which can be taken up and used by the patient, as suggested in section 9.3.2. As has been seen elsewhere in this research study, exactly how the patient does this is not always under the control of the therapist. The patient is clearly an involved member of the treatment process, and the therapist, being active, and personally involved with the patient, may also be likely to be responsive to the patient. Both participants are therefore in the process of trying to make use of the interaction in a way which is productive and meaningful, using the resources that they both possess, in order to do so.

9.5.2) Therapy as debate or negotiation.

All of the above seems to suggest that many of the ways in which therapy is presently conceptualised, are inadequate in that they fail to account for the interactive nature of the process. Because of this, it may be that a model of therapy as "debate" or "negotiation" would be more appropriate; both therapist and patient can be thought of as striving in the therapy to reach an interpretation of "reality" which is meaningful, and usable, to them. (Another way of describing the process might be as dialectical, although I have chosen here, for a variety of reasons, to explore the notion of therapy as a form of debate or negotiation, rather than as a dialectic.) Patients and therapists may have different resources on which to draw during the process of debate, and they may use different strategies by which to organise their experiences, but nevertheless they have both entered the interaction with the intention of modifying their current understanding of the world and each other. It is in this way that the process of therapy can be seen as a constructive disagreement, as is a debate or negotiation.

The notion of therapy as negotiation has been advanced by a number of writers, including Smail, (1978); Kiesler, 1979; and Strong and Clai born, (1982). According to Smail, negotiation consists of two elements, understanding and persuasion; a communicative process through which therapist and patient reach shared meanings. Similar processes also occur in debate, where two parties communicate with each other, in an attempt to increase their understanding of a topic, as well as to persuade each other of the value of their own perspective. Also implicit in the notion of debate or negotiation (as with the notion of the dialectic) is the view that two parties are attempting to work out a view of "reality" which differs from that with which they began the interaction, although as Smail points out, this does not mean that the aim of therapy is to produce identical world views. (The concept of the dialectic does however carry with the

notion of synthesis, as to a certain extent does the concept of negotiation, which is why I have chosen to include the term "debate" in outlining this model.) As will be discussed below, this last point is a particularly crucial one.

A number of writers (for example Smail, 1978; Strong and Clai born, 1982; and Dorn, 1984) have also suggested that it is the process rather than the outcome per se of the communication that is therapeutic, as the patient has to adapt and change the way in which he or she makes sense of the world and the self, which now includes the therapist and the experiences which the therapy has involved or catalysed. As was suggested in section 9.4.2, the impact of therapy may therefore be in its capacity to alter the way in which the patient (or less crucially, the therapist), is able to make sense of the world. It is interesting to note at this point that this notion of therapy as debate or negotiation, implies that the therapist too is in the process of change. And indeed there is some evidence that this is the case. Change in the therapist does seem to take place, particularly when therapy is effective. Schonfield et al (1969) reported that in helpful therapy, not only do patients tend to adopt some of the views of therapists, but also, therapists can be seen to adapt some of their techniques and behaviour in response to the particular patient, supporting the notion that therapy is a process of mutual influence. Obviously, it might well be the case that the major movement occurs in the sense-making of the patient, rather than in that of the therapist, although some willingness on the part of the therapist to adapt to the needs of the patient may well be what characterises the effective therapist; that is, it may be a consequence, not a cause.

This may also be why there is some suggestion that the ability to act independently of one's theoretical orientation is a key to success as a therapist. Sundland (1977) writes that "as people (ie., therapists, S.P.L.) gain experience, they rely less on rules laid down for

them by others, and more on a differentiated assessment of what particular situations require. Or perhaps the ability to do this is what distinguishes the more effective person from the less effective." (p.214). In addition, Strupp (1978) points out that theoretical orientation fades into the background with experience, and that good therapy involves listening closely to the patient's experience: "If as therapists, we approach our task with the proper humility and respect for another human being, if we can listen to and fathom the meanings of the patient's latent schemata ... and if ... we can mesh the foregoing requirements with broad clinical knowledge and experience, we will have gone as far as humanly possible in helping our patients..." (p.27, Strupp, 1978). Strupp is here clearly pointing out the need to work with the concerns presented by the patient, if effective therapy, or negotiation, is to occur; also implied is the need to be able to adapt to the sense that the patient has already made of the world. But in order to be able to proceed, Strupp also points out that the therapist has to use his or her own ways of making sense, based on professional knowledge and experience, so as to be able to stimulate therapeutic change. These ways of making sense are essentially different from the patients' ways.

So how exactly does this process of debate or negotiation take place? From the results of this study, it appears that the provision of a positive relationship (indicated by the presence of both reassurance/relief, and personal contact), is crucial for effective therapy, but, as shown in section 9.4.1, similarity in viewpoint concerning the process of therapy, has few direct consequences for outcome. How can we make sense of this? Could it be that the differences in perception, given a positive relationship, point to a mechanism for change? If this is indeed the case, then some discrepancy in perspective may in fact be an essential stimulus for change.

A number of other writers, particularly those who have adopted an interactive model of the therapeutic

relationship, have reached somewhat similar conclusions. For example, Strong has expressed the notion of change through negotiation, as follows: "Only when the participants disagree about how they should relate to one another's influence, is change in one or both participants a potential outcome of their relationship." (Strong, 1984, p.17). In addition, Carson (1969) suggests that the main vehicle of therapeutic movement is the challenge by the therapist to the patient's existing ways of making sense of him or herself and the world; thus the therapist's major function is to provide "non-confirmation of the client's constricted view of self." (p.281).

This could be the case because change is not very likely to result from reassurance/relief or personal contact alone, since neither of these factors confront the patient with very much need to make sense of the world in a different way. Therapy also has to present the patient with a problem: how to understand and deal with a world in which his or her way of making sense of the world exists, at the same time as the therapist's. Another way of putting this is that the therapy demonstrates to the patient that solving his or her current problems, at the same time as maintaining his or her existing ways of making sense of the world, is impossible. Exactly how the patient sorts out this question may constitute the process of therapy.

One of the implications of this view is that, far from being a negative aspect of the therapy process, the fact that therapists and patients have different perspectives on the world, is actually a positive force for movement. It may be precisely because they do have different views that the patient is stimulated to work on his or her way of making sense of the world, and hence to solve problems. This is consistent with the view of Dorn (1984) who suggests that when interpretations are effective, their impact is due to the fact that the patient has to re-attribute behaviour to circumstances that can be controlled, away from unproductive, uncontrollable

circumstances; in other words, he or she has to make sense of events in a different way. Indeed, it may be that insight and problem solution are both involved in requiring the patient to reorganise his or her existing perceptions of the world, because of new experiences. Exactly how these two may be related in time is not clear; maybe there is some causal sequence which links the two, although this was not examined in the present study.

Before concluding, it is important to stress that although I have chosen to use the terms "debate" and "negotiation" to describe the therapeutic interaction, there is no suggestion that the patient should terminate therapy making sense of the world in the same way as the therapist; a therapy which results in a patient who merely reproduces the ideas and beliefs of the therapist, is generally understood to be at best unhelpful, or at worst, iatrogenic malpractice. (See for example the paper on psychotherapeutic cults by Temerlin and Temerlin, 1982, which provides a series of disturbing examples of therapies which require the patients to conform to the therapists' view of the world.) This has been recognised by Smail (1978) amongst others, who points out that total understanding, indicated by sharing and mutuality, cannot be "the" therapeutic goal. In therapy, just as in any close relationship or friendship, differences in ways of making sense of the world are a vital stimulus for growth and development. A relationship where two people persuade each other to adopt identical perspectives on the world, is a dead one.

In conclusion, it is therefore rather tempting to speculate that, rather than being a rather frustrating inconvenience for psychological therapy researchers, it could be that the Rashomon phenomenon is actually one of the keys to understanding how it is that therapeutic change is achieved. In fact, it was suggested that if therapists and patients didn't see things differently, there would be neither the motivation, nor the necessary conditions or tools, for change to take place. This

possibility will be discussed in more detail in chapter 10 below.

Chapter Ten

Conclusions.

10.1) Introduction.

In the first section of this last chapter (section 10.2), there will be an overview of the results obtained, and some conclusions will be drawn. Implications of these results will also be outlined. Following this, (in section 10.3), some suggestions will be made concerning further research in this area, and finally, (in section 10.4), there will be a brief and speculative discussion concerning the future of psychological therapy and psychological therapy research in the light of the results of this study.

10.2) Overview of the Results and Implications.

As with the last section of the previous chapter, it must be pointed out that in some sections of this discussion concerning the implications of the present study, I intend to draw upon both the evidence obtained, and also on the sense that I have been able to make of the findings. Hence I wish to point out that some of the discussion which follows, especially that part which concerns the model of therapy as negotiation or debate, is speculative, and has not been demonstrated conclusively by the present results.

10.2.1) Overview.

The results of this study have shown that patients and therapists, when asked to describe the most helpful events that occurred in their psychological therapy, reported different factors to have been of the greatest importance. Therapists were more likely to have reported the helpfulness of Insight, whereas patients were more likely to have reported the importance of Problem Solution and gaining Reassurance/Relief. However, therapists and patients did not need to be completely agreed on their

perceptions for therapy to be effective. It was suggested that this implies that different aspects of the therapeutic process have different degrees of salience for therapists and patients. Further, it was also suggested that these differences in perspective may in fact point to one of the ways in which therapy is effective, in that patients may reach solutions to problems in part because the therapeutic situation leads them to adapt and change the ways in which they previously made sense of the world. Hence a difference in perspective, within a supportive and reassuring relationship, may act as a stimulus for change. However, it was also noted that patients did not need to adopt the therapists' ways of making sense of the world in order to solve their problems in new and more constructive ways. Rather, the crucial factor was their development of their own, new ways of making sense. It was suggested that the model of therapeutic change which seems to encompass most effectively the implications of these results is that of therapy as a negotiation of different ways of sense-making.

10.2.2) Implications of the model of therapy as debate or negotiation.

One of the first implications of the model of therapy as a debate or negotiation which involves both support for, and a challenge to the patient's existing ways of sense-making, is that the balance between these two elements is likely to be a fairly crucial one. If the major impact of the therapist was merely to challenge the patient, without regard for his or her pre-existing ways of sense-making, then the patient would probably fail to trust the therapist enough to attempt to develop new ways of sense-making; hence the therapy would fail. In addition therapist and patient would not be talking the same language unless there was some attempt, primarily by the therapist but also to an extent by the patient, to adapt to the other's frame of reference; without this progress would be virtually impossible. If on the other hand, the therapist acted in such a way that he or she merely

supported and accepted the patient, without offering any alternative perspectives or actions, then this would also be unlikely to lead to much positive change. It might be expected therefore that a therapy with positive outcome should show some initial and continuing discrepancy between the therapist's and patient's views, but not too much. This indeed seemed to be the case in the results of the study reported here. However the total number of patients involved in this study, and the absence of many patients who had benefited very little from their therapy, meant that it was not possible to compare outcomes from interactions of therapists and patients who had no disagreement in perspective, with those who had either a moderate degree of disagreement, or many disagreements. It would be extremely interesting to see if, as predicted by this curvilinear model, outcome for the two extreme groups was not as positive as for a group where some, but not too many discrepancies existed. Of course, this also implies that a means of quantifying the discrepancy is needed. One possible way of doing this might be through measures derived from Kelly's Personal Construct Theory, although this is beyond the scope of this thesis, so will not be discussed further here.

