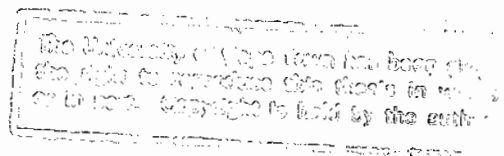


ASSESSMENT FOR PSYCHOTHERAPY  
WITHIN LOCAL PSYCHIATRIC  
TRAINING UNITS: SOME GUIDELINES

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A thesis submitted in partial fulfillment of  
the requirements for the degree of  
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ABSTRACT

Assessment for psychotherapy is an area of crucial importance for positive outcome of therapy and hence should be an integral part of the training of intern psychologists. This thesis attempts to develop guidelines for the assessment of patients for psychotherapy in the local hospital setting, and is informed by a survey of the circumstances in the various training units.

Quantitative work on psychotherapy outcome is reviewed in an attempt to derive such guidelines. The review is highly selective, focusing on areas relevant to the local context. Although some useful pointers emerged, at the present time this body of work is somewhat disparate, and hence not particularly helpful in the development of an integrated set of guidelines. Therefore, greater reliance was placed on literature based on work in the clinical tradition.

The focus is on short-term forms of intervention. The approaches included within this rubric are categorised into reconstructive, reeducative and supportive modes (Wolberg, 1977), and selection criteria were presented for each of these. Perhaps the most complex area is the assessment of ego function, which is given detailed attention. The literature on assessment of ego function derives mainly from the reconstructive tradition, but has relevance for reeducative and supportive approaches as well.

It is argued that comprehensive assessment, particularly for reconstructive forms of intervention, is a complex process requiring considerable skill. Although guidelines have an important role to play, the process of assessment, like all aspects of psychotherapy, can only be learned through practice under careful supervision. The implications for training in the local psychiatric units are discussed.

SECTION I : THE PROBLEM

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Chapter One: Introduction

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CHAPTER ONEINTRODUCTION

The issue of assessment for psychotherapy has a long history in clinical writing. Freud's original criteria at the turn of the century were that psychotically disturbed patients, and patients over 50 years of age were poor candidates. Later he added unfavourable life circumstances as a poor prognostic feature. Other psychoanalysts such as Jones (1920) regarded diagnostic criteria as important; Fenichel (1945) emphasized that certain conditions seemed to be associated with greater accessibility to treatment, leading to the development of the concept of "analysability" (Bloch 1979a).

Researchers and clinicians continue to underline the importance of appropriate assessment for therapy. There is considerable evidence that under certain circumstances psychotherapy can be harmful, both overtly in the form of exacerbating symptoms, and in less obvious ways, such as allowing the development of dependency on therapy. Appelbaum (1976) points out the potential dangers of insight-oriented therapy, focusing particularly on the fact that it is highly problematic to facilitate a patient's recognition and experience of her conflicts unless she clearly has the resources to resolve them. He describes the patient who, deprived of quasisolutions and unable to develop more satisfactory ones, becomes suicidally depressed; the patient whose contact with reality is

tenuous, being precipitated into psychosis by the inappropriate demand to recognise and absorb her feelings; the patient whose therapy leaves her in a state of incomplete change and who is therefore precarious and vulnerable to stresses (Appelbaum, 1976).

It appears, therefore, that psychotherapy can be detrimental if it is inappropriately applied. Case studies, such as the one by De Courcy (1971) provide examples of inappropriate treatment resulting from inadequate assessment. That this problem not only occurs in isolated cases is borne out by the work on deterioration effects in psychotherapy (to be discussed in the next chapter). In addition, Hadley and Strupp (1976) did a survey of the opinions of researchers and practitioners and reported that deficiencies in assessment were described by many respondents as one of the fundamental factors contributing to negative effects.

It is clear from the above that the issue of assessment for psychotherapy is a basic and vital one. It is important to note that in modern clinical practice there are many forms of therapeutic intervention, and many authors suggest that the type of patient who does well in one form of therapy is not the same as the type who will do well in another (Haskell et al., 1969). Hence it is important to avoid the approach frequently taken, of attempting to define the type of patient who will respond well

to an undefined general psychotherapeutic intervention. It would seem more appropriate to move towards greater specificity in terms of the intervention and the patient for whom it is advocated.

If assessment for any form of intervention (whether medical or psychological) is undertaken in a serious manner, the possibility of withholding the intervention cannot be excluded. Despite the fact that therapy is sometimes detrimental or unnecessary, it is rarely withheld. Francis and Clarkin (1981) make the following important points:

(1) Treatment has a risk-benefit ratio; the potential harm it can inflict on some people may outweigh its possible benefits. (2) Treatment has a cost-benefit ratio; the resources of the mental health system expended on this person are not available for someone else perhaps more likely to benefit.

(p.542)

The issue of appropriate assessment for psychotherapy, therefore, has relevance (1) for the provision of the most effective and efficient form of intervention for individual patients and (2) for the most appropriate distribution of mental health resources.

Aims of the current study:

There is some evidence that trainees have the most difficulty in assessing for appropriate forms of intervention (Auerbach & Johnson, 1977; Avallone, Aron, Starr, & Breetz, 1973). The primary aim of this thesis is to examine the problem of assessment for psychotherapy in terms of the clinical psychology intern in the local training hospital setting. This thesis cannot attempt to cover the entire field of assessment for all forms of psychotherapy. The aim is rather to select relevant information from various sources and to present this in a way that is useful and appropriate to the local context. It is hoped that recommendations for the training of psychology interns can be developed from this thesis. As Meltzoff (1969) points out, this is one of the most powerful ways in which clinical practice can ultimately benefit from psychotherapy research.

Information about local conditions was obtained by means of questionnaires sent to five psychologists-in-charge and twelve interns completing the clinical Masters programme. All of them were placed in training units within the Groote Schuur-Valkenberg complex during 1982/83. Eight of the interns involved were completing their internship at the time the forms were distributed while three had already completed their internships. The questionnaires were designed to establish, among other things,

the primary goals of intervention in the unit, range of pathology seen, the amount of time interns had available for individual psychotherapy, and the amount of supervision available (Appendix I).

### Results:

Information was obtained from four units:

(1) Cape Town Neuroclinic, the admission ward on the white side of Valkenberg Hospital (interns placed here also worked in other wards, frequently locked wards).

(2) Two of the three firms on the black side of Valkenberg Hospital, to be referred to here as the Pinelands firms. Except under unusual circumstances, psychology interns work mainly in closed wards, including the admission ward.

(3) Ward D12, a psychiatric ward for white patients in Groote Schuur Hospital.

(4) The psychiatric unit at Avalon Treatment Centre in Athlone, which takes black patients only, most frequently those classified "coloured". Information on Avalon refers only to the period from February 1982 to May 1983, as no psychology interns were placed there for the rest of 1983.

### Summary of questionnaire findings:

The findings are reported in detail in Appendices II and III. The following is a brief synopsis of the most

important findings.

Ward D12 and Avalon are similar in that both are designed to be treatment milieux, in which neuroses and personality disorders are the problems most frequently presented, with functional psychosis, mental handicap and organic psychoses rarely being dealt with. They both have a fairly small number of inpatients at any one time (approximately 14). As one would expect in a milieu treatment setting, patients are automatically involved in individual therapy, group therapy, evocative activities such as role play and projective art, and a substantial number are involved in family therapy run by a psychiatric social worker. In both units, the intern spends one hour a week individually with four to six inpatients.

There are important differences between these two units, the main one being that the average length of stay in Ward D12 is three months, while at Avalon it is approximately six weeks. As one would expect, the primary goals of intervention also differ, with long-term personality change being cited as the primary goal of ward D12, while short-term intervention with the goal of stabilization of behaviour or medication being the primary goal at Avalon.

The types of individual intervention expected of the intern also differ slightly in these two units. An eclectic model is preferred in Ward D12, involving supportive therapy, behavioural approaches, crisis counselling and psycho-

dynamic therapy, as needed. At Avalon, crisis intervention and brief forms of therapy are expected. The intern may conceptualise her work within a Rogerian or analytic framework, but it is expected that the therapy remain fairly superficial.

Cape Town (C.T.) Neuroclinic and the Pinelands firms are located within a large psychiatric hospital, and deal with a similar range of pathology. Functional and organic psychotic disorders are the diagnostic categories most frequently seen, followed by personality disorders. Neurotic problems and mental handicap are least often dealt with. The average number of inpatients is much higher than in the treatment milieu settings; the average for C.T. Neuroclinic being 45 and for Pinelands firms, about 200.

Predictably, the goals are primarily the stabilization of behaviour or medication through short-term intervention, crisis intervention and thirdly, assessment or observation.

In terms of staff, there are more psychiatric registrars and fewer trained nurses who are actively involved in therapy in the latter placements than in the treatment milieux. Compared to C.T. Neuroclinic, there are fewer staff in relation to number of inpatients in the Pinelands firms, particularly social work and occupational therapy personnel.

