UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

CHAPTER 2 - THE PATIENT AS A VARIABLE IN THE PSYCHOTHERAPEUTIC RELATIONSHIP

There are many variables which contribute to the development of the psychotherapeutic relationship and the outcome of psychotherapy. A wealth of literature exists which explores the contributing aspects of the patient, the therapist, the situation and the psychotherapeutic relationship. The current chapter deals with what successful outcome means in psychotherapeutic terms and the factors that the patient contributes to the psychotherapeutic relationship and healing. The following two chapters explore the variables of the therapist and the situation and are followed by a discussion of the psychotherapeutic relationship itself.

THE OUTCOME OF PSYCHOTHERAPY:

There has been much written about successful outcome in psychotherapy. Possibly one of the most well-known articles is "The Effects of Psychotherapy, an Evaluation" written by Eysenck (1952). Causing considerable controversy, he states that two thirds of neurotic patients improve no matter how they are treated or whether they are treated at all and he reinforces this view in subsequent articles in 1960 and 1965 (Malan, 1973). In the ongoing argument about these findings many authors question these results and Malan (1973) refers to Bergin's 1966 paper which he regards as one of the most important papers to have emerged in the past twenty years. Bergin (1966) discusses Rogers, Gendlin and Truax's Wisconsin four-year study of 16 schizophrenics which concludes that psychotherapy can make patients either better or worse. This is supported by Bergin and Garfield (1971) who evaluate the outcome of many studies including those of Eysenck, 1952; Rogers and Dymond, 1954; Cartwright and Vogel, 1960; Truax and Carkhuff, 1965 and Volsky, 1965. These studies were all empirically based, Rogers and Dymond assessing the effects of psychotherapy, Cartwright and Vogel administering the TAT to assess whether there was any deterioration in patients when in psychotherapy with inexperienced therapists and Truax and Carkhuff conducting repeated empirical studies of psychotherapy in different settings. These authors found that what happens in psychotherapy is powerful and this can have either beneficial or harmful effects.

Eysenck has also raised the question of how spontaneous remission plays an important role in the improvement of patients in psychotherapy. Bergin and Garfield (1971) found, in their review of Eysenck's studies and their own follow-up of 52 outcome studies, that the spontaneous remission rate is lower than expected and improvement is linked to therapeutic procedures of many different types. Meltzoff (Malan, 1973), concludes that there is little doubt that some patients will improve over time without psychotherapy but clearly many patients benefit from the psychotherapeutic experience. This conclusion is based on Meltzhoff's research of over 100 controlled outcome studies, most of which yielded positive results. Bergin (1966) supports this finding and adds that psychotherapy is more likely to be successful under the right conditions. Lambert and Bergin (1992) discuss how numerous authors have come to the same conclusion that "psychotherapy is effective at helping people achieve their goals and overcome their

psychopathology at a rate that is faster and more substantial than changes that result from the client's natural healing processes and supportive elements in the environment" (p. 363).

Smith, Glass and Miller, 1980, in a study with 475 patients, found that the "average psychotherapy patient is better off than 80% of the untreated sample" (Lambert & Bergin, 1992, p. 364). Smith and Glass (1977) found that the average patient receiving psychotherapy fared better than 75% of the untreated control group. Seligman (1995) studied the results of the 1995 Consumer Reports conducted in America. This questionnaire survey of patients in ongoing psychotherapy found that "of the 246 people who were feeling very poor when they began therapy, 87% were feeling very good, good or at least so-so" (p. 968) at the time of the survey. Overall the survey indicates that people had "fewer symptoms and a better life after therapy than they did before" (p. 974). Results generally support the fact that psychotherapy treatment is considerably more effective than no treatment at all (Luborsky, Singer & Luborsky, 1975; Smith & Glass, 1977; Smith, Glass & Miller, 1980; VandenBos, 1986; VandenBos & Pino, 1980). However, let it not be forgotten that a minority of patients do not improve and some do deteriorate.

Stubbs and Bozarth (1994), in a qualitative study of psychotherapeutic research over four decades (1950 - 1993), found enough evidence to reject Eysenck's findings that psychotherapy is no better than no psychotherapy. Subsequent research has led to an overall rejection of the Eysenck study. Bergin found value in Eysenck's study in that it was a "prime stimulant, if not irritant" (Stubbs & Bozarth, 1994, p. 111) pushing for further research in the field.

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

Successful psychotherapy does, therefore, involve change. Garfield (1989), in his research of empirical studies, found that this is not a unitary phenomenon with uniform change but a mixture of positive and negative, overt and covert changes. Patients come to psychotherapy in distress, with a more or less disorganised state of being, and we can assess whether what we have offered them has helped by the change or gain in their behaviour. Thus, successful psychotherapy implies a visible and significant change and not just a belief, on the patient's part, that he has changed (Carkhuff, 1966). Garfield (1989) suggests that successful outcome also means increased understanding about the self and personal difficulties. Good psychotherapy has a wholeness and a continuity that makes it a unique experience for each patient-therapist team. Successful resolution, according to Rice and Greenberg (1984), involves a sense of completion and relief and an implicit sense that something has changed. Rogers (1965), on the basis of his experience as a client-centred psychotherapist as well as empirical studies, views change as having occurred when the patient is able to perceive

himself as a more adequate and worthwhile person. This includes a more realistic appraisal of himself as a whole, his relationships and the environment as well as having learned to place the basis of standards within himself. For Buber (1958), confirmation of the person as a human being, is at the core of healing. This confirmation of self will allow the patient to finally move back into relationship in his whole world.

An important indicator of psychotherapeutic success is the symptomatic relief experienced by patients after the completion of psychotherapy. Battle et al. (1966) view psychotherapeutic success as the removal or relief of psychiatric complaints with no new ones taking their place.

Thus, successful psychotherapy is a change in personality organisation, structure and behaviour for the betterment of the patient, through insight, understanding and awareness, which includes improved functioning and some degree of symptom relief (Rogers, 1965). Hycner (1991) views the goal of dialogal psychotherapy to be "the enhanced relational ability of the client" (p. 4) which is achieved when some restoration of the "atrophied personal center" (Buber, 1958, p. 133) of the patient has been gained.

Many patients evaluate the effectiveness of psychotherapy by the degree of alleviation of the distress associated with their problems and this allows for systematic research of success in psychotherapy to be conducted. However, research into the components that make for successful psychotherapeutic outcome is confounded by the lack of clear definitions and shared fundamental beliefs amongst researchers and psychotherapists (Forsyth & Strong, 1986). The difficulty in applying the answers from efficacy studies to the actual practice of psychotherapy further complicates issues. Seligman (1995) states that experimental research under highly controlled conditions provides very different answers as to what actually occurs in the reality of a psychotherapeutic context and to what is successful in practice in the field.

Research findings must be extrapolated from the data to the real world to be of any use to clinicians in practice. Howard, Moras, Brill, Martinovitch and Lutz (1996) ask three fundamental questions: Does the treatment work under special, experimental conditions ? Does it work in practice, that is, how effective is it ? Is it working for this patient ? Jacobson and Christensen (1996) believe that "single-participant" (p. 1038) designs and qualitative research methods will play a more important role in providing relevant answers to practising clinicians. In order to gain some insight into what makes for successful psychotherapy, the following aspects are explored.

THE PATIENT AS A VARIABLE IN THE PSYCHOTHERAPEUTIC RELATIONSHIP:
As the psychotherapeutic relationship is created by an interaction between the patient and therapist, it is important to explore what factors have traditionally been viewed as positive contributors in terms of the patient. People react differently to the process of psychotherapy with some being able to change and resolve problems. Others may be unable to change and learn from the experience and, for some, their symptomatology may even worsen (Wolberg, 1977). It is, therefore, important to seek common denominators to enhance knowledge and understanding.

Whilst there has been little comparability from study to study and the research on patient variables has produced inconsistent results, some important factors have emerged. The following variables have been identified as being significant to the outcome of psychotherapy.

1. **Initial state of adjustment.**

Luborsky, Chandler, Auerbach, Cohen and Bachrach (1971) and Astrup and Noreik, 1966 (Luborsky et al., 1971), suggest that the patient's initial state of adjustment is the highest predictor of outcome. This is supported by a three to nine year follow-up study of 84 patients conducted by Clementel-Jones, Malan and 77Trauer (1990) where a clear, positive correlation was found between good initial adjustment and successful outcome. Cartwright, 1957, and Kirtner and Cartwright, 1958 (Bergin & Garfield, 1971), found that those patients who perceived themselves as fairly well adjusted at the start of psychotherapy and exhibited a higher level of personality integration tended to find psychotherapy more helpful. Several other empirical studies support this finding that patients who are better adjusted at the beginning of psychotherapy show the greatest improvement (Gelder, Marks & Wolff, 1967; Stone, Frank, Nash & Imber, 1961; Stephens & Astrup, 1965, in Strupp (1971); and Rogers, 1965). Luborksky (1992) avers that the more severe the problems, the more limitations and difficulties there will be in attaining a good outcome for the patient. Many clinicians comment that the most well-adjusted people are given the most intensive treatment whilst the more seriously disturbed are viewed as having a poor prognosis and receive less psychotherapeutic input (Garfield, 1992). So, this view holds that not only does the more seriously disturbed patient have more problems to deal with due to the deeper levels of damage, but he is also less likely to receive the best psychotherapeutic assistance from the therapist.

2. **Patient expectation.**

Carkhuff (1966) agrees that the patient's initial level of functioning is important but contends that his expectations are also critical. Fiske et al. (1970) found positive expectancy to be a necessary condition for psychotherapeutic effectiveness. Bergin and Garfield (1971) cite findings by Frank and his colleagues (Frank, 1959; Frank, Gliedman, Imber, Stone & Nash, 1959; Rosenthal & Frank, 1956) which all point to the fact that the greater the distress and need for help, the greater the expectancy or likelihood of that help being perceived as successful. Bergin and Garfield refer to the findings made by Lennard and Bernstein, 1960, Lipkin, 1954, Goldstein and Shipman, 1961, who all report a positive link between expectancy and perceived symptom reduction. However, this finding should be viewed cautiously as this relationship was curvilinear - patients with very high or very low expectancy showed the smallest symptom reduction.

Perhaps more important is that there is congruence between the patient's and therapist's expectations and this variable has been shown to be consistently related to psychotherapeutic progress (Lennard & Bernstein, 1960; Heine & Trosman 1960, in Strupp (1971); Heine, 1962, in Bergin & Garfield (1971)). But what is it that the patient is expecting from the therapist ? Rogers (1965) says that the patient could expect the therapist to be like a surgeon who will probe deeply, causing pain against his wishes resulting in the patient perceiving the therapist as threatening. Or he could view the

therapist as a father figure or psychotherapy as a place to solve problems and thus have a positive outlook. Clearly the perception and expectancy of the psychotherapy and therapist is of critical importance.

3. **Level of motivation.**

Malan (1973), conducted a study at the Tavistock Clinic in London, where he treated 20 patients with brief psychoanalytic psychotherapy. The study was later replicated with 30 patients and similar findings were made. He found that, of all the selection criteria studied, motivation and a desire for insight were the most important predictors of successful outcome. This finding is also reported by Sifneos (in Malan, 1973); Strupp (1971); Rogers and Dymond (1954); Truax and Carkhuff, 1967; White, Fichtenbaum and Dollard, 1964 (in Strupp, 1971). Sifneos stresses that the patient's motivation ought to be for change within the self rather than simply a motivation for symptom relief as he speculates that this is associated with a good prognosis. Malan (1963) found that a high proportion of patients who experienced psychotherapy as successful had a high level of motivation and those with low motivation had poorer results. Rogers, Gendlin, Kiester and Truax (1976) report finding that the more motivated a patient is, the easier it is for the therapist to become involved in and committed to the relationship. However, Rogers and Dymond (1954) did an extensive study on motivation as a factor in personality change and found that motivation alone is insufficient to bring about this change in the absence of psychotherapy.

4. **Patient involvement in psychotherapy.**

Rice & Greenberg (1984) report that Mathieu-Coughlan and Klein believe that the critical aspect in psychotherapy is what Gendlin describes as the patient's engagement in the process so that the patient has a bodily, felt sense of what is occurring. Without this, the authors state, subsequent steps of struggle, shift or resolution would be both meaningless and impossible. Truax and Carkhuff (1964) found that the greater the degree of patient involvement, the greater the constructive personality change. Involvement includes an ability to be open, rather than defensive. Involvement was found to be the most consistently positive correlate of psychotherapeutic outcome in the Orlinsky and Howard 1986 study of patient variables. Involvement also included the ability for "greater immediacy or affective expression" (Stubbs & Bozarth, 1994, p. 115).

5. **Referral.**

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

6. **Age.**

Bergin and Garfield (1971) did not find age to be of any major significance and Seeman, 1954 (Cartwright, 1955), also found no significant association between the age of the patient and the rated success of psychotherapy. Likewise, in a study involving patients between the ages of 21 - 40, Rogers and Dymond (1954) found no correlation between age and movement in psychotherapy. In contrast, Casner (1950)

found a significant difference in improvement and success when patients were under the age of 30. Similarly, Truax and Carkhuff (1964) state that Stone, Frank, Nash and Imber's 1961 study found that younger patients changed more positively.

7. **Gender of patient.**

Rosenbaum, Friedlander and Kaplan (1956) found that a significantly higher number of women than men are in psychotherapy and suggest that this could be because women are more likely to accept the fact that they are suffering from emotional distress. Seeman, 1954 (Cartwright, 1955), and Casner (1950) report finding a significantly higher rate of women being more successful than men in psychotherapy. Rogers and Dymond (1954) also found women to make significantly more progress than men.

8. **Education and socioeconomic status.**

Most studies report a positive relationship between education and length of stay and success in psychotherapy. Bergin and Garfield (1971) point out that educational level is only part of a larger factor that may include verbal ability, sophistication about and interest in psychotherapy, and income. Angus (1992) conducted a retrospective research study with 18 patients on their experience of the effectiveness of psychotherapy with therapists-in-training. A very positive outcome on this factor was expected in this study as the entire sample consisted of students with a minimum of 12 years education. The result of an 89% success rate supported this.

Socioeconomic status is also linked to psychotherapeutic progress in that the Rosenbaum et al. (1956) study found that those patients who were "much improved" following psychotherapy were of a higher social strata. It can be speculated that a high socioeconomic status generally provides an individual with
more opportunities for a higher education level and the other qualities mentioned by Bergin and Garfield (1971) above.

9. **Severity of symptomatology.**

It is generally felt that the less severe the symptomatology and diagnosis, the more chance there is of psychotherapy being successful. Bergin and Garfield (1971) cite many authors to have found less-disturbed patients more likely to respond positively to psychotherapy. Truax and Carkhuff, in their 1967 study, offer the hypothesis that patients who perceive their symptoms as inwardly experienced and not mainly overtly displayed tend to be more in touch with themselves and show the greatest psychotherapeutic improvement. This suggests an ownership of and responsibility for problems by the patient which further enhances growth in psychotherapy. The more egodystonic the symptom the higher the motivation for change is likely to be and this hypothesis has found support from many authors (Bergin & Garfield, 1971). However, Stone et al.'s study found that the patients who evidenced the most difficulties and problems exhibited the greatest positive change after psychotherapy.

10. **Patient's perception of the therapist/perceived similarity to patient**.

The patient's experience of the therapist and his functions are critically important to the psychotherapeutic process. Rippee, Harvey and Parker, 1965, found that the patient's perception of the therapist is influenced directly by what the therapist does in the psychotherapeutic contact (Carkhuff, 1966). Robinson, Redlich and Myers' 1954 study

suggests that a similarity of culture and understanding facilitates psychotherapy and that patient-therapist differences may hamper the development of the psychotherapeutic relationship and thus the effectiveness of psychotherapy (Rosenbaum et al., 1956). This is supported by empirical research conducted by Halpern, 1955; Fiedler and Senior, 1952; Normal, 1953; Notcutt and Silva, 1951; Wolf and Murray, 1937 (in Lesser, 1961), who all note that similarity between the therapist and the patient does have a positive effect on psychotherapeutic outcome. Fiedler and Senior, 1952, point out that the perceived similarity is of more importance than reality as it suggests a positive attitude by the therapist towards the patient indicating that he has connected with and understood the patient's experience (Lesser, 1961). This results in an enhancement of the psychotherapeutic process and creates a deeper, richer understanding. Truax and Carkhuff (1964) state that Stoler, 1963, supports this with his finding that successful patients were those who were more liked by the therapist thus suggesting that this perceived similarity is reciprocal. However, Lesser (1961) cautions that the best results will not be obtained if this similarity is overestimated. Rogers (1965) comments that how the patient perceives the therapist has a significant and profound effect on how much the patient will reveal of himself and the rate of progress in psychotherapy. Lorr, 1965, found a significant relationship between patient improvement and patient perception of the therapist as accepting and understanding (Carkhuff, 1966).

Whilst patient-therapist similarity does seem to be positively correlated with outcome, Bergin and Garfield (1971) caution that no clear conclusions can yet be drawn as more definitive research needs to be done. The Angus (1992) study reveals that, despite 44% of the sample finding the therapist to be dissimilar in attitude, only one subject perceived psychotherapy as a failure. This suggests that, despite perceived dissimilarities, psychotherapy can and does have successful results if other critical variables are present.

11. **Patient satisfaction.**

How the patient perceives psychotherapy and the degree of symptom reduction is critical for rating success. Cartwright (1955) found that those patients who rated themselves as satisfied with psychotherapy had been viewed by the therapist as having achieved success in psychotherapy. Part of the experience of satisfaction is assumed to be the patient's perception of being heard and accepted by the therapist (Rogers, 1965). This experience allows the patient to accept those previously unacceptable aspects of the self.

With the Angus (1992) study revealing that 56% of the patients perceived their own characteristics as hampering the process and outcome of psychotherapy, it is clear that the patient himself is a critical factor in the psychotherapeutic equation. A difficulty in self-disclosure (6%), a fear of their own emotional reaction (11%), of taking risk or of being judged (11%) and of their own self-destructive behaviour and thoughts (11%) were perceived as being the most important patient factors hampering the process and outcome of psychotherapy. Despite this, results indicated that 89% of the subjects assessed psychotherapy as having been successful.

Based on the above findings some assumptions can be posited about the kind of

patient most likely to succeed in psychotherapy. Positive indicators on the part of the patient for successful outcome include: a relatively high level of adjustment, good expectation and motivation and thus involvement in the psychotherapeutic process, middle to upper-class socioeconomic status, at least twelve years of education, being female, self-referral, egodystonic symptoms and some perceived degree of similarity between patient and therapist.