Another implication of the view of therapy as a debate or negotiation between two people who are trying to use and adapt their pre-existing ways of making sense of the world is that the process, as well as the outcome of sense-making, is likely to vary according to the particular goals and psychological structures (or sense-making) of the two people involved. The ways in which they each do so would not necessarily be accessible to the other; hence differences in the perception of therapeutic factors would be expected. This indeed was the case according to the results of this study. It might also be expected, according to this model, that few significant differences would be found between the perception of therapeutic factors by groups of patients in different types of psychological therapy, (such as behaviour therapy or interpersonal therapy), since the process of sense-making occurs inside

the heads of patients and seems to be relatively unaffected by the exact nature and theoretical basis of the challenge offered to them. In other words, if the sense-making of patients is relatively idiosyncratic, and not based upon the theoretical beliefs of their therapists, then the therapeutic factors identified by patients in different types of therapies, will not necessarily be distinguishable. This indeed is what has been found by studies which have compared the views of patients receiving disparate types of therapy (for example, Sloane et al (1975); Llewelyn and Hume (1979)). However, this question was not systematically examined by this research study, although it will be considered again in more detail in section 10.3.2.

A third implication of the model of therapy as a "balanced" negotiation by idiosyncratic sense-makers, is that some therapists are more likely than others to be effective in the process of supporting whilst challenging the patient's existing ways of making sense; furthermore, any given therapist is likely to be more effective with some patients than with others. That is, those therapists who are able on the one hand to adapt to the ways in which their patients construe reality, and hence to support them, and yet on the other hand whose own construal system is not too similar to the patient's, will be most able to negotiate effectively with the patient. Indeed, this seems to be the case. A study by Alcorn and Torney (1982), for example, suggested that a positive relationship exists between a therapist's level of cognitive/emotional complexity (as measured by the number of categories of emotional experience used by the therapist about him or herself), and the level of empathy experienced by their clients in therapy. This could be seen to imply that complexity, or breadth of construing on the part of the therapist permits a more empathic (and hence more supportive?) relationship to develop with the client, which can in turn be seen as supporting the argument (advanced above) that a degree of adaptability within the therapist's process of sense-making, would be related to

positive outcome.

As regards the part of the argument advanced above concerning the importance of some limited degree of divergence in perspective, there seems to be some supporting evidence from studies of persuasion. For example Sherif, Sherif and Nebergall (1965) have shown that an attempt to persuade an individual about any given topic, is more likely to be successful if the discrepancy between the views already held by that individual, and the intended new views, is not too great. This would seem to suggest that some change in the views of a patient is most likely to occur when the therapist does not try to change those views too extensively. These are intriguing suggestions, although much more work needs to be carried out in this area before they can be seen as strongly supportive of the model outlined in this study.

Another implication of the model is that it is those therapists who are able to make some tentative suggestions to patients regarding solutions to problems who are most likely to be able to catalyse constructive change, mainly because of the challenge that such interventions offer to the patient's existing ways of sense-making and acting. It was suggested in section 9.3.2 that the offering of advice or problem solution, was often valued by the patient, although in the spirit of debate, the patient also had to be free to reject the intervention. Indeed, a number of recent studies (for example Hunt, 1984; and Murphy, Cramer and Lillie (1984) have shown that patients do seem to value being given advice and guidance more than many other aspects of the therapist's activity; however, I am not aware of any research which has examined the ways in which patients have used (or not used) that advice. Incidentally, it might be interesting to speculate at this point that direct intervention through negotiation could be an important therapeutic factor from the viewpoint of the therapist as well as the patient, in that it could be seen as satisfying the therapist's need to understand the patient (in other words, for the therapist to gain

insight?), as well as for the patient to solve problems. It could be that this is because the giving of advice acts for the therapist as a test of his or her understanding of the patient; and for the patient, as both an indicator of the therapist's concern, and as a stimulus towards finding an answer to his or her difficulties. It could also be seen as acting by method of contrast; that is, any given suggestion highlights what is inadequate about that particular suggestion, and hence aids in the development of a better solution.

The last implication of the model outlined is that the ethical aspects of therapeutic interaction become crucial. It will be obvious that in most if not all cases the therapist is in a position of considerable power relative to the patient, such that the therapist has the potential to render the notion of debate or negotiation meaningless due to his or her superior ability to persuade. Although this power discrepancy is also present in all therapeutic encounters, implicit within both the medical and educational models of therapy are some assumptions which guide the conduct of therapists; that is, they attempt to "cure" or "educate" the patient according to standards of health or maturity which are usually fairly widely understood and often shared by patient and therapist (even if suspect on many other grounds). However the debating or negotiation model, which has a conflict of world views as a basic assumption, also has to face issues of morality which are often obscured in the other models. For example, how does the therapist have the right to challenge the patient's views, according to the therapist's own particular viewpoint? How can the therapist justify the conscious use of his or her own values in the therapy situation? More importantly, how does the therapist have the right <u>not</u> to convert the patient completely to the therapist's own way of thinking, since from the therapist's viewpoint, that is obviously the "best" way? There are no easy answers to these questions (which also of course arise in all psychological therapies), but it is important to recognise their importance in the

application of the debating or negotiation model.

Obviously there are a number of other implications which could be drawn from the model of therapy which has been suggested here, and which should be examined in order to determine how useful the model could be in other circumstances. Clearly further research is called for before the model can be seen as anything other than speculative. Now, however, I shall turn to a somewhat closer examination of other issues which have been raised by the present study, in order to suggest some more specific extensions of the present findings.

10.3) Avenues for Development in the Future.

10.3.1) Further research suggested by the results of the present study.

It may be recalled from the introductory chapter of this thesis that a number of psychotherapy researchers have in recent years been calling for the development of a wider range of data gathering research strategies, through the implementation of studies which do more than simply testing out yet another wrinkle in an established theory. I remain firmly convinced of the value of such an approach, although I also accept the value of more traditionally structured approaches when specific answers to specific questions are being sought, or when important aspects of theory are being examined, as will be outlined below. Some further research strategies using both of these approaches will now be suggested. (Some of these possible research questions have already been mentioned in chapter 8, when the limitations of the present research study were discussed.)

10.3.2) Extension of the approach used in this study.

The findings of the present study support the value of a rather "low status" research strategy, that is, to approach a phenomenon without well formulated hypotheses to be tested, but rather to examine carefully the

phenomenon in question in order to formulate hypotheses. It has used one particular method of exploratory investigation, that of looking at the written accounts of therapy participants which described the therapy process. Numerous other methods could be developed which also attempt to get close to the experience of participants. Leiman (1983), whose work was described in the previous chapter, is currently working on a research study which will include a measure of the ways in which therapists make sense of their interactions in terms of the level of conceptual complexity used. It might be extremely interesting to do the same with patients, using an analysis of either written accounts or verbal reports after therapy sessions. The use of I.P.R. in a number of fields, including psychotherapy process, is growing. A research group in Sheffield (including Robert Elliott and myself) is currently carrying out a series of studies using this method. The aim of such studies is to look at the way in which individuals make sense of the interaction in which they are taking part through repeated questioning regarding their intentions and reasoning.

Of particular interest for further research of this kind would be the examination of the sequences of events which lead up to the occurrence of a particular type of therapeutic event. One of the problems in the interpretation of the results reported in this study was that no evidence was available by which helpful events could be placed in context; future studies could remedy this omission. It was suggested in section 9.4.3, for example, that patients, as compared with therapists, might have reported fewer insight oriented events as having been helpful, because such events were less salient to them; however it could also be the case that insight did occur very frequently and was helpful, but only as a step towards the major concern of the patient, which was problem solution. Careful observation of the sequence in which events tend to occur, both between and across sessions, could perhaps clarify this question. In addition, it would be possible to discover, given any particular type of therapeutic

event, what the previously occurring type of event was, and what tended to follow it. For example, does Insight tend to follow Reassurance/Relief, and is it followed by Problem Solution? Or does Reassurance/Relief precede Insight, which leads to Problem Clarification rather than Problem Solution? Does Personal Contact tend to precede Involvement? and if so, what is the outcome likely to be?

The question of the impact of certain types of therapeutic activity could also be examined more closely by this research methodology. A study by Bottari and Rapoport (1983) for example, has related patients' perceptions of the therapists' functioning during the first session to subsequent symptom change and to length of treatment. Such a strategy, but using types of helpful event as coded by the Elliott system, might also be of interest. In the study currently being carried out by myself and others in Sheffield, which includes the questionnaires used in this study, some reasonably accurate outcome data is being collected, (both immediate and long-term), which will permit some more comprehensive analyses of the relationship between certain types of helpful event, and outcome.

Another interesting question which could be explored by an extension of the technique described in this study concerns the exact characteristics of particularly crucial sessions. What is going on during a session which both therapist and patient describe as particularly significant? How do such sessions compare with those which both agree to have been poor sessions? Some preliminary answers to some of these questions have been suggested in studies by Hill, Carter and O'Farrell (1983); and Elliott (1984). Hill et al also point out the need to examine particularly effective interventions in the context of an entire therapy relationship, as follows: "It seems crucial to study such complex interventions in the context of an entire relationship and to examine the immediate precursors to determine what renders them acceptable to the client." (Hill, Carter and O'Farrell, 1983, p.15). In other words, such an examination could only be effective

if at least some of the patient's particular ways of making sense were understood, and some degree of support had been established. Of course, research strategies such as these are time-consuming and intensive; it would be difficult to examine more than a handful of therapies in such depth. This then limits the generalisabilty of the results, although as was suggested in earlier chapters, this is probably a necessary step in extending our understanding of psychotherapy process.

A further question of interest is whether there are systematic differences between the ways in which both therapists and patients involved in different types of therapy conceptualise helpful events. As was suggested in section 10.2.2, the implications of the research reported in this study, which points out the lack of similarity between the types of event seen as helpful by patients and therapists, as well as the outcome-oriented sense-making strategies of patients, would of course be that no consistent differences will be found in the views of patients receiving different types of therapy. This is also the implication of other work in this area. Thus the prediction would be that patients would be just as likely to report problem solving events as helpful, for example in exploratory therapy as in prescriptive therapy. On the other hand, as active-sense makers who use their theories of psychological change to make sense of the therapeutic situation, differences should be expected in the views of therapists with clearly different theoretical orientations. However, as was pointed out above, this prediction needs to be examined with data from patients whose therapists (and therapies) have been carefully selected according to orientation, which was not done in this study. Again, the data currently being collected in Sheffield should allow some consideration to be given to this question.

A final extension of the current research strategy would be to examine the ways that perceptions of therapists and patients vary over time. As has already been

suggested previously, it may be the case that perceptions vary according to whether the therapy is short-term or long-term; similarly, the level of agreement between therapists and patients may also vary. This was certainly the implication of the studies by Horn-George and Anchor (1982); and Deitzel and Abeles (1975). A future study using the present methodology might examine this issue in more depth. Further, it might be possible to construct a sense-making model which included the notion that particular sequences of event would be likely to occur in specific orders; for example it might be speculated that Reassurance/Relief predominated in early sessions; to be replaced by Problem Solution (from the patient) or Insight (from the therapist) in the middle sessions; and Personal Contact in the latter stages. Of course, it might be expected that the particular sequences for therapists and patients would also differ.

10.3.3) Social psychological approaches to an understanding of the experience of patients and therapists in therapy.

From the world of social psychology, a number of extremely interesting approaches have been developed which attempt to uncover the meanings behind people's actions; some of these might be of particular value to psychological therapy researchers. For example, Harre (1979), Marsh, Rosser and Harre (1978) and others have developed the theory and methodology of ethogenics, whereby individuals are repeatedly asked to account for their actions and intentions; such accounts are supplemented by accounts of involved others until some level of agreement can be negotiated. Other social psychologists such as Brown and Sime (1980) have examined the different ways in which individuals may organise their perceptions of the world, in an attempt to account for their actions, and have demonstrated that individuals tend to develop different ways of making sense of the same event. A number of research instruments and statistical techniques currently in use within social psychology could be used with in a

clinical setting, such as Indescal and Multi-dimensional Scaling.

As has already been suggested in chapter 9, some aspects of Attribution theory might have especial relevance for conceptualising the differences in perception between therapists and patients; in particular the actor/observer distinction drawn by social psychologists might have consequences for clarifying and understanding the significance of the difference in viewpoint between therapist, patient and researcher. Predictions from Attribution theory, as well as from the work on logical errors made by naive attributionists, could clarify issues concerning the accuracy of reports of the therapeutic relationship. For example, the work of Tedeschi and Reiss (1981) concerning errors in attribution could have considerable relevance for interpreting the ways in which therapists and patients account for their actions. However, further discussion of such possibilities is beyond the scope of this thesis.

A number of other areas well known to social psychologists seem to have implications for the model of therapy as an interaction, which is being developed here; in particular the research on persuasion and cognitive tuning seem relevant. It is to be regretted that there is so little cross-fertilisation between the different areas of psychology, with the result that only a small amount of research exists which applies the theories and findings of social psychology, in a clinical context.

10.4) The future of psychological therapy and psychological therapy research.

In concluding this last section of this thesis, I shall attempt to summarise some of the implications of the preceding discussion for the future of psychological therapy and for psychological therapy research. What I shall say will be clearly speculative, and based only on my own opinions and the sense that I have been able to make of both the research literature that I have read in

connection with this thesis, and the results of the empirical study carried out.

The process of psychological therapy is still an object of curiosity, controversy and mystery to many people, not least to those in the helping professions. During therapy, a vast amount of time is spent by therapists and their supervisors carefully dissecting the precise meaning of the responses and actions of patients, in order to decide which particular brand of resistance, transference, illogical thinking or reciprocal inhibition they are displaying at any given time. In particular, from the evidence obtained in this study, therapists seem to focus on the need to formulate appropriate interpretations which they hope will lead to patients obtaining insight into themselves and their behaviour. Yet what appears to be going on inside patients' heads is somewhat different; they certainly seem to use the therapeutic interaction as a stimulus for change, but they also use other situations occurring elsewhere in their lives in the process of seeking solutions to their problems. Yet relatively little time is spent by therapists or researchers in considering either the patient's part in sense-making in therapy, or the other important influences that are occurring in patients' lives. It is my belief that, if it is to progress, psychological therapy research will have to recognise both the complexity of the ways that people use the therapeutic interaction to modify their own strategies of sense-making, and also to recognise the limitations of the therapeutic setting.

Perhaps the simplest way of expressing this is to say that therapists should perhaps realise that they are less important than they often seem to think they are, and that the specific techniques that they use are less crucial than they are claimed to be. This is not to say, however, that people don't need other people to assist them in the process of change; they clearly do, and sometimes it may be a therapist who is in the best position to offer that assistance. The most crucial aspects of a therapeutic

encounter seem to be that the patient works on new ways of making sense of the world; a task which is made possible at least in part by the provision of a reassuring and supportive relationship, which at the same time acts as some form of stimulus for change. However there seems to be no clear reason why the person in question should only be a therapist with any particular type of therapeutic training. His or her ability to provide the right balance of support and challenge seems to be more important than any particular qualification or theoretical orientation.

The suggestion that there is no specific type of theoretical approach or even professional training which is vital for one person to be helpful to another, does not imply that there is in fact no need for therapists. There will always be some people for whom therapy is appropriate. In 1940, Sachs, the psychoanalyst who provided the analysis for Boring referred to in chapter 2, agreed that a friend could have done as much for the patient as he did: "A life-long, very intimate friend, to whom the analysand could have confided many repeated and unrestrained outpourings of all his woes and worries, might have done him the same service. But it was not accidental that such a friend did not exist... " (Sachs, 1940, p.13). It has also been repeatedly pointed out that we cannot simply abandon those who are hopeless and friendless, and in addition, that there are many fundamental differences between friendship and therapy; for example, in therapy the goal is eventually to part. Another point is that in therapy, the needs of one participant normally predominate over the needs of the other; this probably could not be sustained for any length of time in a friendship. It is interesting in this connection to note that the lay therapists in Strupp and Hadley's study suggested that they could not tolerate the demands of patients for long, nor were they willing to cope with more than a very small number of patients. If for no other reason, therefore, therapists will still be needed.

However, all of this means that psychological therapy researchers should perhaps recognise and accept some important challenges to their ways of thinking. Four of these will be suggested here.

The first challenge is that the traditional approach to therapy research, which includes only the accounts or views of the therapist and/or a detached observer, is quite insufficient. The Rashomon phenomenon is, as Howard and Orlinsky (1977) suggested, "a methodological Pandora's box"; although as Caskey, Barker and Elliott (1984) adde " ope remained behind". The Rashomon phenomenon may, as I have suggested, point to the crucial mechanism for change.

Secondly, an understanding of the process of therapy which is not interactive is likely to fail to recognise the fundamental nature of the process, in that it may be the interaction, rather than anything that the therapist does or says to the patient, which is central.

Thirdly, a view of therapy which does not take into account the fact that the patient is an active sense-maker who has many experiences outside the hour of therapy, is likely to overlook a large number of the variables which influence therapy outcome, thus ignoring factors which could perhaps be sed to increase the effectiveness of therapy.

Lastly, a lack of recognition that therapy is, after all, a human activity, which is not so vastly different from other human relationships, will surely serve to mystify the process rather than to clarify it. Recognition of the basically human and interactive qualities of the helping process might reorient both therapists and researchers away from the technological and mechanistic approaches to therapy and research which have confounded so much work in the past, towards the human and moral nature of the un ertaking.

It is my view that if therapists and therapy researchers were to take the above points seriously into

consideration, the quality (although possibly not the quantity) of both psychological therapy and psychological therapy research, would increase.

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+ addendum p 322

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* Addendum

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INSTRUCTIONS

Thank you for agreeing to participate in the study. The answers that you give will help us to understand how to help people more in the future.

What you have to do is as follows:-

1. Fill in the Personal Information Sheet, straight away. This consists of a few questions to do with your feelings about the therapy that you are shortly to begin.

2. At some time during the day, after the end of each session with your therapist, please complete the 'Helpful Aspects of Therapy' (H.A.T.) questionairre. This should then be put into the envelope addressed to the research worker running the study. It should not be shown to your therapist, but sealed and given back to him or her before the next session.

3. As soon as you have finished your series of therapy sessions, you will be asked to complete another questionairre. This will be about your feelings of satisfaction with the therapy and how much better (or worse) you are.

4. About six months or so after completing therapy, the research worker will write to you. She will ask you how you are feeling then, and looking back over all that has happened if you can say anything else about your therapy.

Notes to help you in the study

1. If you feel at any time during the study, that completing the questionairre is getting in the way of your treatment, or is upsetting you, please explain this to your therapist. If he or she cannot help you solve this difficulty, then you are completely free to stop participating. However, we would ask you, once you have started, to try to complete the study.

2. Your completed (H.A.T.) questionairres will not be shown to your therapist during the study. You are asked not to discuss the answers you have given on the questionaires, with your therapist, as far as possible.

3. Your answers will be kept completely confidential. Any report which is made of the results will be done in such a way that your identity is kept secret. We only need to know your name so that your H.A.T. questionairres can be put together with information provided by your therapist, and so that we can contact you at the end of the study.

4. If for some reason you decide to discontinue therapy, the research worker will write to you to ask you to fill in the questions which are normally given at the end of treatment.

5. Sometimes big changes happen in your life which have nothing to do with your therapy. You will see that there is a question on the H.A.T. questionairre about this. Please fill this in if something of great importance happens between sessions, for example, you move house, or have to spend some time in hospital.

6. Occasionally you may forget to fill in a H.A.T. questionairre. If this happens, do it as soon as possible before the next session. If this isn't possible, just put a blank form into the envelope.

THERAPIST'S INSTRUCTIONS

Thank you for agreeing to participate in this study. Your task is to approach the next three patients whom you agree to take on in individual therapy (without selecting according to criteria relating to likely outcome) according to the following limitations:

a. The patient is aged between 15 and 60
b. You expect the therapy to last for at least six sessions
c. There are no obviously organic features relating specifically to the patient's illness or set of difficulties.
d. The distress experienced by the patient falls with the broad category of 'neurotic', including relationship problems, phobias, obssessions, depression, personal difficulties, sexual difficulties etc.
e. You think that the patient will be able to follow the instructions without too much difficulty, and will be co-operative.

You are then to ask the patient to agree to participate in the study. If he or she refuses, please ask the next patient, and so on until you have three patients agreeing to participate. The instructions to give the patients are included at the end of these instructions. Your instructions are as follows:-

Stage 1 Complete the Therapy Information Sheet which includes questions regarding the approach you think you will use in the therapy, and data about the patient. This is to be done immediately after the assessment interview, when you have agreed to take the patient on for therapy and when the patient has agreed to participate in the study. In addition, ask the patient to fill in the 'Personal Information Sheet' and return these two documents to me.

Stage 2 After every session with the patient, complete the 'Helpful Aspects of Therapy' H.A.T. Questionairre. This should be done at sometime during the day when the session is over, *or the day after, and placed* in the envelope addressed to me. In addition, you should give the patient his or her 'Helpful Aspects of Therapy Questionairre' (H.A.T.) and an envelope addressed to me, and remind the patient to complete the H.A.T.

Stage 3 At the beginning of the next session, collect the patient's completed H.A.T. which should be in a sealed envelope. Repeat stages two and three until the therapy is terminated, or after a period of 6 months (whichever is the sooner)

Stage 4 When therapy is terminated, or after a period of six months (whichever is the sooner) there is an additional questionairre to be completed. This relates to the overall outcome of therapy, and an overview of the most helpful aspects of the therapy. This will be given to you when the therapy is completed.

Stage 5 Approximately six months after the completion of therapy, you will be asked to repeat some of the measures taken at stage 4. I will also contact the patient at this stage to obtain follow-up-data.

Additional Note

If you are not the medical officer responsible for the patient would you please also complete the enclosed consent letter and address it to the patient's consultant or G.P., when you consider including a patient in the study. You simply have to fill in the consultant's name, and the patient's name, in the fourth paragraph of the letter. If there are any other queries, please refer them to me.

Notes

1. It may be that, during the course of therapy, the nature of your treatment of the patient will change, e.g. you decide to refer the patient for group therapy, or to include the patient's spouse. Equally circumstances may change, unexpectedly, for example, the patient may be admitted to hospital. If so please mark these changes on the 'Helpful Aspects of Therapy (H.A.T.) Questionnaire, but whenever possible, continue to complete the questionnaire at the end of each session, and ask the patient to do likewise. This applies even if you have included the spouse or seen the patient in a different setting, e.g. in hospital.

2. It is important that you and the patient do not exchange completed questionnaires, or compare notes on the information that you have provided.

3. It may be that on occasion, you or the patient may forget to complete the questionnaire. If this happens try to complete it at some time before the next session. If this is completely impossible, please return a blank H.A.T. simply indicating the session number.

4. If the patient fails to attend a session without explanation, please indicate this at the end of the next completed H.A.T.

5. Termination is frequently difficult to define. If the end of the therapy is not marked by a clearly agreed 'last session' please proceed as follows:- For the purpose of this study, termination can be asumed if one of the following criteria operates:

a. The patient fails to attend for at least three consecutive sessions, without explanation.

b. The patient indicates by writing, telephone contact or message that they do not intend to come again.

c. The patient promises to contact you again when he or she feels this to be necessary, but does not do so after a period of one month. Unless you indicate otherwise to me, I shall then contact the patient myself at this stage to request completion of end of therapy data.

6. Confidentiality Please note that you will not be shown the patient's H.A.T. questionnaires. Any presentation of the results of the study will be done in such a way that both your and the patient's identity will be protected.

7. Both you and your patients have the option to discontinue participation in the study if it is felt to be counter - therapeutic, or causing undue stress to the patient. This must be made clear to the patient. If you do decide to discontinue participation, however, please indicate this on the last H.A.T. questionnaire. Please then select another patient for inclusion in the study.

APPENDIX 2a

Personal Information Sheet Date:

1. Your Name:

2. How long do you expect the therapy to last? Please ring the answer.

1-6 sessions
7-12 sessions
13-20 sessions
more than 20 sessions
don't know

3. How hopeful are you that this therapy will help you?

very hopeful
fairly hopeful
unsure
not very hopeful
unhopeful

4. Can you describe your present difficulties, in a few words?

5. How serious do you feel these difficulties are?

Very serious
Fairly serious
Inbetween
Mild
Very Mild

APPENDIX 2b

Therapy Information Sheet (Therapists)

Please complete after acceptance of the patient into therapy, and before therapy commences. When appropriate ring one of the answers provided:

Section A The Therapist Date:

1. Name of therapist:

2. Nature of training:

3. Type of qualifications:

4. The main theoretical orientation of Training: Psychoanalytic
   Behavioural
   Rogerian
   TA
   Gestalt
   Kellian
   Other (please specify)

5. Years of Post qualification experience

   1-2 years
   3-6 years
   7-12 years
   more than 12 years

6. How would you describe your current theoretical orientation?
   Psychoanalytic
   Behavioural
   Rogerian
   TA
   Gestalt
   Kellian
   Eclectic
   Other (please specify)

Section B The Patient

7. Name of Patient:

8. Address (needed for follow up):

9. Age: 16-20 21-25 26-35 36-45 46-60

10. Sex: M F

11. Occupation:

12. Marital Status: Single
Married/Cohabiting
Seperated/Divorced
Widowed

13. Socio-economic Status: Middle class/Working class

14. a. Has the patient had individual therapy before? YES/NO
b. If yes, describe briefly:

15. What at present is your formulation of the difficulty?

16. If possible, can you place the patient's main problems into one of the following categories?

General Anxiety
Depression
Phobic Reaction
Sexual Difficulties
Personality Problems
Obssessions
Relationship Difficulties

17. How seriously disturbed or unhappy do you think the patient is?
Very Serious
Fairly Serious
In between
Mildly
Very Mildly

18. How long has the patient had these problems?
Less than one year
1-2 years
3-5 years
more than 6 years

Section C The Therapy

19. What general orientation do you intend to use with this particular patient?

Psychoanalytic
Behavioural
Rogerian
TA
Gestalt
Kellian
Eclectic

Other (please specify)

20. How long do you expect the therapy to last?

1-6 Sessions

7-12 Sessions

13-20 Sessions

More than 20 Sessions

21. How hopeful are you that you will be able to help this patient?

Very Hopeful

Fairly Hopeful

Unsure

Not Very Hopeful

Unhopeful

Helpful Aspects of Therapy Questionnaire (H.A.T.)

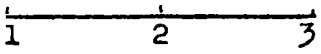
Session No:

Your Name:

Date of Session: Today's Date:

1. Of the events which occurred in this session which one do you feel was the most helpful for you personally? It might be something you said or did, or something the therapist said or did. Can you say why it was helpful?

2. How helpful was this particular event? Mark this on the scale, where '1' is very helpful, and '3' is neither helpful or unhelpful.



3. Can you rate how helpful this session was overall:

Very Helpful
Fairly Helpful
Neither Helpful or Unhelpful
Fairly Unhelpful
Very Unhelpful

4. Did anything else of particular importance happen during this session? Include anything else which may have been helpful, or anything which might have been unhelpful.

5. Has anything particularly important happened in your life since your last session?

Therapists

Helpful Aspects of Therapy Questionnaire (H.A.T)

Session No:

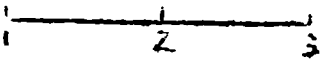
Your Name:

Patient's Name:

Date of Session: Today's Date:

1. Of the events which occurred in this session, which one do you feel was the most helpful for this patient? It might be something you said or did, or something the patient said or did. Can you say why it was helpful?

2. How helpful was this particular event? Mark this on a scale where '1' is very helpful and '3' is neither helpful or unhelpful.



3. Can you rate how helpful the session was overall

Very Helpful
Fairly Helpful
Neither Helpful or Unhelpful
Fairly Unhelpful
Very Unhelpful

4. Did enything else of particular importance happen during this session? Include anything else which may have been helpful or anything which might have been unhelpful.

5. Has anything particularly important happened in your patient's life since the last session?

6. Have any circumstances of the therapy changed?

7. Has the patient failed to attend any sessions without explanation, since the last session? YES/NO

End of Therapy Information Sheet

1. Your Name: Date:

2. How helpful do you think that your therapy was, overall?

   Very helpful
   Fairly helpful
   Neither helpful nor unhelpful
   Fairly unhelpful
   Very unhelpful

3. How much better do you think you are, compared with when the therapy started?

   Much better
   A certain amount better
   Neither better nor worse
   A certain amount worse
   Much worse

4. Looking back over the period of therapy, do any aspects of therapy stand out as having been particularly <u>helpful</u>? If so, please write these below. Use another page if necessary.

1.

2.

3.

4.

5.

5. Looking back over the period of therapy, do any aspects of therapy stand out as having been particularly <u>unhelpful</u>? If so, please write these below. Use another page if necessary.

1.

End of Therapy Information Sheet (Therapists)

1. Name of Therapist: Date:

2. Name of Patient:

3. What general orientation did you use with this particular patient?

   Psychoanalytic
   Behavioural
   Rogerian
   TA
   Gestalt
   Kellian
   Eclectic
   Other (Please Specify)

4. How long did the therapy last?

   1-6 Sessions
   7-12 Sessions
   13-20 Sessions
   More than 20 Sessions

5. How did the therapy terminate?

   Mutual Agreement
   Therapist initiated termination, against patient's wishes.
   Patient initiated termination, against therapist's advice.
   Patient failed to attend more than three sessions.
   Patient failed to attend follow up, or contact again.

6. How helpful do you think the therapy was to the patient, overall?

   Very helpful
   Fairly helpful
   Neither helpful nor unhelpful
   Fairly unhelpful
   Very unhelpful

7. How much better do you think the patient is compared with when the therapy started?

   Much better
   A certain amount better
   Neither better nor worse
   A certain amount worse
   Much worse

8. Looking back over the period of therapy, do any aspects of the therapy stand out as having been particularly <u>helpful</u>? If so, please write these below. Use another page if necessary.

1.

2.

3.

4.

5.

9. Looking back over the period of therapy, do any aspects of therapy stand out as having been particularly <u>unhelpful</u>? If so, please write these below. Use another page if necessary.

1.

2.

3.

4.

5.

Thank you very much for your help.

APPENDIX 5

PATIENT NO: _____ REPORT TYPE: _____ CODER NO: _____

DATE: _____

	QUESTION (1)		QUESTION (4)	
	PRIMARY	SECONDARY	PRIMARY	SECONDARY
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				
(11)				
(12)				
(13)				
(14)				
(15)				
(16)				

3. Awareness (client approaches uncomfortable experiences
Informant describes client as increasing affective insight, lessening or overcoming blocks to experiencing of uncomfortable thoughts, feelings, perceptions, including less guardedness, defensiveness, or self-control. Client describes actively approaching uncomfortable experiences, or allowing previously-warded-off experiences to emerge into awareness. Rating note: either one or both of the following 2 criteria must be satisfied: (a) there must be an increase in awareness of experience(s); (b) there must be reference to the experience(s) being uncomfortable or previously avoided.

Examples:
a) -T helped me bring out an emotion that I hadn't really wanted to look at before.
b) -He was avoiding the issue of how he would feel about himself, and I brought the issue out.
c) -I showed her that she really felt that way.
d) -T made me see myself more clearly.
e) -I had been avoiding the issue of how I would feel about myself and T brought it out.

4. Problem Solution (client progresses toward a practical plan of action): Informant makes reference to problem-solving efforts that took place in the event, such as specification of alternatives, selection of or participation in a course of action, solution development, or learning how to cope with situations outside of therapy.
Examples:
a) - T showed me one way to improve, one way to go about it.
b) - I was giving her an alternative to try, throwing out a possibility.
c) -We got to the problem. She felt better that there was a way to control her nervousness.
d) -T put up a hypothetical situation that was really relevant and that made me think "Hey, that's a new idea that maybe I should try."
e) -T allowed me to figure out what I should do about my problem, and what wouldn't work.
f) - I was offering a solution to the problem.

5. Involvement (working alliance strengthed or client cognitively stimulated): Informant describes client becoming more involved or invested in the tasks of therapy or more willing to approach them. There are two major types of involvement:
(a) client stimulation in which the client is described as thinking more or as more able or willing to express self to T;
(b) alliance strengthening, in which the client is described as becoming more confident in the tasks of the therapy or the therapist's ability to help the client.
Examples:
a) - T got the ball rolling and just kept me going at the same time putting into perspective what I was going to say.

b) -T started me thinking and I felt better about where the therapy was going.
c) -I felt better about the fact that T seemed to know what she was talking about and could help me.
d) -What I said gave her something to think about.
e) - I was asking his opinion on our progress and made him want to respond.

6. Understanding (client experiences being accurately understood): Understanding events can be discribed in two ways:
(a) Personal understanding involves the informant describing client feeling deeply understood by the therapist, in relation to the client's exoeriences or person.

Examples:
a) -T really understood me.
b) -T really hit the nail on the head.
c) -I felt I really saw how he felt (what it meant to him.)
d) - I was empathizing with her, putting all of myself in her place.

(b) Accurate following involves descriptions limited to the accuracy of T's communication or feedback about what the client said.

Examples:
a) -I felt that what I said was accurate (it fit; it was right on.)
b) -She made me feel like I was getting across to her
c) -T knew (saw) what I meant by what I said (was following me).
d) - I was giving back to me exactly what she said - showing her I understood

7. Reassurance (client feels better): Informant describes client experiencing a sense of relief, reassurance, or support. This may refer to relief from painful feelings, such as guilt, or the enhancement of positive feelings such as self-worth, self-confidence, or general hopefulness about being able to change.
Examples:
a) -I felt more confident that I could control my problem.
b) -I was glad that I was going to be able to talk with someone that had thought about my problem.
c) -She felt more at ease.

Rating Note: Reassurance is frequently accompained by understanding or personal contact. These should be multiply-classified, although please indicate which has priority
Examples:
a) - I reassured him that I was aware that he was happy. (both Understanding and *Reassurance)
b) -It was nice to have someone understand me. (both *Understanding and Reassurance)
c) -It gave me reassurance that T had some background. (both *Reassurance and Personal contact)

8. Personal Contact (client experiences therapist as a person): Informant describes client as experiencing a greater sense of

therapist as a person or fellow human being, perhaps one who has also struggled with the issues the client struggles with. There are two major types of personal contact:
(a) The client's perception of positive characteristics of T as a person (e.g., honesty, professionality, open-mindedness, personality, background).
Examples:
a) -She made me feel like she was more involved.
b) -T showed concern.
c) -I showed that I was human!
d) -T showed that he had my best interests in mind.
(b) Mutuality in which the informant describes a sense of weness, sharing activities, or of the client not being alone. Informant describes client as becoming more trusting of the therapist and coming to relate to the therapist as a person.
Examples:
a) -T made me feel as though I wasn't the only one to have the problem.
b) -I showed her that I was familiar with her problem.

II. HINDERING EVENT CATEGORIES

9. Misdirection (distraction from client task performance): Informant describes the therapist as distracting, confusing, sidetracking or interrupting the client's exploration interfering with the client's chosen focus, or jumping to or returning to topics which seem irrelevant or pointless.
Examples:
a) There was an interruption to what I was saying and thinking about. I didn't want to break the flow.
b) -It didn't have anything to do with the topic per se; T said something just to make me feel good and I felt like I had to respond to it and I didn't want to.
c) -I thought that was already taken care of; we had already gotten out of that and it was sort of irrelevant to go back to it.
d) -T's response cut off a part of our interaction.

10. Misperception (therapist inaccuracy): Informant describes therapist as misunderstanding; feels therapist has missed the point of what client is saying, is using the wrong words, or simply has an inaccurate picture of the client or what he or she is experiencing or trying to communicate.
Examples:
a) -I felt that maybe T wasn't understanding me. I don't know why, but I felt that T was confused at what I was saying.
b) -It was a misinterpretation. It wasn't the way she was thinking.
c) -I didn't feel that T was really correct. Not perceptive, because I really don't "hold back."
d) -I didn't get it right.
Rating Note: Misperception often leads to misdirection.
Examples:

a) -That wasn't really his problem, so I was off track. We were going in the opposite direction.

11. Disappointment (offered help seen as inadequate): Informant describes client becoming dissatisfied, disappointed or critical of therapist's approach or interventions, including feeling that expectations or wishes have not been met, that direction is lacking, or that no progress is being made. Informant describes client as wanting or requesting help and not receiving it. Informant describes client or therapist feeling hopeless about change or experiencing demoralization, or pessimism about therapy or about C's ability to be helped by it. Three subtypes can be distinguished (a) client or therapist demoralization, (b) client critical, and (c) unmet expectations.

Examples:

a) -She wanted me to give her information about other cases, which I refused to do.

b) -T didn't seem to lead me anywhere; he just re-emphasized my problem without doing anything about it.

c) -It made me feel like no matter how hard T tried I'll never improve.

d) -I felt like I was desperate for something to say, like I didn't know what to do next, like I didn't have enough training or something. I showed my inadequacy.

12. Negative Therapist Reaction (therapist withdraws or attacks): Informant describes therapist as responding negatively to client. There are two major subtypes of negative therapist reaction:

(a) Uninvolvement, /in which the therapist is seen as uninvolved, inattentive, or self-indulgent:

Examples:

a) -I kind of felt that I was bored.

b) -I hardly ever talk about that really personal stuff, and T didn't seem to care. T was more concerned that we were pressed for time.

(b) Attacking, in which the therapist is seen as critical, judgemental or rejecting:

Examples:

a) -Just the tone of T's voice, the way T said it, made it sound like I was doing something wrong, and "How could you possibly enjoy something like that?"

b) -T made a joke of it. T was uninvolved. Then T started giggling. That really turned me off.

c) -She felt that I was attacking her- and made it seem like I was looking at her problem from a narrow, one-sided point of view.

13. Unhelpful Confrontation (Non-therapeutic client discomfort): Informant describes client feeling unhelpful discomfort, resulting from: (a) being forced to confront unpleasant experiences, facts, or memories; (b) experiencing pressure from the

therapist to take responsibility in the session or generally; or (c) feeling that the therapist is unwilling to abandon an unhelpful or unpleasant activity. Informant describes client as feeling discomfort which is not linked to change or benefit. Unhelpful confrontation includes avoidance wherein informant describes client as increasing avoidance or warding-off of uncomfortable topics, thoughts, or feelings; tighter self-control or guardedness, or greater defensiveness or emotional distancing from experience or other people.

Examples:

a) -It was bothersome again. I had to think about it again. It made me want to not think about it at all, the whole situation.

b) -T's response put pressure on me to think of something to talk about next.

c) -It was bothersome for me to think about. I felt hindered because I didn't want to see myself that way.

C. UNCLASSIFYABLE

14. Only place an event in this category if no other category applies, from either section A or B.

APPENDIX 7

INSTRUCTIONS TO CODERS

Before you begin the task of coding, please read the following instructions:

1. Coding requires concentration as well as persistence. When you are tired, stop for a rest. Do not continue when you become aware that you are making judgments too quickly.

2. Read and re-read the manual from time to time to refresh your grasp of the categories.

3. Start by reading the manual and working through the practice cards. Discuss these cards until you are clear about their placement in their categories.

4. Each set of cards given to you represents the views of an informant regarding the helpful events of therapy in which they were a participant (either therapist or patient). Read through the whole set of cards, so that you gain a grasp of the entire proceedings of the therapy.

5. Starting with card 1, work your way through the events, placing them in categories according to the manual.

6. The informants were asked the following questions

   (a) "Of the events which occurred in this session which one do you think was the most helpful for you personally? (for the patient?) It might be something you said or did, or something the therapist (patient) said or did. Can you say why it was helpful?"

   (b) "Did anything else of particular importance happen during this session? Include anything else which may have been helpful, or anything which might have been unhelpful."

   Your task is to pick out from the material provided by the informant, the event found to be helpful/unhelpful. You should treat each answer as a description of the event and its impact on the patient.

7. Do not code the intentions of participants as events, unless it is clear that the intended event actually occurred, in some way or another. For example, treat "I tried to clarify the fact that she had misunderstood her husband's approach" as an event which occurred during the session, (classified as category 2) even though the therapist is perhaps unsure about the success of his intention. Whereas "My intention was to clarify the fact that she had misunderstood her husband's approach" cannot be categorised as it is unclear whether or not this event actually occurred.

8. Do not confuse the content of the event with its impact; be sure to categorise it in terms of its impact. For example, "I felt the therapist really understood me when I explained that I could not carry out my relaxation exercises" should be categorised in terms of the therapist's understanding (6) not in terms of the content of that understanding, i.e. the failure to complete relaxation (4).

9. Any response to either question a) or b) may be taken to refer to an impact on the client, i.e., you may assume that the answer is a report of an impact even if the informant does not explicitly say so. For example, the response to question a) "Discussing my return to work" may be assumed to mean that the informant found this discussion had a helpful impact.

..../.

10. If the informant makes an explicit distinction between impact and/or intention or content, then always code in terms of impact.

11. Some reports include accounts of the patient's behaviour subsequent to the most helpful event discussed. These accounts should not be considered as new 'helpful events', but rather, should be treated as evidence substantiating the impact of the reported 'helpful event'.

12. If you feel that there is more than one way in which the helpful event can be categorised choose the dominant category, but note the other by placing it in brackets. You may be helped in your decision by noting the informant's reason for selecting the particular event.

13. When you come to the end of therapy, the questions asked of the informants were as follows:

    (a) "Looking back over the period of therapy, do any aspects of therapy stand out as having been particularly helpful?"

    (b) "Looking back over the period of therapy, do any aspects of therapy stand out as having been particularly unhelpful?" Again, your task is to pick out the impact, or events that were helpful, or unhelpful, not the helpful or unhelpful intentions, or content.

spl:sds:15.3.83

CODING EXAMPLES

1. Starting to be critical of wife, and her overspending, general irritation coming to the surface.

2. How the therapist spoke to me allowed me to see that I must help myself.

3. I walked around the shops for an hour. I am agoraphobic so it proved I was better.

4. Being able to talk to someone about my problems.

5. Continuing flow of material about her past, which she seems to get benefit from.

6. Importance of relationship with boyfriend developing.

7. Talked about his inability to cope with unpredictability of the future, and so having to have rules in the present. He talked about panic feelings when facing unpredictability. Connected to this is a feeling that his body is a machine, out of his control.

8. Therapist said how important it was to stay on the bus when I panic and not get off early; likewise with my job, not to rush home early.

9. Talked about his problems in being emotional, especially angry. Does this account for his current symptoms, I wonder? Also his feelings of powerlessness.

10. I summarised part of today that the main issue is his anger and talk of acceptance of it, not his diagnosis. We continued by discussing anger, and assertion - this seemed to make him feel more hopeful.

11. Decided to take risks with my therapist who understands and helps me to express what I want to say. But this makes me feel nervous.

12. The doctor commented that I seem to be rather unforgiving to myself, confirming the idea that it is my own standards I don't live up to, not anyone else's.

13. John started looking at the way his sister teased him, becoming part of his Top Dog.

14. Just the general talk about the accident involving my mother, not particularly relevant to my symptoms but it eased my mind.

15. That he told me more about the problems and that I gave no simple answers.

16. Having my husband there -

17. Allowed himself to talk about the sexual trauma,showing how he could trust me, and allow me to share the pain.

18. She was able to accept my interpretation of the repetition of her relationships outside, with me here.

19. Yes, the therapist seems to think I am hiding from him. I don't see it as hiding, more just seeing how far I dare to go.

...../.

20. I think that Jane was more assertive after a bit of a slow start. We then talked about the different sides to her - a strong rational side and a soft feminine side, the dark side of which scares her. Established some sort of agreement to have a look at that. More confidence in me that I won't exploit this part of her.

21. Discussion of her feelings about leaving home, mixed because of wanting to be independent and yet enjoying being the baby of the family. Also pressure from family to remain so.

22. For the first time I said something helpful and important to myself.

23. Relaxation exercises. I felt a definite relief of tension for a while afterwards.

24. Discussion of what is his motivation for therapy. Patient sees this as external insight and techniques which I ought to give to him.

25. Confrontation of his avoidance of therapy by being constantly late. But he didn't accept that this was anything he could be held responsible for, so I don't know how helpful it was.

26. Being able to talk with someone who understood me and didn't interrupt. Feeling understood.

27. I was at first on my guard with the doctor. He was new to me and I him. I feared dislike and as I let myself open up, I cried, but, then I realised I would have to try.

28. We have similar backgrounds and I felt we shared some of the problems from that.

29. I felt confused because I got the impression that the analyst doesn't think I'm talking about my emotions. I try very hard but I'm confused about them, I felt he was accusing me of being dishonest.

30. My acceptance of her in a "non judgmental" way; our personal relationship was good.

31. Regularity of our meetings together.

32. We talked about my mother who died when I was ten years old.

33. If we are going to get anywhere the therapist will have to give up some of his clever analysis and get into dialogue with me - which he fails to do.

APPENDIX 9

HELPFUL AND UNHELPFUL EVENTS, SESSIONAL REPORTS ON CATEGORIES 1- 14

RAW DATA FOR ANALYSIS

CATEGORY NUMBER: 1 (Insight)

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
1	0	0	0	1	0	1
2	0	2	0	0	0	2
3	0	3	0	0	0	3
4	1	4	4	3	5	7
5	0	1	1	2	1	3
6	2	4	0	0	2	4
7	0	1	0	1	0	2
8	1	4	2	0	3	4
9	4	4	2	5	6	9
10	1	1	0	0	1	1
11	0	2	0	2	0	4
12	1	2	0	1	1	3
13	0	0	0	0	0	0
14	1	0	0	0	1	0
15	2	0	1	1	3	1
16	0	0	0	0	0	0
17	10	7	5	2	15	9
18	1	3	0	2	1	5
19	0	2	0	0	0	2
20	1	2	0	0	1	2
21	1	4	1	1	2	5
22	2	8	0	3	2	11
23	0	3	0	0	0	3
24	3	8	1	0	4	8
25	1	2	0	1	1	3
26	0	7	0	3	0	10
27	0	3	0	1	0	4
28	0	1	0	0	0	1
29	0	1	1	1	1	2
30	5	6	0	0	5	6
31	1	3	0	1	1	4
32	0	3	0	3	0	6
33	1	6	0	4	1	10
34	7	9	1	2	8	11
35	1	0	1	0	2	0
36	0	4	0	2	0	6
37	0	3	0	0	0	3
38	1	1	0	2	1	3
39	1	4	0	0	1	4
40	1	2	1	0	2	2
TOTAL	50	120	21	44	71	164

RAW DATA FOR ANALYSIS

CATEGORY NUMBER: 2 (Clarification)

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
1	0	0	0	0	0	0
2	2	2	0	1	2	3
3	2	0	0	0	2	0
4	1	1	0	1	1	2
5	0	1	0	0	0	1
6	0	0	0	1	0	1
7	0	0	0	0	0	0
8	1	0	0	0	1	0
9	1	1	0	1	1	2
10	0	1	0	0	0	1
11	1	1	0	0	1	1
12	1	0	0	0	1	0
13	0	1	0	1	0	2
14	0	1	0	1	0	1
15	1	3	0	0	1	3
16	0	0	0	0	0	0
17	0	1	0	0	0	1
18	1	4	0	0	1	4
19	0	0	0	0	0	0
20	0	0	4	1	4	1
21	0	0	0	0	0	0
22	0	1	0	0	0	1
23	0	2	0	0	0	2
24	0	0	1	0	1	0
25	0	0	0	1	0	1
26	0	4	0	0	0	4
27	1	0	0	0	1	0
28	0	0	0	0	0	0
29	1	0	0	1	1	1
30	2	0	0	0	2	0
31	0	0	0	0	0	0
32	0	1	0	1	0	2
33	0	2	0	0	0	2
34	3	1	0	0	3	1
35	0	2	2	2	2	4
36	0	2	0	3	0	5
37	0	1	0	2	0	3
38	1	4	0	0	1	4
39	1	1	1	1	2	2
40	0	0	0	0	0	0
TOTAL	20	38	8	18	28	56

RAW DATA FOR ANALYSIS

CATEGORY NUMBER: 3 (Awareness)

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
1	0	0	0	0	0	0
2	0	0	0	0	0	0
3	0	0	0	0	0	0
4	0	1	0	1	0	2
5	1	0	0	0	1	0
6	0	0	0	0	0	0
7	0	0	0	0	0	0
8	0	0	0	1	0	1
9	0	0	0	0	0	0
10	0	0	0	0	0	0
11	0	2	0	0	0	2
12	0	0	0	0	0	0
13	0	0	0	0	0	0
14	1	1	0	0	1	1
15	0	1	0	1	0	2
16	2	2	0	0	2	2
17	1	2	2	1	3	3
18	0	1	1	1	1	2
19	0	0	0	0	0	0
20	0	0	0	0	0	0
21	0	0	0	0	0	0
22	1	2	0	2	1	4
23	0	0	0	0	0	0
24	1	2	0	6	1	8
25	0	2	1	1	1	3
26	0	0	0	0	0	0
27	0	0	0	0	0	0
28	0	0	0	1	0	1
29	0	0	0	0	0	0
30	0	2	0	0	0	2
31	1	1	1	1	2	2
32	0	0	0	1	0	1
33	1	1	0	1	1	2
34	0	1	0	1	0	2
35	0	1	0	0	0	1
36	0	1	0	1	0	2
37	0	0	0	0	0	0
38	0	0	0	0	0	0
39	0	0	0	2	0	2
40	1	0	0	0	1	0
TOTAL	9	23	6	22	15	45

RAW DATA FOR ANALYSIS

CATEGORY NUMBER: 4 (Problem Solution)

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
1	1	3	0	1	1	4
2	3	0	0	2	3	2
3	3	2	2	0	5	2
4	9	7	0	4	9	7
5	3	2	3	1	6	3
6	0	1	1	0	1	1
7	1	2	0	0	1	2
8	3	4	1	4	4	8
9	3	2	0	0	3	2
10	2	2	2	2	4	4
11	0	0	1	0	1	0
12	1	0	0	0	1	0
13	0	4	0	1	0	5
14	3	3	2	1	5	4
15	0	1	1	2	1	3
16	1	3	0	0	1	3
17	0	1	0	0	0	1
18	1	5	0	2	1	7
19	1	3	0	1	1	4
20	4	2	2	2	6	4
21	2	2	0	1	2	3
22	1	0	1	2	2	2
23	2	0	0	2	2	2
24	0	0	0	0	0	0
25	0	1	0	0	0	1
26	0	1	0	0	0	1
27	1	1	0	0	1	1
28	0	1	0	1	0	2
29	0	0	0	1	0	1
30	0	0	0	0	0	0
31	1	0	0	1	1	1
32	0	0	0	0	0	0
33	0	0	0	0	0	0
34	0	0	0	0	0	0
35	2	4	2	1	4	5
36	1	0	0	0	1	0
37	0	0	0	0	0	0
38	5	3	0	3	5	6
39	2	1	1	1	3	2
40	2	0	0	0	2	0
TOTAL	58	61	19	36	77	97

RAW DATA FOR ANALYSIS

CATEGORY NUMBER: 5 (Involvement)

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
1	1	0	0	0	1	0
2	0	0	0	1	0	1
3	0	2	0	1	0	3
4	1	1	0	2	1	3
5	0	0	0	1	0	1
6	0	0	0	0	0	0
7	0	0	0	0	0	0
8	1	1	2	0	3	1
9	0	0	0	0	0	0
10	0	0	0	0	0	0
11	1	1	1	0	2	1
12	0	1	0	1	0	0
13	2	0	2	0	4	0
14	0	0	0	0	0	0
15	1	0	0	0	1	0
16	0	0	0	1	0	1
17	1	0	3	2	4	2
18	3	1	2	4	5	5
19	0	1	1	1	1	2
20	0	1	0	1	0	2
21	0	0	0	0	0	0
22	0	0	0	0	0	0
23	0	0	0	0	0	0
24	2	3	1	0	3	3
25	0	5	1	1	1	6
26	4	3	1	3	5	6
27	0	0	0	0	0	0
28	0	0	1	0	1	0
29	0	1	1	0	1	1
30	0	2	1	2	1	4
31	0	1	1	1	1	2
32	0	2	0	0	0	2
33	3	4	1	1	4	5
34	0	0	0	2	0	2
35	1	1	0	2	1	3
36	0	0	0	0	0	0
37	1	0		0	1	0
38	0	1	0	1	0	2
39	0	0	0	0	0	0
40	0	0	0	0	0	0
TOTAL	22	32	19	28	41	60

RAW DATA FOR ANALYSIS

CATEGORY NUMBER: 6 (Understanding)

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
1	0	0	0	0	0	0
2	0	0	0	0	0	0
3	0	0	0	0	0	0
4	0	1	0	1	0	2
5	0	0	0	0	0	0
6	0	0	0	0	0	0
7	0	0	0	0	0	0
8	1	0	0	0	1	0
9	0	0	0	0	0	0
10	0	0	1	0	1	0
11	2	0	0	1	2	1
12	0	0	0	0	0	0
13	0	0	0	0	0	0
14	0	0	0	0	0	0
15	0	0	0	0	0	0
16	0	0	0	0	0	0
17	0	0	0	0	0	0
18	0	1	0	0	0	1
19	0	0	0	0	0	0
20	0	0	0	0	0	0
21	0	0	0	0	0	0
22	0	0	0	1	0	1
23	0	0	0	0	0	0
24	1	0	0	0	1	0
25	1	1	0	0	1	1
26	0	0	0	0	0	0
27	0	0	0	0	0	0
28	0	0	1	0	1	0
29	1	0	0	0	1	0
30	0	0	0	0	0	0
31	2	0	1	0	3	0
32	0	0	0	0	0	0
33	0	1	0	0	0	1
34	1	0	0	0	1	0
35	3	1	1	0	4	1
36	0	0	0	0	0	0
37	0	0	0	0	0	0
38	0	0	0	0	0	0
39	0	0	0	1	0	1
40	0	0	0	0	0	0
TOTAL	12	5	4	4	16	9

RAW DATA FOR ANALYSIS

CATEGORY NUMBER: 7 (Reassurance)

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
1	1	1	2	0	3	1
2	1	2	0	1	1	3
3	1	3	0	0	1	3
4	3	1	0	0	3	1
5	5	3	1	1	6	4
6	1	0	0	1	1	1
7	1	1	0	0	1	1
8	4	3	1	3	5	6
9	2	2	1	1	3	3
10	3	1	1	0	4	1
11	0	2	1	0	1	2
12	1	3	1	3	2	6
13	4	2	1	1	5	3
14	2	1	1	1	3	2
15	1	0	1	0	2	0
16	0	1	0	1	0	2
17	1	3	2	1	3	4
18	6	3	2	0	8	3
19	3	0	0	0	3	0
20	2	1	0	1	2	2
21	0	0	0	3	0	3
22	7	3	0	0	7	3
23	1	0	0	0	1	0
24	3	0	0	0	3	0
25	1	1	1	0	2	1
26	8	0	0	3	8	3
27	2	0	1	1	3	1
28	3	2	0	0	3	2
29	4	3	2	2	6	5
30	0	0	0	0	0	0
31	2	4	3	0	5	4
32	2	0	0	1	2	1
33	1	2	1	1	2	3
34	0	0	0	0	0	0
35	4	2	2	0	6	2
36	0	0	0	0	0	0
37	0	1	0	0	0	1
38	2	2	1	0	3	2
39	3	5	0	0	3	5
40	0	1	1	0	1	1
TOTAL	85	59	27	26	112	85

RAW DATA FOR ANALYSIS

CATEGORY NUMBER: 8 (Personal Contact)

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
1	0	0	1	0	1	0
2	1	1	0	1	1	2
3	0	0	0	1	0	1
4	0	1	0	2	0	3
5	0	0	1	0	1	0
6	0	0	0	0	0	0
7	0	1	0	0	0	1
8	0	0	0	0	0	0
9	0	0	0	0	0	0
10	0	0	0	0	0	0
11	0	0	1	0	1	0
12	1	0	0	0	1	0
13	0	1	0	1	0	2
14	0	0	0	0	0	0
15	0	0	0	0	0	0
16	0	0	0	0	0	0
17	2/	0	0	1	2	1
18	0	0	0	0	0	0
19	0	0	0	1	0	1
20	1	1	0	1	1	2
21	0	0	0	0	0	0
22	0	0	0	0	0	0
23	0	0	0	0	0	0
24	1	4	1	1	2	5
25	1	0	0	0	1	0
26	1	2	0	0	1	2
27	1	0	1	0	2	0
28	1	0	0	0	1	0
29	0	0	0	0	0	0
30	1	2	0	0	1	2
31	0	0	1	1	1	1
32	0	0	0	0	0	0
33	0	0	1	3	1	3
34	0	1	0	0	0	1
35	1	3	0	2	1	5
36	0	0	0	0	0	0
37	0	0	0	0	0	0
38	0	1	0	3	0	4
39	0	0	0	0	0	0
40	0	0	0	0	0	0
TOTAL	12	18	7	18	19	36

RAW DATA FOR ANALYSIS

CATEGORY NUMBER: 9 (Misdirection)

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
1	0	0	0	0	0	0
2	0	0	0	0	0	0
3	0	0	0	0	0	0
4	0	0	0	0	0	0
5	0	0	0	0	0	0
6	0	0	0	0	0	0
7	0	0	0	0	0	0
8	0	0	0	0	0	0
9	0	1	1	0	1	1
10	0	0	0	0	0	0
11	0	0	0	0	0	0
12	0	0	0	0	0	0
13	0	0	1	0	1	0
14	0	0	0	0	0	0
15	0	0	0	0	0	0
16	0	0	0	0	0	0
17	0	0	2	1	2	1
18	0	0	1	0	1	0
19	0	0	0	0	0	0
20	0	0	0	0	0	0
21	0	0	0	0	0	0
22	0	1	0	0	0	1
23	0	0	0	0	0	0
24	0	0	1	0	1	0
25	0	0	0	1	0	1
26	0	0	1	0	1	0
27	0	0	0	0	0	0
28	0	0	0	0	0	0
29	0	0	1	0	1	0
30	0	0	0	0	0	0
31	0	0	0	0	0	0
32	0	0	0	0	0	0
33	0	0	0	0	0	0
34	0	0	0	0	0	0
35	0	0	0	0	0	0
36	0	0	0	0	0	0
37	0	0	0	0	0	0
38	0	0	0	0	0	0
39	0	0	1	0	0	1
40	0	0	0	0	0	0
TOTAL	0	2	8	3	8	5

RAW DATA FOR ANALYSIS

CATEGORY NUMBER: 10 (Misperception)

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
1	0	0	0	0	0	0
2	0	0	0	0	0	0
3	0	0	0	0	0	0
4	0	0	0	0	0	0
5	0	0	0	0	0	0
6	0	0	0	0	0	0
7	0	0	0	0	0	0
8	0	0	0	0	0	0
9	0	3	0	0	0	3
10	0	0	0	0	0	0
11	0	0	0	0	0	0
12	0	0	0	0	0	0
13	0	0	0	0	0	0
14	0	0	0	0	0	0
15	0	0	0	0	0	0
16	0	0	0	0	0	0
17	0	0	0	0	0	0
18	0	0	0	0	0	0
19	/0	0	1	1	1	1
20	0	0	0	0	0	0
21	0	0	0	0	0	0
22	0	0	0	0	0	0
23	0	0	0	0	0	0
24	0	0	1	0	1	0
25	0	0	0	0	0	0
26	0	0	0	0	0	0
27	0	0	0	0	0	0
28	0	0	0	0	0	0
29	0	0	0	0	0	0
30	0	0	1	0	1	0
31	0	0	0	0	0	0
32	0	0	0	0	0	0
33	0	0	0	0	0	0
34	0	0	0	0	0	0
35	0	0	0	0	0	0
36	0	0	0	0	0	0
37	0	0	0	0	0	0
38	0	0	0	0	0	0
39	0	0	0	0	0	0
40	0	0	0	0	0	0
TOTAL	0	3	3	1	3	4

RAW DATA FOR ANALYSIS

CATEGORY NUMBER: 11 (Disappointment)

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
1	0	0	0	0	0	0
2	0	0	0	0	0	0
3	0	0	0	0	0	0
4	0	0	0	0	0	0
5	0	0	1	0	1	0
6	0	0	0	0	0	0
7	0	0	0	0	0	0
8	1	0	3	0	4	0
9	0	0	0	0	0	0
10	0	0	0	0	0	0
11	0	0	0	0	0	0
12	0	0	0	0	0	0
13	0	0	0	0	0	0
14	1	0	0	0	1	0
15	0	0	1	0	1	0
16	0	0	0	0	0	0
17	0	0	0	0	0	0
18	0	0	0	0	0	0
19	0	0	2	0	2	0
20	0	0	0	0	0	0
21	0	0	0	0	0	0
22	0	0	0	0	0	0
23	0	0	0	0	0	0
24	0	0	0	0	0	0
25	0	1	0	0	0	1
26	0	0	0	1	0	1
27	0	0	0	0	0	0
28	0	0	0	0	0	0
29	0	0	0	0	0	0
30	0	0	1	0	1	0
31	1	0	2	0	3	0
32	0	0	0	0	0	0
33	0	0	2	0	2	0
34	0	0	1	0	1	0
35	0	0	0	0	0	0
36	0	0	0	0	0	0
37	0	0	0	0	0	0
38	0	0	0	0	0	0
39	0	0	0	0	0	0
40	0	0	0	0	0	0
TOTAL	3	1	13	1	16	2

RAW DATA FOR ANALYSIS

CATEGORY NUMBER: 13 (Unhelpful Confrontation)

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
1	0	0	0	0	0	0
2	0	0	0	0	0	0
3	0	0	0	0	0	0
4	0	0	0	0	0	0
5	0	0	0	0	0	0
6	0	0	0	0	0	0
7	0	0	0	0	0	0
8	0	0	1	1	1	1
9	0	0	0	0	0	0
10	0	0	0	0	0	0
11	0	0	0	1	0	1
12	1	0	0	0	1	0
13	0	0	2	0	2	0
14	0	0	0	0	0	0
15	0	0	0	0	0	0
16	0	0	0	1	0	1
17	0	0	0	0	0	0
18	0	0	0	0	0	0
19	0	0	0	0	0	0
20	0	0	0	0	0	0
21	0	0	0	0	0	0
22	0	1	0	0	0	1
23	0	0	0	0	0	0
24	0	0	0	0	0	0
25	0	0	0	0	0	0
26	0	0	4	0	4	0
27	0	0	0	0	0	0
28	0	0	0	0	0	0
29	0	0	0	0	0	0
30	0	0	0	1	0	1
31	0	0	0	0	0	0
32	0	0	0	0	0	0
33	0	0	0	1	0	1
34	0	0	0	0	0	0
35	0	0	0	0	0	0
36	0	0	0	0	0	0
37	0	0	0	0	0	0
38	0	0	0	1	0	1
39	0	0	0	0	0	0
40	0	0	0	0	0	0
TOTAL	1	1	7	6	8	7

RAW DATA FOR ANALYSIS

CATEGORY NUMBER: 14 (Unclassified)

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
1	0	0	0	0	0	0
2	4	0	0	0	4	0
3	0	0	0	0	0	0
4	0	0	0	0	0	0
5	0	0	0	0	0	0
6	2	0	0	0	2	0
7	0	0	0	0	0	0
8	0	0	1	2	1	2
9	0	0	1	2	1	2
10	0	1	0	1	0	2
11	1	1	0	0	1	1
12	0	0	0	0	0	0
13	0	0	0	1	0	1
14	0	2	0	0	0	2
15	1	0	0	0	1	0
16	1	2	0	1	1	3
17	/0	0	1	2	1	2
18	2	0	0	0	2	0
19	3	1	0	1	3	2
20	0	1	1	1	1	2
21	3	0	0	1	3	1
22	3	1	0	0	3	1
23	0	0	0	0	0	0
24	3	0	0	1	3	1
25	1	5	0	0	1	5
26	3	0	0	2	3	2
27	0	0	0	1	0	1
28	0	0	0	0	0	0
29	0	0	0	0	0	0
30	2	0	0	4	2	4
31	0	0	0	0	0	0
32	0	0	0	0	0	0
33	4	0	0	0	4	0
34	0	0	0	0	0	0
35	0	0	1	1	1	1
36	0	0	0	0	0	0
37	0	0	0	2	0	2
38	0	0	0	0	0	0
39	0	0	1	0	1	0
40	0	0	0	2	0	2
TOTAL	35	16	6	25	41	41

APPENDIX 10: HELPFUL AND UNHELPFUL EVENTS AS SEEN BY PATIENTS AND THERAPISTS DURING THERAPY, (RAW DATA AND SIMPLE PERCENTAGES).

Category	Most Helpful Event		Other Event		Total		Most Helpful Event		Other Event		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
1.	50	18.7	21	18.9	71	18.7	120	33.7	44	22.5	164	29.7
2.	20	7.5	8	7.2	28	7.4	38	10.7	18	9.2	56	10.3
3.	9	3.4	6	5.4	15	4.0	23	6.5	22	11.2	45	8.2
4.	58	21.6	19	17.1	77	20.3	61	17.1	36	18.4	97	17.6
5.	22	8.2	19	17.1	41	10.8	32	9.0	28	14.3	60	10.9
6.	12	4.5	4	3.6	16	4.2	5	1.4	4	2.1	9	1.6
7.	85	31.7	27	24.3	112	29.6	59	16.6	26	13.3	85	15.4
8.	12	4.5	7	6.3	19	5.0	18	5.1	18	9.2	36	6.5
9.	0	0	8	22.9	8	20	2	28.6	3	18.8	5	21.7
10.	0	0	3	8.6	3	7.5	3	42.9	1	6.3	4	17.4
11.	3	60	13	37.2	16	40	1	14.3	1	6.3	2	8.7
12.	1	20	4	11.4	5	12.5	0	0	5	31.3	5	21.7
13.	1	20	7	20	8	20	1	14.3	6	37.5	7	30.4
14.	35	-	6	-	41	-	16	-	25	-	41	-
TOTAL HELPFUL	268		111		379		356		196		552	
TOTAL UNHELPFUL	5		35		40		7		16		23	
TOTAL EXCLUDING UNCLASSIFIABLE	273		146		419		363		118		575	
TOTAL INCLUDING UNCLASSIFIABLE	308		152		460		379		143		616	

Note: the percentages shown in this table are the percentages of responses in each sub-group of cateogires, i.e., helpful or unhelpful. They are "simple", rather than proportional percentages, (see section 6.5 for an explanation of this distinction).

APPENDIX 11: End of Therapy. Categories of Events seen as Helpful or Unhelpful by Therapists and Patients

Patient No.	PATIENTS						THERAPISTS					
1	0	0	0	0	0	0	4	1	13	13	1	0
2	8	4	8	0	0	0	2	7	7	1	9	0
3	4	8	4	0	0	0	4	8	1	8	0	0
4	4	4	2	0	0	0	4	1	1	8	9	0
5	7	7	4	0	0	0	8	0	0	0	0	0
6	3	1	7	4	1	0	6	5	3	0	0	0
7	7	0	0	0	0	0	4	8	2	0	0	0
8	8	6	6	6	7	4	8	4	7	8	0	0
9	0	0	0	0	0	0	1	1	0	0	0	0
10	3	4	13	0	0	0	9	13	0	0	0	0
11	0	0	0	0	0	0	7	3	13	9	0	0
12	2	2	0	0	0	0	7	1	7	14	10	0
13	8	8	14	0	0	0	4	8	14	0	0	0
14	8	5	0	0	0	0	4	4	0	0	0	0
15	4	9	12	0	0	0	9	0	0	0	0	0
16	3	4	4	0	0	0	14	1	4	14	0	0
17	7	7	1	3	7	2	14	1	1	14	0	0
18	5	7	7	7	11	9	8	5	1	9	0	0
19	0	0	0	0	0	0	5	10	0	0	0	0
20	8	1	4	7	4	5	8	6	4	5	0	0

21	7	1	4	0	0	0	7	5	4	14	0	0
22	8	7	1	6	7	0	1	7	1	13	0	0
23	1	8	4	1	9	11	0	0	0	0	0	0
24	0	0	0	0	0	0	8	7	3	1	3	9
25	7	8	8	7	0	0	8	8	7	0	0	0
26	7	7	8	9	0	0	3	5	3	4	0	0
27	14	14	0	0	0	0	7	1	1	4	0	0
28	7	8	8	8	7	0	1	9	9	0	0	0
29	1	8	6	7	13	13	2	4	7	0	0	0
30	5	7	12	12	11	0	1	1	13	12	0	0
31	8	4	1	10	0	0	8	6	7	0	0	0
32	1	0	0	0	0	0	5	7	4	13	0	0
33	0	0	0	0	0	0	3	8	0	0	0	0
34	4	0	0	0	0	0	8	1	7	1	12	0
35	4	2	8	4	8	0	4	4	2	8	0	0
36	4	4	14	14	0	0	2	3	0	0	0	0
37	6	8	0	0	0	0	2	1	11	0	0	0
38	4	1	4	0	0	0	3	8	7	11	11	9
39	4	1	4	0	0	0	1	3	9	11	0	0
40	6	6	4	1	1	13	1	0	0	0	0	0

APPENDIX 12

OUTCOME DATA = GOOD AND POOR OUTCOME GROUPS' VIEWS OF HELPFUL EVENTS ON CATEGORIES 1-8 (SESSIONAL REPORTS)

CATEGORY NUMBER: 1 (Insight)

Good Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
2	0	2	0	0	0	2
3	0	3	0	0	0	3
4	1	4	4	3	5	7
7	0	1	0	1	0	2
8	1	4	2	0	3	4
9	4	4	2	5	6	9
14	1	0	0	0	1	0
17	10	7	5	2	15	9
21	1	4	1	1	2	5
27	0	3	0	1	0	4
35	1	0	1	0	2	0
TOTAL	19	32	15	13	34	45

Poor Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
10	1	1	0	0	1	1
13	0	0	0	0	0	0
15	2	0	1	1	3	1
19	0	2	0	0	0	2
23	0	3	0	0	0	3
25	1	2	0	1	1	3
30	5	6	0	0	5	6
31	1	3	0	1	1	4
33	1	6	0	4	1	10
36	0	4	0	2	0	6
37	0	3	0	0	0	3
TOTAL	11	30	1	9	12	39

CATEGORY NUMBER: 2 (Clarification)

Good Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
2	2	2	0	1	2	3
3	2	0	0	0	2	0
4	1	1	0	1	1	2
7	0	0	0	0	0	0
8	1	0	0	0	1	0
9	1	1	0	1	1	2
14	0	1	0	1	0	1
17	0	1	0	0	0	1
21	0	0	0	0	0	0
27	1	0	0	0	1	0
35	0	2	2	2	2	4
TOTAL	8	8	2	6	10	14

Poor Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
10	0	1	0	0	0	1
13	0	1	0	1	0	2
15	1	3	0	0	1	3
19	0	0	0	0	0	0
23	0	2	0	0	0	2
25	0	0	0	1	0	1
30	2	0	0	0	2	0
31	0	0	0	0	0	0
33	0	2	0	0	0	2
36	0	2	0	3	0	5
37	0	1	0	2	0	3
TOTAL	3	12	0	7	3	19

CATEGORY NUMBER: 3 (Awareness)

Good Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
2	0	0	0	0	0	0
3	0	0	0	0	0	0
4	0	1	0	1	0	2
7	0	0	0	0	0	0
8	0	0	0	1	0	1
9	0	0	0	0	0	0
14	1	1	0	0	1	1
17	1	2	2	1	3	3
21	0	0	0	0	0	0
27	0	0	0	0	0	0
35	0	1	0	0	0	1
TOTAL	2	5	2	3	4	8

Poor Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
10	0	0	0	0	0	0
13	0	0	0	0	0	0
15	0	1	0	1	0	2
19	0	0	0	0	0	0
23	0	0	0	0	0	0
25	0	2	1	1	1	3
30	0	2	0	0	0	2
31	1	1	1	1	2	2
33	1	1	0	1	1	2
36	0	1	0	1	0	2
37	0	0	0	0	0	0
TOTAL	2	8	2	5	4	13

CATEGORY NUMBER: 4 (Problem Solution)

Good Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
2	3	0	0	2	3	2
3	3	2	2	0	5	2
4	9	7	0	4	9	7
7	1	2	0	0	1	2
8	3	4	1	4	4	8
9	3	2	0	0	3	2
14	3	3	2	1	5	4
17	0	1	0	0	0	1
21	2	2	0	1	2	3
27	1	1	0	0	1	1
35	2	4	2	1	4	5
TOTAL	30	28	7	13	37	41

Poor Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
10	2	2	2	2	4	4
13	0	4	0	1	0	5
15	0	1	1	2	1	3
19	1	3	0	1	1	4
23	2	0	0	2	2	2
25	0	1	0	0	0	1
30	0	0	0	0	0	0
31	1	0	0	1	1	1
33	0	0	0	0	0	0
36	1	0	0	0	1	0
37	0	0	0	0	0	0
TOTAL	7	11	3	9	10	20

CATEGORY NUMBER: 5 (Involvement)

Good Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
2	0	0	0	1	0	1
3	0	2	0	1	0	3
4	1	1	0	2	1	3
7	0	0	0	0	0	0
8	1	1	2	0	3	1
9	0	0	0	0	0	0
14	0	0	0	0	0	0
17	1	0	3	2	4	2
21	0	0	0	0	0	0
27	0	0	0	0	0	0
35	1	1	0	2	1	3
TOTAL	4	5	5	8	9	13

Poor Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
10	0	0	0	0	0	0
13	2	0	2	0	4	0
15	1	0	0	0	1	0
19	0	1	1	1	1	2
23	0	0	0	0	0	0
25	0	5	1	1	1	6
30	0	2	1	2	1	4
31	0	1	1	1	1	2
33	3	4	1	1	4	5
36	0	0	0	0	0	0
37	1	0	0	0	1	0
TOTAL	7	13	7	6	14	19

CATEGORY NUMBER: 6 (Understanding)

Good Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
2	0	0	0	0	0	0
3	0	0	0	0	0	0
4	0	1	0	1	0	2
7	0	0	0	0	0	0
8	1	0	0	0	1	0
9	0	0	0	0	0	0
14	0	0	0	0	0	0
17	0	0	0	0	0	0
21	0	0	0	0	0	0
27	0	0	0	0	0	0
35	3	1	1	0	4	1
TOTAL	4	2	1	1	5	3

Poor Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
10	0	0	1	0	1	0
13	0	0	0	0	0	0
15	0	0	0	0	0	0
19	0	0	0	0	0	0
23	0	0	0	0	0	0
25	1	1	0	0	1	1
30	0	0	0	0	0	0
31	2	0	1	0	3	0
33	0	1	0	0	0	1
36	0	0	0	0	0	0
37	0	0	0	0	0	0
TOTAL	3	2	2	0	5	2

CATEGORY NUMBER: 7 (Reassurance)

Good Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
2	1	2	0	1	1	3
3	1	3	0	0	1	3
4	3	1	0	0	3	1
7	1	1	0	0	1	1
8	4	3	1	3	5	6
9	2	2	1	1	3	3
14	2	1	1	1	3	2
17	1	3	2	1	3	4
21	0	0	0	3	0	3
27	2	0	1	1	3	1
35	4	2	2	0	6	2
TOTAL	21	18	8	12	29	30

Poor Outcome/

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
10	3	1	1	0	4	1
13	4	2	1	1	5	3
15	1	0	1	0	2	0
19	3	0	0	0	3	0
23	1	0	0	0	1	0
25	1	1	1	0	2	1
30	0	0	0	0	0	0
31	2	4	3	0	5	4
33	1	2	1	1	2	3
36	0	0	0	0	0	0
37	0	1	0	0	0	1
TOTAL	16	11	8	2	24	13

CATEGORY NUMBER: 8 (Personal Contact)

Good Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
2	1	1	0	1	1	2
3	0	0	0	1	0	1
4	0	1	0	2	0	3
7	0	1	0	0	0	1
8	0	0	0	0	0	0
9	0	0	0	0	0	0
14	0	0	0	0	0	0
17	2	0	0	1	2	1
21	0	0	0	0	0	0
27	1	0	1	0	2	0
35	1	3	0	2	1	5
TOTAL	5	6	1	5	6	13

Poor Outcome

Patient No.	Evnt 1 Pt	Evnt 1 Th	Evnt 2 Pt	Evnt 2 Th	Overall Pt	Overall Th
10	0	0	0	0	0	0
13	0	1	0	1	0	2
15	0	0	0	0	0	0
19	0	0	0	1	0	1
23	0	0	0	0	0	0
25	1	0	0	0	1	0
30	1	2	0	0	1	2
31	0	0	1	1	1	1
33	0	0	1	3	1	3
36	0	0	0	0	0	0
37	0	0	0	0	0	0
TOTAL	2	3	2	6	4	9