The intern's caseload in C.T. Neuroclinic is approximately twice that of the interns placed at Ward D12 or Avalon (ten patients) while in the Pinelands firms the caseload is about three times that of the caseload in the treatment milieu settings (sixteen patients). In terms of time available per week for individual work with patients, the average is 20 minutes in the Pinelands firms, while it varies between 30 minutes and one hour per week at C.T. Neuroclinic, depending on the caseload at the time.

The conditions in C.T. Neuroclinic and the Pinelands firms also differ markedly in terms of activities other than individual therapy. Virtually all inpatients at C.T. Neuroclinic are involved in group therapy and about one-third are seen in family therapy by the intern. By contrast, virtually no family therapy occurs in the Pinelands firms and assessment groups for newly admitted patients were just being started at the time the questionnaires were distributed.

Supervision: Across the four placements, most of the formal supervision appeared to occur in the context of ward rounds and daily staff meetings, and was directed mainly at case management. Supervision of therapy done with inpatients varied from virtually none to one hour per week. The placements in which more time was given to this aspect were those in the treatment milieu settings, while in the two Valkenberg placements much less formal supervision time was allocated to inpatient therapy.

(Appendix III).

Conclusions:

While the four placements described above differ in various respects, certain overall trends emerge. Generally the forms of psychotherapy that the interns are expected to undertake may all be considered as short-term. Even the two "long-term therapy" patients are generally not seen for longer than one year. The bulk of the intern's work in psychotherapy is with inpatients and may last from a few weeks to a maximum of four months, when the interns rotate to another placement. A wide range of pathology may be seen, and depending on the size of the caseload, very limited time for individual work may be available in certain placements.

Some of the results presented in this chapter will be given further attention later in this thesis. For present purposes however, it is clear that the focus of this thesis should be assessment for short-term forms of intervention. Initially, however, it is important to examine quantitative research in the area of psychotherapy, particularly outcome research, in the hope that this will provide information on the relative efficacy of certain forms of psychotherapy with certain types of patients and presenting problems.

SECTION II: THE QUANTITATIVE RESEARCH

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CHAPTER TWO  
QUANTITATIVE RESEARCH IN PSYCHOTHERAPY:  
AN INTRODUCTION

In psychotherapy research the issue of criteria for assessment for psychotherapy is addressed within the body of work on psychotherapy outcome, which, according to Malan (1973), is "surely the crucial variable in psychotherapy- in the investigation of any therapeutic technique there is little point in studying other variables unless their relation to outcome can be established" (p.719). While it is not possible to provide a comprehensive review of research in this area, an attempt will be made to elucidate some of the important issues and trends that have emerged in recent years. This chapter provides some historical and methodological background to quantitative research into psychotherapy.

The Eysenck-Rachman surveys can be seen as the first comprehensive reviews of the outcome studies. In his 1952 article, Eysenck stated that two thirds of neurotics improve within two years whether they are treated or not, a provocative statement that led to a flood of publications. It is worthwhile examining some of the details of this debate here, as Eysenck's position implies that psychotherapy per se is not a very valuable enterprise. A re-examination of Eysenck's original data revealed that different percentages of improvement could be de-

rived, depending on rating of improvement and tabulation methods. It also appeared that stricter criteria for improvement were applied to the treated group than to the untreated group (Malan, 1973).

Many other criticisms of Eysenck's work have appeared in the literature, among them the fact that there was considerable variation across the studies used by Eysenck in terms of type of case, type and duration of therapy, and thoroughness of follow-up. Bergin (1971) argues that the two thirds remission rate suggested by Eysenck was not supported by the evidence and that a more appropriate figure would be around 30%. Garfield and Bergin (1978) agree with this conclusion but suggest the slightly higher figure of 43% after reviewing research in the area. The point is also made that "spontaneous remission" may in fact include improvement due to intervention by non-mental health sources such as clergymen and doctors (Garfield & Bergin, 1978, chap. 5).

An extremely important perspective was added to the picture with an article by Cartwright in 1956 who re-examined the results of Barron and Leary's (1955) study of dynamically oriented individual and group therapy. Cartwright showed that while there was no difference in the average improvement between the experimental subjects and the controls, there was a significantly greater variation in the treated patients - some of whom therefore, had

improved significantly, while others had shown greater deterioration.

Cartwright's article attracted little attention at the time, but researchers took up the issue years later. Bergin (1966) named the phenomenon "the deterioration effect", "deterioration" meaning worsening of symptoms, the development of new symptoms, or more subtle factors. Examples of such factors include the development of sustained dependency on psychotherapy, or the development of unrealistic expectations resulting in patient activities that are clearly beyond his capabilities. In support of Cartwright's work, Bergin (1966, 1967) and Truax and Carkuff (1964, 1967) showed that within results that appeared to indicate the ineffectiveness of psychotherapy, evidence for both considerable improvement and deterioration could be found. "Thus hidden in these null results, there could be found - admittedly double-edged - evidence that psychotherapy was effective" (Malan, 1973, p.721).

The evidence that psychotherapy can lead to deterioration - at least some of which could be considered to be therapist-induced - is of profound importance and lends urgency to the investigation into factors associated with success and failure in psychotherapy. In their seminal review, "Some empirical and conceptual bases for co-ordinated research in psychotherapy", Strupp and Bergin (1969) make the important point that psychotherapy is not a unitary

process being applied to a unitary problem. It is not meaningful, therefore, to ask whether psychotherapy is effective. A more appropriate line of enquiry attempts to establish the particular changes that occur through using certain modes of intervention in specific groups of patients.

Strupp and Bergin's review is of considerable relevance here; not only does it provide a critical examination of methodological problems in the area, it also reflects a certain ideological position in relation to research, which is no doubt widely held. Strupp and Bergin state that the research on outcome in psychotherapy has failed to make much of an impact on clinical practice. They feel that this can be partly explained by the deficiencies in the research, such as the lack of adequately controlled studies. A particular problem is the lack of communication among researchers, leading to lack of comparability of conceptual tools and hypotheses. There is also poor agreement on the specific aims and objectives of psychotherapy, as well as on criteria for outcome. In addition they note that the process of therapeutic change is multifactorial and that methods of criterion measurement must match this diversity. Strupp and Bergin suggest that one of the contributing factors to the disappointment with outcome studies could be that subjects were poorly assigned to different treatment modalities, with the result that important results are obscured.

Strupp and Bergin acknowledge that the phenomena under study are very complex and that it is difficult to impose rigorous designs. Results emerging from highly controlled experimental studies become difficult to relate to actual therapy situations. They nevertheless suggest moving in the direction of increased technology, in terms of optimum matching of therapist, patient, problem and technique. They clearly are in favor of the use of standardised interviewing schedules such as the Psychiatric Status Schedule (Spitzer et al., 1968).

In ultimately taking up an experimental position, Strupp and Bergin open themselves to attack from various quarters. Robbins (1969), for example, regards it as highly problematic to attempt to reduce the complexity of the psychotherapeutic dyad to a few simple dimensions. He asserts his belief that further knowledge about psychotherapy cannot come from the traditional reductionist approach, and that work in this area requires new, more holistic concepts.

Robbins goes on to comment that most investigations work on the basis of limited diagnostic considerations, usually in the form of one or two presenting symptoms. He argues that clinical psychiatry experience indicates that such symptoms as anxiety, depression and phobias are frequently symptoms of a broader disturbance, and hence that it is very important to understand the personality matrix in which a symptom develops. He suggests that the fact that

research into psychotherapy has largely failed to do this, may account for the lack of impact on clinical practice. Such research, he asserts, is simply relatively unrewarding from a clinical point of view (Robbins, 1969).

Traditional psychotherapy research is criticized from a feminist viewpoint by Klein (1967). She argues firstly that successful outcome is usually defined by a decrease of symptoms. Symptoms may in fact be adaptive, for example in a woman in an unfulfilling life situation. In the process of healthy change, such as leaving an unsatisfactory marriage, an individual may in fact experience a transient increase in distress. A symptom measure at this point would be unable to distinguish between such a case and one in which no progress had occurred.

Klein also points out that many instruments e.g. measures of self-esteem, are biased against women in various ways. Measures of adequacy of role performance are laden with problems of sex role stereotyping, so that women tend not to be evaluated outside of home-making and men are not evaluated in their caretaking roles. (Examples of such bias come from the Psychiatric Status Schedule, highly recommended by Strupp and Bergin.) Klein suggests that it is necessary to evaluate such aspects as how the individual has chosen and refined his/her roles and how role conflicts are resolved:

She concludes that traditional theory has focused on the

way individuals learn and carry out the social values; traditional therapy has been geared to helping individuals accept this. Measures have therefore been primarily concerned with assessing adjustment in terms of these norms. Feminist and humanist traditions however, are more likely to focus on individuality and to look at processes used to personalize roles and values rather than focusing on the specific content.

While Strupp and Bergin's position can be criticized on many counts, they make the extremely important point that "it is important for therapists to realise that their views of living and experiencing and their emphasis on self-knowledge and introspection are greatly determined by their own particular values and styles of living. There is therefore nothing sacred about the kinds of demands and criteria that they tend to impose upon patients" (Strupp & Bergin, 1969, p.53).

This point has relevance for various areas of research, such as the so-called dropout problem. Many researchers have put a great deal of energy into attempting to identify "dropouts" and developing methods of preventing this (e.g. Cartwright et al., 1980). Gradually other researchers have begun to suggest that many people who leave therapy after brief contact may in fact have received the optimum amount of therapy (Baekland & Lundwall, 1975). This, of course, excludes the specific problems of attrition from therapy associated with sociopathic person-

alities, alcoholics, and drug-dependent patients. There is, in fact, considerable evidence that many early terminators derive benefits from brief therapeutic contacts (Reder & Tyson, 1980; Rockwell & Pinkerton, 1982). A further point made by Strupp and Bergin is that some of the limitations in outcome research can be explained in terms of poor selection of subjects for the different forms of therapy under study. It appears therefore that the issue of selection is primary in a certain sense, and that meaningful results can only emerge through a dialectical process of research into both selection and outcome.

#### Conclusion:

It is argued in this chapter that much of the quantitative research into psychotherapy suffers from methodological flaws and ideological bias. With this caution, various areas of quantitative research will be systematically reviewed in the next three chapters. In chapter three, research is presented that has attempted to address the question of which form of intervention is most effective with which patient/type of presenting problem. In chapter four, research is examined which addresses the same question from the starting point of the patient/type of presenting difficulty. A further factor needs to be taken into account, namely the characteristics of the therapist administering the psychotherapy. Research on therapist characteristics that may affect outcome of psychotherapy is discussed in chapter five.

CHAPTER THREECOMPARATIVE RESEARCH IN PSYCHOTHERAPY

"Like beauty, therapeutic effectiveness is in the eye of the beholder. No form of psychotherapy has ever been initiated without a claim that it has unique therapeutic advantages, and no form of psychotherapy has ever been abandoned because of its failure to live up to these claims" (Parloff, 1968, in Luborsky, 1969, p.137).

In this section, conclusions emerging from research on comparisons of therapeutic conditions and modalities will be considered. The focus is on research on individual forms of psychotherapy, hence group, marital and family therapy are not given attention and conditions involving medical regimes are mentioned only briefly. In examining studies and reviews the criteria for methodological adequacy laid down by Luborsky, Singer and Luborsky (1965) were used. These include the controlled assignment of patients to the therapy conditions, the use of real patients and not volunteers or students, valid outcome measures, evaluated independently, the administration of each treatment in reasonable amount to allow benefit to occur, and many others.

Major conclusions emerging from the research:

(1) Major reviewers maintain that the efficacy of insight-

oriented therapies, client-centred therapies and behaviour therapy by comparison with "no treatment" controls, rests on a solid empirical base (Clarkin & Francis, 1982; Garfield & Bergin, 1978; Luborsky, Singer & Luborsky, 1975; Meltzoff, 1969). Important studies in this area include the following: Endicott and Endicott, 1964; King, Armitage and Tilton, 1960; Morton, 1955; Schlien, Mosak and Dreikurs, 1969 (all reviewed in Luborsky et al., 1975).

Nevertheless a fair proportion of studies in this area show no difference in outcome between treatment and "no treatment" groups. One argument that is advanced to account for this is that the so-called control groups are not in fact no-treatment groups. In many cases they are waiting-list controls, or patients receiving regular hospital care; they may have contact with researchers through testing or interviews. It is clear, therefore, that such subjects may well be receiving considerable attention and reassurance, and may therefore benefit from these non-specific effects of treatment.

The second point is made (Luborsky et al., 1975; Luborsky, 1969) that the issue of expectation of improvement is very important. Controls have no expectation of improvement is very important. Controls have no expectation of improvement and presumably would be very pleased with any sign of change. Experimental subjects, on the other hand may under-report change if it does not live up to their expectations of improvement. Both these issues

would bias research results in favour of the control groups.

(2) While the major types of therapy (i.e. insight-oriented, client-centred and behaviour therapy) have shown their efficacy over control conditions, there is very little evidence for differential effectiveness (Garfield & Bergin, 1978; Luborsky et al., 1975; Malan, 1973; Meltzoff & Kornreich, 1970; Strupp & Bergin, 1969).

It appears that as each mode of therapeutic approach has subjected its results to empirical study, positive evidence has been obtained. While considerable work was done on client-centred and behaviour therapy in the 1950's and 1960's, psychodynamic therapies, rather late in the day, derived empirical support from the Menninger and Tavistock studies (Malan, 1973).

The above conclusion is interesting in the light of the fact that early work done by behaviourists (particularly by Wolpe and Lazarus in the late 1950's and early 60's) reported very striking improvement rates and generally evoked a great deal of excitement. It became evident however, that these conclusions were based on very poorly designed studies with no controls and no independent criteria. Even some studies done later, with apparently superior research designs, have considerable flaws.

An example is Paul's study (1966), frequently quoted as

providing firm evidence for the superiority of desensitization over three other conditions: brief insight therapy, an attention-placebo condition and a "no-treatment" control group (Bergin, 1967). On closer examination it emerges that this study involves volunteers, who were all involved in a speech course. The desensitization condition was aimed at reducing speech anxiety while the insight therapy had no focus; in addition the treatment period was limited to five sessions. It is evident that this study does not meet at least two of the criteria laid down by Luborsky et al. (1975) i.e. that the treatment conditions being compared should be equally valued (clearly in this study the desensitization condition offered far more to the subjects than did the insight therapy condition), and that a reasonable length of time be given for each treatment modality to demonstrate positive effects.

Similar problems characterized five out of the six studies reporting superior effects of behaviour therapy that were included in the review by Luborsky et al. (1975). It is not the intention here to argue that there is no evidence for the usefulness of behavioural techniques with certain problems, but simply to point out that the original claims were somewhat inflated.

At this point I would like to turn to the actual evidence for differential effects of treatment modality. First, there is considerable evidence that combined administration of psychotherapy and a medical regime is very much

more effective in treating psychosomatic conditions than either psychotherapy or pharmacotherapy alone (Luborsky et al., 1975). Secondly, the major reviewers mentioned above agree that there is evidence that behavioural techniques (particularly systematic desensitization) are especially effective with circumscribed phobias, some sexual dysfunctions (Luborsky et al., 1975), and certain obsessive-compulsive conditions (Garfield & Bergin, 1978). Operant conditioning has also been found to produce improvement in the social behaviour of institutionalized subjects (Bergin, 1967).

Despite Wolpe's original claims that behavioural techniques are highly effective with more complex neuroses, there remains little evidence for this. In this respect some interesting findings emerged from a study by Gelder, Marks and Wolff (1967), referred to by Strupp and Bergin (1969). In this study, patients with phobias, anxiety and depression were examined, and it was found that systematic desensitization was more effective than psychoanalytically-oriented therapy in reducing the phobic symptoms. It was also found, however, that when patients with more complex or severe symptomatology were studied, and when criteria measuring anxiety and depression were used as outcome indices, differences between the treatment types did not appear.

The results presented above, while useful, appear rather meagre when one considers the amount of energy and resources

that have been invested in this area of research. The non-significant results are all the more impressive when one takes into account the fact that many of these studies are undertaken by partisans of one of the modalities under examination. In addition, researchers and editors tend to hesitate about publishing studies with non-significant results.

One way of understanding this phenomenon is offered by Luborsky et al., (1975). They suggest that much of the improvement that occurs in psychotherapy is due to non-specific therapeutic variables, that is, nonspecific to any particular approach. Statistically, then, considerable improvement would appear across all approaches, making it extremely difficult for various modes of therapeutic intervention to demonstrate differential effectiveness over and above this.

A considerable volume of research has been done in the area of nonspecific therapeutic variables, and some of the more interesting points will be briefly discussed. It is recommended that the interested reader refer to the authors mentioned here for more detailed information.

A point made by many workers in this field is the fact that in all forms of intervention, the patient enters into a relationship with a therapist. Assuming that the therapist is reasonably competent, this relationship can be described as a constructive one, providing the patient

with a sustained experience of contact and commitment to another person (Frank, 1979; Hobbs, 1962; Marmor, 1979). It is hypothesized that within this professional relationship the patient can risk intimacy, receives strong positive reinforcement and hence has an important learning experience which will then extend to relationships outside therapy. There is some evidence that therapy is related to increased social effectiveness (Frank, 1975).

Further important points are made by Hobbs (1962). He suggests that another nonspecific therapeutic variable is the opportunity offered the patient to divest symbols of their potential to cause anxiety/discomfort. While this process is frequently understood in terms of the development of insight, Hobbs argues strongly for a learning theory model and provides an intriguing critique of the concept of "insight". He ultimately argues that the content of the "insight" is unimportant, and that the real value lies in providing the patient with a conceptual framework that will allow him to experience a feeling of control over his life. All psychotherapeutic approaches attempt to provide such a framework. This argument is supported by Garfield (1974).

Obviously, many other factors that appear to be non-specific are given attention in the literature. Among these are: the placement of the locus of control in the patient (Hobbs, 1962) which seems similar to Frank's (1974) description of the importance of the patient de-

veloping a sense of mastery over his problems. Marmor (1979) regards emotional catharsis as an important non-specific factor, as well as the process of identification with the therapist. Expectancy of therapeutic gain is widely referred to as an important factor (e.g. Wolberg, 1977) but has been subjected to a hardhitting conceptual and empirical critique by Wilkins (1973). The claim of the client-centred theorists that their concepts of empathy, warmth and genuineness have wide applicability as therapeutic factors has also been challenged (Garfield & Bergin, 1971).

While the study of nonspecific therapeutic factors has obvious appeal, its relevance here rests on the assumption that the null findings in studies on differential effects of psychotherapies can be taken at face value. However, an important point made by Strupp and Bergin (1969) and Frank (1979) is that differences may be obscured through the use of patient groupings and techniques that are too heterogeneous. Patients are frequently described simply in terms of diagnostic classification or the nature of the presenting problem. It is quite evident that individuals with very different personality characteristics can be encompassed within such groupings. Thus, many important variables are simply not taken into account. Strupp and Bergin point out that labels such as "client-centred" or "behavioural" provide only gross information about what the therapist actually does. (Frank's seminal work on reinforcement in Rogerian psychotherapy, 1966,

brings this point home.)

It is evident that unambiguous and detailed definitions should be provided when referring to any form of therapy. For the purposes of this thesis, Wolberg's categories of psychotherapy (1977) will be utilized. This system permits many forms of individual intervention to be subsumed under three main headings, and provides adequate definitions of the techniques and approach employed in each category.

#### 1. Supportive Therapy:

The primary goal in supportive intervention is to return the individual to a state of equilibrium - generally his previous best level of functioning. The focus is on removal or amelioration of symptoms, and hence on the strengthening of existing defences. Attempts may also be made to develop more effective means of maintaining control. The techniques that may be employed include guidance and advice, environmental manipulation and reassurance. Medication and relaxation techniques are frequently used as adjuncts.

#### 2. Re-educative Therapy:

The aim here is to modify maladaptive attitudes and inappropriate goals. This involves the patient developing an awareness of some of his ways of reacting; then with the help of the therapist, examining which of these are adaptive and which are not. This understanding is then

applied in modifying the behaviour so as to allow more flexible and creative modes of thinking and reacting. Wolberg includes client-centred therapy here as well as all forms of behaviour therapy. This grouping is somewhat gross; it may be useful to consider the categories offered by Beutler (1979), according to which client-centred therapy is considered an "affective-insight" approach, i.e. one which focuses primarily upon current emotional experiences of the patient. This is distinguished from behavioural treatments such as systematic desensitization, aversive therapy and "cognitive modification" approaches such as anxiety management and assertiveness training.

### 3. Reconstructive Therapy:

In many ways this is the most ambitious of the approaches, aiming at the development of "insight into unconscious conflicts, with efforts to achieve extensive alterations of character structure" (Wolberg, 1977, p.15). This approach attempts to examine the source of the presenting problem rather than focusing mainly on its effects. The uncovering of childhood conflicts, and relating these to present problems and to the relationship with the therapist, are core elements of this approach. Forms of psychodynamically oriented psychotherapy would fall into this category.

Conclusion:

It appears from this literature review that various commonly used forms of psychotherapy have been shown to be more effective than no treatment. The evidence for differential effectiveness of specific forms of psychotherapy for specific problems is presented in this chapter. These positive findings are relatively meagre and apply only to certain circumscribed disorders. Methodological problems are considered to account in large measure for this scarcity of definitive results. One of these methodological problems is inadequate specification of treatment modalities, and a system according to which various forms of psychotherapy may be categorized, is presented for use in this thesis.

CHAPTER FOURTHE RELATIONSHIP BETWEEN PATIENT CHARACTERISTICS AND  
OUTCOME IN PSYCHOTHERAPY

Frank (1979) suggests that much of the outcome work indicates "that more of the determinants of therapeutic success lie in the personal qualities of the patient and the therapist and in their interactions than in the therapeutic method" (p.311). This view is thoroughly compatible with the conclusions reached at the end of the previous chapter. In this chapter, some research into the relationship between patient variables and outcome in psychotherapy will be reviewed. The volume of work in this area is staggering. This has two implications for this thesis. First, only certain areas have been covered. Obviously the areas that appear to have produced the most valuable results have been selected. Secondly, considerable reliance on reviewers was unavoidable. This is problematic as reviewers cannot but report selectively. Attempts were made to refer to original work wherever possible.

Diagnosis:

The relationship between diagnosis and psychotherapy outcome has traditionally been regarded as an important one. As Bloch (1979a) points out, clinical experience has led to the postulation of contraindications to psychotherapy, which may be expressed in the form of diagnostic categories. Organic brain syndromes, acute psychoses, severe

personality disorders, drug addiction and some sexual deviations tend to be seen as poor risks for intensive psychotherapy. Similarly, Hildebrand's exclusion criteria (Malan, 1979, p.225) include patients who have undergone long-term hospitalization or more than one course of electro-convulsive therapy (E.C.T.), which effectively excludes chronic schizophrenic and manic-depressive patients.

Two points are worth noting here. Firstly, these exclusion criteria apply to intensive, or reconstructive forms of psychotherapy and there is considerable evidence that other forms of intervention are useful with such disorders (to be discussed below). Secondly, diagnostic categories alone tend to be seen as a rather restrictive framework and various factors such as the severity of the disorder and its duration, are crucial in terms of predicting response to treatment of any kind. These points should be borne in mind while reading this section, in which the research on the relationship between diagnosis and outcome will be discussed in terms of psychotic and non-psychotic disorders.

(i) Psychotic disorders:

In several studies psychotic trends have been found to be associated with low levels of improvement in psychotherapy (Luborsky, Chandler, Auerbach, Cohen & Bachrach, 1971). These authors point out that the distinction between the process and non-process types of schizophrenia is important

for outcome, non-process schizophrenia having a better outcome. Meltzoff and Kornreich (1970) report however, that the majority of studies using psychotic subjects have produced positive results. They state that traditional forms of intervention (i.e. verbal, insight-oriented psychotherapy) have not been shown to be of particular benefit to schizophrenics, but other approaches have shown success. They cite group approaches (Peyman, 1956; Tucker, 1956) and supportive approaches (Dreiblatt & Weatherley, 1965; Zirkle, 1961).

Rogers and his associates (1967) found small but significant differences in the improvement of a group of hospitalized schizophrenics who were given client-centred therapy, compared to a schizophrenic group receiving hospital care only. The treated group showed more favourable discharge rates, were more successful in maintaining themselves out of hospital and showed significant improvement in the appropriateness of their emotional expression.

It is not possible within the scope of this thesis to review all the forms of intervention that have shown some promise in terms of helping schizophrenic patients. The interested reader is referred to King, Armitage and Tilton (1960), who outline an operant-interpersonal method, and to the comparative investigations of various approaches to schizophrenia by Marks, Sonada and Schalock (1968) and Appleby (1963). The use of phenothiazine adjuncts has been strongly supported (Bellak, in Karasu & Bellak, 1980; Grinspoon, Ewalt & Shader, 1968).

In discussing the psychotherapy of the depressed patient, Mendelson (in Karasu & Bellak, 1980) points out that many authors have advocated analytic therapy in cases of severe depression. He also cites the work of Abraham (1927) who, however, advocated that such treatment should occur between psychotic episodes in view of the difficulties in making contact with severely depressed patients. According to Mendelson, Fenichel (1945) expressed similar views, and pointed out that while the patient was psychotic the analysis could not continue but that the patients appeared to derive support from having a listener. In the terms employed in this thesis, a supportive rather than a reconstructive mode of intervention seems indicated with a depressed patient who is acutely psychotic.

Mendelson cautions that psychoanalytically orientated psychotherapy appears to be less successful in chronic conditions. (It needs to be noted that forms of therapy other than psychoanalytic ones are mentioned by Mendelson; Beck's cognitive approach (1967, 1973) being an important one.) Mendelson also maintains that the manifestation of vegetative symptoms (such as early morning wakening, loss of weight and appetite, psychomotor retardation) is an indication for the concomitant use of antidepressant medication. Arieti (1982) also acknowledges the usefulness of drug treatment while maintaining that the intensity of the depression is not a contraindication for psychotherapy. Mendelson makes explicit the importance of careful assess-

ment of the risk of suicide. This will be given further attention in chapter eight. Various interesting papers on the treatment of depressed and suicidal patients appears in the Fifteenth Emil A. Gutheil Conference (1975). The papers by Toolan, Lesse and Kiev are particularly useful. Detailed discussion of the psychodynamics and psychotherapy of the depressed patient may be found in Arieti and Bemporad (1978).

Patients diagnosed as having borderline personality disorders are widely considered as being at risk for negative response to therapy (Garfield & Bergin, 1978; Wolberg, 1977). Friedman (1969) writes cogently about the potential problems of dealing with a borderline patient in an intensive milieu setting, which he maintains may often intensify disruptive behaviour. He maintains that firm limit-setting and consensus among all the staff involved is essential for success with this type of patient.

Kernberg (Karasu & Bellak, 1980) reports that various investigations indicate that interpretive or re-educative methods are more effective with borderline patients than a purely supportive approach. He goes on to discuss the possibility of a "transference psychosis" occurring which is defined as "the loss of reality-testing and the appearance of delusional material within the transference that does not affect very noticeably the patient's functioning outside the treatment setting". (Karasu & Bellak, 1980,

p.99). He points out the difficulty of distinguishing such a reaction from a broader psychotic breakdown, and while maintaining that hospitalization may be necessary, feels that it is often possible to resolve the transference psychosis in the sessions. In his discussion it is clear that Kernberg assumes a considerable level of skill, training and experience on the part of the therapist. It would appear that a trainee would be unwise to undertake an ambitious form of therapy with a borderline patient, unless in the context of very close supervision.

(ii) Nonpsychotic disorders:

There is no evidence for different prognostic significance among various nonpsychotic diagnoses (Bloch, 1979a), although certain types of problems are traditionally seen as poor therapeutic risks; antisocial behaviour problems certainly fall into this category. Meltoff and Kornreich (1970) however maintain that controlled experiments with antisocial behaviour have produced results that are "overwhelmingly positive" (p.208), and cite Arbuckle and Boy (1961), Massimo and Shore (1963) and Persons (1965, 1966, 1967). The authors do present studies that produced null results, one of which is the eight-year long Cambridge-Somerville Youth Study (Teuber & Powers, 1953). Another category that tends to be associated with poor outcome is that of drug addiction. Baekland and Lundwall (1975) point out that the problem of drop-outs in this group is much greater when they are not dealt with in a specialized unit. Once again it is clear that factors other than

nosological ones are crucial for positive outcome.

Factors related to the illness/disorder:

(i) Severity of maladjustment: Meltzoff and Kornreich (1970) point out that there are contradictory findings in the literature. They quote several studies that indicate that patients who are initially better integrated are more likely to improve (Barron, 1953; Katz, Lorr, & Rubinstein, 1958), as well as a number of other studies that show no difference in terms of initial disturbance (e.g. Cappon, 1964; Frank, Gliedman, Imber, Nash, & Stone, 1957; Marks & Gelder, 1965; Page, 1953).

Meltzoff and Kornreich go on to present the more complex findings of Gottschalk, Mayerson and Gottlieb (1967). In investigating patients attending an emergency brief therapy clinic, they found that those patients with an initially high level of malfunctioning (on the Psychiatric Morbidity Scale) were more likely to show malfunction at the end of treatment. The interesting finding was that it was these same patients who showed the greatest degree of change during treatment.

At follow-up (3-7 months), initial level of impairment was not related to outcome. Other studies have also suggested that the greatest change is found in the most severely disturbed patients. Meltzoff and Kornreich cite several such studies, including Meltzoff and Blumenthal (1966)

and Levis and Carrera (1967).

The above reviewers conclude that a possible reason for the diversity of results in this area is that "severity of maladjustment" is looked at in terms of very different things, such as symptom intensity, duration and pervasiveness, to performance on psychometric tests. Many investigators confuse personality assessments indicative of maladjustment with high initial distress ratings. They suggest that research needs to address itself to specific hypotheses, and regard the following as the five general possibilities: (1) Both groups (i.e. the initially well adjusted and the initially poorly adjusted) improve but the latter improve more, although never reaching the level of the former. (2) Both groups improve but the first group improves more or faster. (3) The first group improves, while the second one remains the same or deteriorates. (4) The second group improves, and the first group does not, or deteriorates. (5) The two groups improve in parallel; those who are initially better adjusted remain so at the end.

Work on the problem of deterioration in psychotherapy seems to indicate that severely distressed patients are more likely to deteriorate. Some studies indicate however, that this may not be a simple and direct relationship. Yalom and Lieberman's study of outcome of group therapy (1971), for example, indicated that patients who deteriorated were not only more disturbed, but also had higher anticipation

of gain from therapy. The investigators hypothesized that patients who are at risk for deterioration are those who have strong needs for therapy but who are unable to achieve their goals due to lack in social skills and other abilities that are required for success in therapy.

It seems likely therefore, that severity of maladjustment interacts with other factors in affecting outcome in therapy. The research in this area is far from providing unequivocal results, not only because of the lack of specificity mentioned above, but also because of other methodological flaws. Garfield (in Garfield & Bergin, 1978) for example points out that it is insufficient simply to report a statistically significant change on some instrument before and after therapy. This change must be demonstrated to be practically significant.

Gurman and Razin (1977) suggest that the methods of Malan and his colleagues (Malan, Heath, Bacal & Balfour, 1978 in Gurman & Razin, 1977) are more thorough. They examine change both in terms of symptomatic and dynamic criteria.

(ii) Duration and course of disorder:

Meltzoff and Kornreich cite studies (e.g. Frank et al., 1957) which found that patients with disturbances of short duration do better in therapy, but they also note that other researchers, notably Swensen and Pascal (1954) and Marks and Gelder (1965) did not find duration to be related to outcome. Swensen and Pascal however, in a continuation of the abovementioned study, found that more sudden onset is

associated with better outcome in psychotic patients.

Wolberg (1977) maintains that the more chronic the disorder, the poorer the prognosis. He defines chronicity as duration of more than five years and qualifies his statement by saying that some disorders which have continued for more than this period may be very resistant to therapy. Bloch (1979a) cites Dewald's work which indicates that a longstanding condition which has shown fluctuation is much better prognostically than an entrenched one. This has had some support from other investigators (Bloch, 1979 a).

(iii) Type of presenting symptoms:

According to Bloch (1979a) several studies indicate that high levels of anxiety, depression or anger at the beginning of therapy are positive prognostic signs (also reported in Frank, 1974; Garfield & Bergin 1978; Luborsky et al., 1971). Important in this regard is the work of Truax and Carkuff (1967), who distinguished "felt" disturbance from overt behaviour disturbance. They suggest that patients with high levels of 'felt' or subjective disturbances, and low levels of behavioural disturbance should have the most favourable outcome in therapy, "i.e. the more promising patient tends to be anxious and dissatisfied with himself yet is able to meet life's basic demands" (Bloch, 1979 a).

It does seem that low levels of anxiety or depression are

related to dropping out of treatment (Baekland & Lundwall, 1975). It is possible that the higher level of affect means that the patient is showing a reaction to a situational stress (and hence is not severely impaired in terms of overall adjustment), or it is possible that motivation is heightened because of a higher level of distress. According to Meltzoff and Kornreich (1970), there is considerable evidence for the latter hypothesis. Among other studies they cite Katz, Lorr and Rubinstein (1958) and Gottlieb, Mayerson and Gottlieb (1967).

Garfield and Bergin (1978) make the important point that while anxiety at the beginning of treatment appears to be a good prognostic sign, this obviously depends on the type and severity of the anxiety as well as the stimuli that affect it. (This applies to depression as well. Baekland and Lundwall, 1975, report that very depressed patients with a primary diagnosis of depression are at risk for dropping out of treatment.)

Bloch (1979a) reports several studies that indicate that complaints of somatic symptoms are a poor prognostic sign (Frank, 1974; Stone, Frank, Nash & Imber, 1961). This does not include psychosomatic conditions. There is evidence that some psychosomatic conditions, e.g. peptic ulcer, asthma and migraine are more responsive to treatment than others, e.g. hypertension. Furthermore, there is considerable variation in response within these groups.

There is some evidence, therefore, that the type of symptoms presented by the patient may have prognostic significance. It is interesting however, that Frank (1974) concludes that prognosis largely depends, not on symptomatology, but on the individual's coping capacities and the extent to which the stress that led to him seeking treatment can be modified. There is some evidence, however, that both these variables, symptomatology and coping capacity, may vary in their relationship to outcome depending on the sex of the patient (Distler, May & Tuma, 1964). This suggests that a complex interactive situation may exist.

#### Therapy-related factors:

##### (i) Motivation:

Therapists generally agree that this is a vital factor (Bloch, 1979a; Wolberg, 1977). Baekland and Lundwall (1978) found that drop-outs tend to be poorly motivated. Despite this, contradictory results have emerged, and Meltzoff and Kornreich (1970) conclude that motivation at the beginning of treatment is not as important as the development of motivation. This will be pursued further in chapter eight.

##### (ii) Expectancy: There are two aspects here.

a) Expectation of improvement: Wilkins (1973) provides a useful review of work in this area. He points out that much of the research, in which

expectation of improvement was positively related to outcome, depended on patient self-ratings. When behavioural ratings were used as outcome measures, the relationship between expectation and outcome was not significant. This is obviously problematic, and Wilkins concludes that this concept is poorly founded empirically.

- b) Expectation of participating in a particular therapeutic process: There is considerable evidence that patients' expectations of the therapeutic process is important and hence that exploration of expectations should occur during assessment. Much of this work is based on experiments with Role Induction Interviews and will be discussed later in this chapter when social class of the patient is examined.

Demographic and other factors not directly associated with the disorder:

A great deal has been written on the relationship between demographic and general personality variables and outcome in therapy. A comprehensive review is beyond the scope of this thesis, but an attempt will be made to draw out some of the main lines of investigation in this area. Reviews are cited to which the interested reader should refer.

(i) Age:

According to Meltzoff and Kornreich (1970), no relationship between age and outcome in psychotherapy has been demonstrated. They cite various studies in which this conclusion has been reached, including Seeman (1954), Cartwright (1955), Friedlander and Kaplan (1956), Rosenthal and Frank (1958) and Rachman (1965). Special mention is made of Cabeen and Coleman (1962), who examined a very broad age range.

According to Meltzoff and Kornreich, some studies reported that younger patients had a better prognosis, but these reviewers report that these studies tend to have serious flaws, such as concurrent physical treatment or small sample size. These reviewers also cite studies that concluded that older patients have a better outcome. All of these results, however, emerge from studies that were not designed specifically to examine the variable of age. As a result, various flaws are common, particularly the problem of systematic selection bias. Clinics and therapists tend to select younger patients (Meltzoff and Kornreich cite several studies that show this) hence those older patients who are selected may well have special attributes. Such factors have to be controlled before any conclusions can be drawn. A more general criticism of work in this area is that various investigators tend to use different age groupings, making comparison difficult.

It certainly is a commonly held opinion that older people are inflexible and more resistant to change (Garfield & Bergin, 1978). Yesavage and Karasu (1982) maintain, however, that not all older patients have a rigidity that prohibits work or change, and that it is problematic to assume that this is physiologically based. They report that there is some evidence for decreased resistiveness among the aged for example, who have the need to integrate and consolidate emotional experience.

Yesavage and Karasu and Garfield and Bergin suggest that reconstructive modes of intervention may not be suitable for older patients, mainly in view of the increased amount of material that requires working through. Even this statement may be too general. Bloch (1979<sup>a</sup>) and Wolberg (1977) conclude that age, per se, does not seem to bear a relationship to outcome and that it is crucial to take into account the intimately associated factors of flexibility and opportunities for readjustment. Perhaps as Garfield and Bergin (1978) suggest, attempts to relate age to outcome in an abstract way should be abandoned in favour of an attempt to "specify a particular age in relation to a particular therapy and with full awareness of the other potential factors that may play a possible role in outcome" (p.213).

(ii) Sex and marital status:

While there have been certain studies suggesting that there may be interactional effects relating to sex/marital status

of the patient and that of the therapist (Bloch, 1979a), Meltzoff & Kornreich, 1970), there does not seem to be evidence for a relationship between these variables and outcome (Cartwright, 1955; Garfield and Bergin, 1978; Meltzoff & Kornreich, 1970).

(iii) Social class:

Work in this area, which is particularly relevant in the South African context, makes fascinating, if somewhat complicated reading. Much of the work takes the form of statistical results with little attempt to evaluate various possibilities that might give rise to such results. An exception is the review by Jones (1974) and for a critical examination of the role of ethnic and socio-economic factors in psychiatry, the reader is referred to Littlewood and Lipsedge (1982).

A seminal study in this area was undertaken by Hollingshead and Redlich (1954) whose work is reviewed by Meltzoff and Kornreich (1970). Among these findings was the fact that referral for psychotherapy differed for various social groups, so that, for example, 85.9% of the lower class patients were referred by legal sources, while 27.6% of the two upper classes were referred by such sources (Meltzoff & Kornreich, 1970, p.238). There is evidence that higher status patients are more readily accepted for psychotherapy (Garfield & Bergin, 1978; Jones, 1974). Jones (1974) reports that some, but not all studies find that higher status patients are assigned to more experienced

therapists. Meltzoff and Kornreich (1970) also report studies indicating that the experience level of the therapist differs with social class of the patient, and that lower class patients experience more delay in being assigned. Another very significant finding by Hollingshead and Redlich (1954) was that patients from higher social strata receive more psychotherapy than those from lower classes, with the inverse being true for drug treatment. Within the category of psychotherapy more intensive forms of therapy tend to be given to higher class patients (Bloch, 1979a; Meltzoff & Kornreich, 1970).

In examining these findings, Jones (1974) points out that the more severe disorders are generally regarded as poor prognostic indicators for psychotherapy. He goes on to say that there is evidence that diagnostic procedures, particularly using psychometric tests, influence the clinician to diagnose lower class patients as more severely ill. Hollingshead and Redlich found three times the frequency of diagnoses of psychotic disorders in the lower classes than in the upper. Jones maintains that psychosis is not in fact more common among lower class individuals but that there is a basic assumption among mental health personnel that middle-class values in themselves indicate better prognosis and less pathology. He discusses how such factors as motivation and psychological-mindedness tend to be assessed according to values and assumptions that tend to disadvantage lower class patients.

Jones goes on to point out that these assumptions lead to a circular argument - less intensive treatment is provided, less improvement is seen, and the original assumptions are confirmed. He points out that social class attainment itself, if taken as an index of health or pathology, assumes that one's society is an open one, allowing ready movement in social status providing one shows sufficient merit - an assumption that he describes as blatantly untrue. Jones, interestingly, is writing about America.

It appears then that patients from lower socio-economic backgrounds are discriminated against in terms of acceptance into psychotherapy. It seems furthermore, that patients from lower classes tend to reject therapy (e.g. refusing any contact, making an appointment but not keeping it, not coming after the initial interview) (Baekland & Lundwall, 1975; Bloch, 1979a; Garfield & Bergin, 1978). Work on continuation in therapy indicate that lower class patients are more likely to drop out (Jones, 1974) even when experience level of the therapist is controlled for.

These findings can be interpreted in a number of ways. Bloch (1979a) comments that there are likely to be problems in the interaction between (usually) middle class therapists and lower class patients. The therapist, for example, may convey a lack of enthusiasm or optimism which influences the patient's motivation to attend. This argument of course cannot account for the tendency to refuse any contact, which

is also found among lower class patients. The whole practice of psychotherapy, however, is traditionally associated with the values and life-style of the middle and upper classes. This fact, and the fact that the vast majority of practitioners of psychotherapy are middle class, cannot escape the attention of the lower class patient, even prior to any contact.

Furthermore, the work on continuation in psychotherapy is based on rather problematic assumptions. Investigators in this area frequently take continuation or lack thereof as an outcome measure. While many investigators have found a positive relationship between length of treatment and outcome, this may well be related to assumptions on the part of the therapists (who frequently are the raters of improvement) that real and lasting change can only occur after a certain length of time.

While this assumption may hold true in certain cases, some investigators have found a curvilinear relationship between length of therapy and outcome. Cartwright (1955) found a "failure zone" which ranged around 17,5 interviews; this was interpreted as indicating that there are successful short-term and long-term patients with some potential long-term patients tending to drop out. Cartwright hypothesized that the short-term patients were those with situational problems and the long-term ones had more deep-seated personality problems. Jones (1974) suggests that lower class patients may frequently present with situational

problems related to such factors as social problems, housing and employment. Jones suggests that such patients are frequently in need of information and advice, and despite negative attitudes from mental health personnel, may still derive a good deal from psychotherapy.

Mutuality of expectations has been found to relate to continuation in psychotherapy (Jones, 1974). Jones cites a study by Heine and Trossman (1960), which concludes that a higher frequency of incongruence with regard to expectations occurs with lower class patients and that this may lead to earlier termination.

Many investigators have found that lower class patients expect advice, guidance and/or medication rather than emotional exploration (Garfield & Bergin, 1978; Meltzoff & Kornreich, 1970). This finding is not unanimous, however. Meltzoff and Kornreich report the findings of White, Fichtenbaum, Cooper and Dollard (1966) who conclude that amount of physiological focus does not vary with social class. Similarly, Jones cites the study by Goin and his colleagues (1965) who found that 52% of their lower class patients wanted insight-oriented therapy. Similar results have been found with the criterion of verbal expression (Jones, 1974).

Various researchers have suggested alterations in technique with lower class patients, particularly the introduction of guidance, role-play and other more directive

techniques rather than dynamic approaches. As Jones (1974) points out, this fails to take expectation and other needs into account. Some middle class patients would benefit from these techniques, while some lower class patients would not.

It appears that if the patient does present with unrealistic expectations of psychotherapy, they can be modified. The work of Hoehn-Saric, Frank, Imber, Nash, Stone and Battle (1964) is very important in this regard. These investigators showed significant improvement on various criteria when a Role Induction interview was given to patients prior to therapy. This interview involves (1) a general discussion of therapy, (2) an outline of expected behaviour of the patient and the therapist, (3) preparation for certain phenomena such as resistance, and (4) an indication that improvement is unlikely to occur before four months. Garfield and Bergin (1978) refers to researchers who report similar interventions.

It is hardly surprising, given the number and complexity of factors that influence the lower class patient who enters psychotherapy, that contradictory results emerge when outcome is related to social class. (Bloch, 1979 a ; Garfield & Bergin, 1978; Luborsky et al., 1971; Meltzoff & Kornreich, 1970). Jones (1974) suggests that patient-therapist matching on demographic variables may enhance outcome with lower class patients. He argues strongly that responsibility is seldom assumed by mental health

professionals for their difficulty in empathising and communicating with lower class patients, and looks at factors that seem to make therapists more suitable for working with lower class patients. Personal therapy experience on the part of the therapist for example, seems important (Jones, 1974).

(iv) Intelligence and education:

A positive relationship between intelligence and therapeutic outcome is found in several studies (Luborsky et al., 1971; Meltzoff & Kornreich, 1970) but the relationship does not appear to be a simple linear one. Meltzoff and Kornreich quote a study by Thorly and Craske (1950) who found that below-average intelligence was clearly a disadvantage in terms of outcome but did not find that superior intelligence necessarily was related to better outcome. Wolberg (1977) agrees, stating that borderline intelligence or mental handicap will make any techniques other than supportive ones difficult, but also stating that high intelligence is not necessarily correlated with positive outcome.

It is suggested that intelligence may bear a stronger relationship to outcome in certain forms of psychotherapy, notably verbal-insight approaches (Garfield & Bergin, 1978; Meltzoff & Kornreich, 1970). Cabeen and Coleman (1962) found however, that intellectual defences can slow the process of change (quoted in Meltzoff & Kornreich, 1970). It appears therefore, that lack of intelligence will affect

some forms of psychotherapy more than others, and that other personality factors (such as defensiveness) interact with intelligence in affecting outcome.

Garfield & Bergin (1978) report that many investigations into the relationship between educational level and outcome have found a positive relationship, but that many of these studies have methodological flaws. Meltzoff and Kornreich (1970) maintain that there is little adequate research testing the relationship of education to outcome and conclude that there is probably a complex relationship with other variables. Certainly, in the South African context, social and political factors have a tremendous impact on education, and this author agrees with Bloch (1979a) that it is probably more important to investigate ways of preparing the patient for therapy than to attempt to establish the basic levels of intelligence and education that are needed.

Many other personality factors have been studied in relation to outcome and it is impossible to give them more than a passing mention in this thesis. Luborsky et al., (1971) report that ethnocentrism is a negative predictor of outcome and that the number of social achievements is a positive predictor. Ego-strength, which is often regarded by clinicians as directly related to prognosis (Bloch, 1979a) will be discussed in chapter eight.

Patient characteristics elicited by psychological tests:

In discussing the Menninger Foundation Project, Garfield and Bergin (1978) report that these investigators found clinical appraisals of ego-strength to be positively correlated with measures of global improvement. Two major scales have been developed attempting to tap this variable: The Klopfer Rorschach Prognostic Rating Scale (RPRS) and the Barron Ego-strength Scale. The latter has been subjected to considerable criticism (Garfield & Bergin, 1978; Meltzoff & Kornreich, 1970) and contradictory results have emerged from its use. The RPRS seems to be more strongly supported although there appear to be some problems in practical utility. In addition there is the question of whether it can exceed base rates as a predictor. Generally it is reported that the RPRS can predict outcome in about two thirds of cases - this level could well be achieved without any instrument (Garfield & Bergin 1978).

A major drawback to these two scales is that both derive from other instruments (the RPRS from the Rorschach, Barron's Scale from the Minnesota Multiphasic Personality Inventory - MMPI) and were initially designed to predict outcome. Only later were they labelled as ego-strength scales (Bloch, 1979a). It generally appears, therefore, that attempts to operationally define and measure ego-strength using a psychometric instrument have been unsuccessful thus far.

Meltzoff and Kornreich cite many studies that attempt to isolate single Rorschach determinants of outcome and report contradictory findings, with cross-validation being rare. As we might expect from the discussion of the relationship between intelligence and outcome, studies examining IQ and response to therapy produce inconsistent results (Garfield & Bergin, 1978). Fulkerson and Barry (1961) conclude that the commonly employed one-stage design, in which a potential predictor is correlated with an outcome measure, is inadequate. They suggest that factors such as duration, severity and type of onset of the problem bears more relation to outcome than do test results.

#### Life circumstances:

Life circumstances and events have major and continual effects on any individual. Researchers into psychotherapy need to be aware that therapy occurs in a context and that "many of the determinants of outcome lie outside the patient-therapist dyad, and therefore no matter how sophisticated the focus on it, important sources of variance will be missed" (Frank, 1979, p.314). Factors in the patient's life are especially important with respect to maintenance of change.

Relatively little research has been done in the area of life circumstances and their effect on prognosis, and one has to rely mainly on clinical lore (Bloch, 1979 a). It is generally felt that a patient in the middle of any type of life crisis will not be suitable for therapy requiring

systematic and extended work. Bloch (1979a) suggests that a crisis intervention approach is more appropriate, with referral for therapy after the crisis if necessary. A patient who is in an unresolvable difficult situation will probably gain more from a supportive approach than a reconstructive one. Wolberg (1977) supports this view, citing such problems as economic stress, poor housing, disrupted routine, discord or violence as having a negative effect on prognosis. He includes discrimination on racial grounds here.

Sargent, Modlin, Faris and Voth (1958) point out however, that the patient's personality may play an important role on the creation of his life situation. These authors report on the method of evaluation of situational factors used in the Menninger Foundation Project. This method includes, among other factors, an evaluation of the amount of support offered by the patient's life situation, the extent to which problems in the patient's life coincide with his/her areas of conflict, and the degree to which the external problems are mutable.

#### Conclusion:

It is clear from the foregoing discussion that a wide range of patient characteristics are related in various ways to the issue of outcome in psychotherapy. The review provided here is necessarily limited, but some tentative conclusions may be drawn. First, certain

factors do not appear, in themselves to be related to outcome; these include sex, marital status, and more unexpectedly, age. Secondly, it appears that it is important to consider the psychiatric diagnosis given the patient. A diagnosis of an organic brain syndrome contraindicates psychotherapy as the primary intervention. A diagnosis of a chronic psychotic disorder, a severe personality disorder, a sexual deviation or drug addiction indicate that the patient is a poor risk for reconstructive forms of intervention undertaken by a trainee. In addition, the diagnosis alerts the therapist to specific problems, such as the risk of suicide in depressed patients, and the possible need for a specific treatment setting for drug addicts and some borderline patients.

Certain other factors appear to be important in facilitating or hampering psychotherapeutic intervention. Below average intelligence is regarded as a disadvantage for therapy, particularly reconstructive forms. Chronic disorders, i.e. disorders that have existed over several years, seem not to respond well to psychotherapy. Furthermore, low levels of motivation and the presence of difficult and unresolvable life circumstances mitigate against success in psychotherapy, particularly when fundamental changes are required.

It is clear from the above that the relationship between various patient variables and outcome cannot be considered in isolation. Depending on the type of intervention employed,

various factors have greater or lesser significance. Furthermore, it is likely that there are complex inter-relationships between patient variables. The factor of severity of maladjustment, for example, appears to have an important bearing on outcome, but contradictory results have emerged from research in this area. Methodological problems may account for this to some extent, but it is also likely that additional patient factors, particularly relationship skills, need to be considered in combination with severity of maladjustment, in order for meaningful predictions of outcome to be made.

A further example relates to high initial levels of anxiety or depression, which are widely regarded as good prognostic signs. Once again there is evidence that other patient factors play an important interactive role, particularly the ability on the part of the patient to cope with his/her responsibilities despite high levels of discomfort. It is worthy of note that the ability to cope adequately under stress is an indication of high ego-strength (Wolberg, 1977), as is the presence of relationship skills, which was mentioned earlier. It seems therefore, that the factor of ego-strength, despite the difficulties in its evaluation, may play an important interactive role with other patient variables.

Given the likelihood of a complex set of interactions between patient factors, it appears that much of the quantitative research in this area is inappropriate in

design, particularly in terms of the tendency to isolate and purify single variables.

The complexity of this area is further underlined when the issue of social class is examined. It becomes clear that patient characteristics not only affect each other in various ways but that they are also strongly affected by non-patient factors. The tendency for fewer patients of lower social status to be accepted into therapy, and to continue in therapy once accepted, cannot be evaluated without taking into account the social status and attitudes of the therapist.

It is obvious that the therapist's expectations and attitudes can strongly influence his/her perception of the capacities and needs of the patient. It may be concluded therefore, that not only must one consider a complex web of patient factors in relation to outcome, but that therapist factors need to be explored and considered in addition. Research on therapist variables in relation to psychotherapy is the subject of the next chapter.

CHAPTER FIVETHERAPIST VARIABLES IN RELATION TO PSYCHOTHERAPY

The therapist variables most frequently selected by the researcher for study are, unfortunately, such simplistic global concepts as to cause this field to suffer from possibly terminal vagueness. (Parloff, Waslow & Wolfe, 1978, p.273).

There are considerable problems in the research in this area. For example, there is considerable use of student subjects and many analogue studies. There also seems to be a tendency among investigators to pursue one idea to the exclusion of all other variables.

In this discussion a selective review of the area is provided, focusing on such convergent results as have emerged. An attempt has been made to discuss only those studies that meet with the criteria of adequacy outlined in chapter three. The material is presented in the following sections:

1. Therapist variables independent of the treatment setting.
2. Therapist variables within the treatment setting.
3. Therapist variables in combination with patient variables.

Therapist variables independent of the treatment setting:

Three areas will be discussed in this section. They are

the personality of the therapist, the mental health of the therapist and the therapist's level of experience.

(i) Personality:

Hadley and Strupp (1976) conducted a survey of the views of researchers and practitioners on negative effects of psychotherapy. The therapist was one of the most often cited sources of deterioration, if not directly, then indirectly, through not picking up the problem and taking counter-measures. Wolberg (1977) supports this view, and argues that failures in psychotherapy are generally the product of mismanagement of the therapeutic relationship on the part of the therapist. According to the respondents in Hadley and Strupp's study, the main problem areas were deficiencies in training and skill on one hand and personality problems on the other. The latter included the possible ill-effects of incompatibility, which will be addressed later in the chapter. More serious was the concern with "noxious personality traits in the therapist" (p.1296), which included exploitative tendencies, excessive need to make people change, unconscious hostility, and over-emphasis on pathology. This line of thinking is carried further by Stone (1975), in a discussion of unethical behaviour among personnel in a psychiatric hospital. The present focus, however, is on more subtle problems rather than gross exploitative tendencies. One would hope that individuals with gross psychopathology would not, in fact, be selected for clinical training.

Ricks (1974, cited in Garfield and Bergin, 1978) examined the effect of therapist personality on outcome. He compared the work of two therapists who were dealing with disturbed adolescent boys in an outpatient clinic. Case-loads of the two therapists were matched on important variables, including degree of patient disturbance.

Therapist A invested more time in those patients who appeared more severely disturbed and used techniques described as ego-strengthening and supportive. This involved using resources outside of the therapy, encouraging autonomy and facilitating problem-solving in everyday tasks while at the same time maintaining a strong therapeutic relationship. Therapist B did not invest more energy in those cases that seemed more disturbed and tended to explore emotionally-charged material with these patients. On the basis of case-notes it was reported that he seemed to become involved in his patients' feelings of hopelessness. 84% of therapist B's patients became schizophrenic, while 27% of therapist A's patients had this outcome.

While much of the difference between these two therapists relates to style, it appears that therapist B had a more vulnerable personality. The results of this study are particularly interesting in that the difference in outcome between the two therapists only manifested in relation to the more disturbed of their patients.

It may be concluded then, that there is some evidence that

personality factors of the therapist in combination with aspects of therapist style may have an effect on outcome. While it is clear that there is considerable concern with the potential harm that may result from personality difficulties of therapists, there does not seem to be concerted and systematic investigation of the pervasiveness of this problem. It is no doubt extremely difficult for the profession to examine itself in this way, just as it requires a great amount of courage and integrity for the individual therapist to constantly examine his behaviour and motivations in his work with patients (Guggenbühl-Craig, 1968).

(ii) "Mental Health" of the therapist:

There is evidence to suggest that therapists with more personal pathology promote less change in their patients (Parloff et al., 1978; Reder & Tyson, 1980). Strupp and Bergin (1969), for example, cite various studies indicating that therapist conflict relating to hostility, dependency and intimacy will have a negative effect on therapy.

The question of whether personal therapy experience is of benefit appears to have no unequivocal answer. Reviewers argue that there is contradictory evidence here (Garfield & Bergin, 1978; Meltzoff & Kornreich, 1970; Parloff et al., 1978). It has been suggested that personal therapy experience is valuable, but that if this runs concurrently with therapy training there is a danger that the neophyte therapist will be too preoccupied with her own problems to be able to deal with patients effectively (Parloff et al.,

1978). It could be argued however, that while this may be true for some therapists at certain times in their training, psychotherapy running concurrently with clinical training may be very valuable, for example in terms of exploring counter-transferential reactions. It is clear that attitudes towards personal therapy bear a strong relationship to theoretical orientation. Thus, psychoanalytically-orientated therapists see personal therapy as more important than do non-psychoanalytic therapists.

(iii) Level of experience:

Meltzoff and Kornreich (1970), in reviewing work in this area, comment that in other fields, improved performance with experience is axiomatic. That this is a research issue at all in psychotherapy, they view as a reflection of the continual doubt about the efficacy of psychotherapy that besets the field. However, it may well be useful to examine how experience affects the work of the therapist, if at all.

While in the rest of this chapter the focus is on outcome studies, a digression is necessary here. In view of the fact that this thesis is directed to inexperienced therapists, it might be useful to present some work relating level of experience to aspects of the therapeutic process.

Auerbach and Johnson (1977) provide a useful review of research on process factors. They point out that it is generally problematic to assume a linear relationship

between experience level and process variables. Directiveness for example, may be strongly evident in a beginner, may reduce during training, and may then reappear in a new form with experience.

Auerbach and Johnson report that non-professionals tend to conceptualize therapeutic behaviour as active and directive. They report that less experienced therapists tend to "play safe", preferring exploratory and reflective forms of intervention. In their summary, these reviewers report that "experienced therapists are more talkative, commit themselves by use of interpretations... and more often take the initiative" (Auerbach & Johnson, 1977, p.88). In the body of the review however, they do refer to a study by Grigg (1961), in which it was found that the more experienced therapists made fewer interpretations and allowed the client more control over the session than did the less experienced therapists. While Auerbach and Johnson do not mention the theoretical orientation within which the various investigators work, it is likely that such factors as frequency of interpretation and level of activity bears a strong relationship to theoretical orientation.

Research on the relationship of attitudes to experience has also offered some thought-provoking evidence. It needs to be borne in mind, however, that much of this work is based on self-report questionnaires and hence a direct relationship to therapist behaviour during therapy cannot

be assumed. According to Auerbach and Johnson, attitude studies indicate that experienced therapists are more revealing of themselves, make more interpretations and draw on a wider range of behaviour than do inexperienced therapists. These factors, particularly the first two, seem once again to relate to orientation. However, these conclusions are based on the work on Anthony (1967), which reports similar changes with experience for Rogerians, Sullivanians, and Freudians (Auerbach & Johnson, 1977, p.93). The review also reports that less experienced therapists show a preference for verbally active patients. Auerbach and Johnson suggest that the inexperienced therapist, who may well feel anxious about finding something to say, experiences relief when dealing with those patients who tend to take the initiative in therapy.

Auerbach and Johnson maintain that there is considerable evidence that experienced therapists develop better quality relationships with their patients, according to criteria derived from the client-centred school, namely empathy, positive regard and congruence. Another important conclusion is that experienced therapists formulate more specific goals for therapy. The review also reports a study by Brown (1970), who found that inexperienced therapists are more likely to see favourable qualities in the patient and to be more optimistic about outcome.

Interestingly, these reviewers also cite Taplin's work (1968),

in which no significant difference in the psychodynamic formulations written by experienced therapists and those written by inexperienced ones was found. While these two groups were not very different in this study (the inexperienced group being trainees with less than one year's experience while the experienced group were post-internship), this finding suggests that the differences that emerge with experience are not academic ones. In sum then, it appears that more experienced therapists form better relationships with their patients, draw on a wider range of behaviour in therapy, and show some differences in structuring therapy and in judging certain patient qualities.

Turning now to studies that relate therapist level of experience to outcome, some methodological problems will be briefly mentioned. One of the most common problems is that the assignment of patients to therapists is not controlled; a serious shortcoming in the light of considerable evidence that more experienced therapists tend to be assigned patients with better prognoses (Parloff et al., 1978). Another problem is the definition of "experienced" and "inexperienced" therapists, which differs considerably among investigators, to the extent that in some studies "inexperienced" therapists have had considerably more experience than those labelled "experienced" in other studies. As has already been mentioned, another shortcoming is that the two therapist levels of experience being compared are sometimes not very different. This makes it unlikely that meaningful results will be obtained.

Furthermore, outcome measures remain problematic (Meltzoff & Kornreich 1970). Frequently the only outcome measure is the therapist's rating of client improvement (which, of course, may also be affected by experience) or the client's own rating. Very few studies utilize independent clinical or psychometric ratings.

In the light of these problems, it is hardly surprising that the results are disappointing. Meltzoff and Kornreich (1970) and Luborsky et al. (1971) suggest that there is a positive relationship between experience level and outcome. Auerbach and Johnson (1977) and Parloff et al. (1978) however appear to adopt more stringent criteria of methodological acceptability and are more cautious in their conclusions. They report a number of studies that have yielded null results and argue that no firm conclusions can be drawn.

Auerbach and Johnson raise the point that seeing there is evidence that more experienced therapists develop better relationships with patients, it is strange that they do not seem to achieve better results. They present the following arguments in attempting to account for this. First, the conclusion that therapists form better therapeutic relationships is based largely on client-centred work using specific concepts, which may not be able to account for all the important aspects of the therapeutic relationship.

Meltzoff and Kornreich (1970) point out that this work was generally done on populations that were not severely disturbed.

Generalization is, therefore, difficult.

Secondly, more sensitive outcome measures may be necessary. Experience may be more important in increasing self-acceptance than in symptom relief, for example. Finally, Auerbach and Johnson suggest that much of the variance may be attributable to patient factors. Parloff et al. (1978) also suggest that experience may be more important in the therapy of some patients than others.

Therapist variables within the treatment setting:

The variables to be discussed here may be subsumed under the general rubric of "style". Work has been done on such factors as formal speech characteristics, including for example, number of words per therapist response, latency time in therapist response, and percentage of emotional words. