CHAPTER 4 - THE SITUATION AS A VARIABLE IN THE PSYCHOTHERAPEUTIC RELATIONSHIP

There is considerably less literature available dealing with the importance of the contextual or situational variables which play a critical role in defining the psychotherapeutic milieu. Patients respond not only to the therapist but to the physical and psychotherapeutic conditions surrounding them which have a definite effect on the outcome (Goldstein, 1971). Garfield (1992) stresses the importance of situational variables in affecting the patient's process in psychotherapy. Goldstein (1971) defines situational variables as "all those events occurring around an individual which are not a property of the individual himself" (p. 61).

1. **Length of psychotherapy**.

Seligman (1995) discusses the findings of the 1995 Consumer Reports study conducted in the United States of America. This study found that long-term psychotherapy resulted in more improvement than short-term therapy. The major general findings are that a moderate length of time is most productive, that is, approximately six months of weekly psychotherapy (Lambert & Bergin, 1992).

Kirtner, Cartwright, Robertson and Fiske (1961) found that the correlation between length of time in psychotherapy and measures of change in personal integration was not significant. However, Malan (1973), in his study of successful cases, comes to the conclusion that considerable change is generally obtained in 10 - 50 sessions and this is supported by the brief-term psychotherapy done by Sifneos, 1981, and Mann, 1981 (Ursano & Hales, 1986). Clementel-Jones et al. (1990) conducted a three to nine year follow-up study on 84 patients who had been treated with individual psychotherapy at the Tavistock Clinic. The findings reveal that people with poor adjustment, severe pathology and a disturbed childhood, gained some success in 40 sessions. The best results were seldom obtained in less than 60 sessions. Contrary to this, Muench, 1965, found that time-limited and short-term psychotherapy was more effective than long-term and Truax, Carkhuff and Kodman, 1965, support the fact that time-limited psychotherapy is effective (Carkhuff, 1966). McNair, Lorr, Young, Roth and Boyd's (1964) results indicate that the extent of improvement is linked to the length of psychotherapy which was a minimum of four months in that study. Rogers and Dymond (1954) support this with their view that, with more than 20 sessions, there is a considerable assurance of psychotherapeutic gain.

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

problems and ones with personal adjustment problems. Longer-term psychotherapy is deemed to be necessary in the latter instances.

Kirtner and Cartwright (1958) and Cartwright (1955) speak of a "failure-zone" which falls roughly between 13 - 20 sessions and both found that outcome was more successful if the length of psychotherapy was on either side of these figures. This suggests that if it is not possible to solve the problem within the short-term period, it tends to require longer-term psychotherapy to resolve the issues.

There is little literature that specifically speculates about the success and power of long-term psychotherapy. Qualitative studies would be useful indicators in this respect. In the Angus (1992) study, the average number of sessions was 23. The 89% successful outcome rate supported the findings that short-term, in-depth psychotherapy can be extremely effective with relatively well-adjusted patients. However, 28% of the patients stated that they would have preferred more time in psychotherapy and felt that issues could have been explored in greater depth, more effectively, given a longer time span.

Spontaneous remission also confounds the issue. Rogers and Dymond (1954) state that spontaneous remission is so commonly observed that its existence can hardly be doubted. Fiske et al. (1970) argue that its effects can be considerable. However, Bergin and Garfield (1971) maintain that studies show that there is something unique about psychotherapy which causes improvement beyond the effects of spontaneous remission. Bergin and Garfield (1971), as stated earlier, found that the spontaneous remission rate is lower than expected. Although this may be a factor, it is evident that there can be deeper and more meaningful exploration and thus more possibility for growth in long-term psychotherapy.

2. **Type of psychotherapy.**

While it is safe to argue that each school of thought probably considers its own style of psychotherapy to be the most efficacious, studies suggest that there is little proof that any one method is the best. The proliferation of therapies available today confuses the issue. Arkowitz (1992) and, more recently, Kazdin, 1986 (Garfield, 1992), state that there are about 400 different techniques or therapies available today.

Much of the literature indicates that no specific type of psychotherapy is better than any other. Subsequent to Eysenck's 1952 study, much research has been conducted to test his findings. Most researchers have disagreed with his results. Strupp and Howard (1992) quote studies by Howard, Kupta, Krause and Orlinsky, 1986, and McNeilly and Howard, 1991, which reveal that Eysenck's study in fact showed that 67% of people who did seek psychotherapy improved within two months. This was a clear indication that psychotherapy did have some success. Bergin, 1971, in reviewing Eysenck's results found that if the number of patients who dropped out of psychotherapy were excluded from Eysenck's results, the improvement rate jumped to 91% (Wolberg, 1977). This suggests that motivation is a key to successful psychotherapy and that those who stay in psychotherapy have more chance of improving than those who drop out early, rather than indicating that any one type of psychotherapy is superior or more effective than any other. This statement is supported by the findings of Cartwright, 1966; Heine, 1953 (Luborsky et al., 1971); Wolberg (1977); Smith and Glass (1977) and

Bordin (1986). Bergin and Garfield (1971) further support this view with their findings of the outcome of 52 studies as a function of the nature of the psychotherapy. These authors found that the type of psychotherapy appeared unrelated to outcome. Bergin and Garfield also studied the reports of the results of psychotherapy on 8,053 patients from psychoanalytic and eclectic schools ranging over a 30 year period from 1920 - 1951. The findings highlight that each type of psychotherapy has both its successes and failures and no single type of psychotherapy was found to be more successful than any other. This is supported by Arkowitz (1992) who declares that there is little evidence that any of the over 400 different psychotherapy approaches is more effective than any other. One can rather ask whether the particular patient's condition will respond to a particular type of psychotherapy and assess whether it does work for that patient. And under what circumstances is a particular technique or particular kind of therapist suitable ?

One could speculate that the process determines the outcome and the type of problem being treated plays an important role in what type of psychotherapy would be most beneficial. Garfield (1992) asks the pertinent question of whether the psychotherapeutic approach is more important that the overall therapeutic skill of specific therapists. Although research on this question is limited, this paper argues that, regardless of the type of psychotherapy, healing is possible if the dialogal approach of 'healing through meeting' is provided by the therapist as a base within the context of the psychotherapeutic relationship.

Lazarus, 1977, wisely states that he would like to see "an advancement in psychological knowledge, an advancement in the understanding of human interaction, in the alleviation of suffering, in the know-how of therapeutic intervention" (p. 993) rather than further research of types of psychotherapy (Goldfried, 1980).

3. **Tape recorded sessions**.

Psychotherapy sessions can be tape-recorded by therapists to ensure an accurate chronicle of the session or for learning purposes in supervision. The question is whether the patient is adversely affected by being tape recorded or not. Roberts and Benzaglia, 1965, found that patients made more positive self-references when they knew they were being recorded and more unfavourable self-references when not being recorded (Carkhuff, 1966). An interesting factor here is that tape recording also affected the therapists who were less patient-centred when aware of being recorded. In the Angus (1992) study, 33% of the sample were inhibited by being tape-recorded. So, although there is value in having an accurate recording of a session, this factor can interfere with the psychotherapeutic process.

4. **Setting and atmosphere**.

Despite the importance of the physical setting in which psychotherapy takes place, little research has been conducted concerning this variable. The perceived comfort, atmosphere, noise level and privacy can either positively or negatively impact on the psychotherapeutic process and more research on the result of these factors is needed. Goldstein (1971) writes of the profound effect that these variables have on psychotherapeutic outcome but does little to identify specific factors. The Angus (1992) study revealed some of the negative effects of the setting. For example, the room was

experienced as uncomfortable or too noisy by 22% of the sample and this adversely affected self-disclosure. Langs (1989) believes that, unconsciously, the setting in which psychotherapy is conducted becomes part of the psychotherapeutic experience. He suggests that the setting should, ideally, be private, comfortable, soundproof, have a separate entrance and exit and be tastefully furnished.

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

5. **Patient's cultural setting.**

An important facet of outcome is the existing cultural milieu from which the patient comes and will be returning to. Wolberg (1977) comments on how the patient's prevailing lifestyle can either neutralise any success gained in psychotherapy or encourage success by rewarding healthy behaviour. Phenomenology's whole approach to the patient is based on the fact that he exists as a human being in relationship to his world. Thus, the context of the patient's background, family and culture are critically important.

6. **Payment of fees**.

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

The above variables can have a subtle, yet profound effect on psychotherapy. Many of these factors are, however, largely ignored by therapists in the field. It is, therefore, important that therapists become more aware of these factors and incorporate the value gained from research into their practices on a daily basis.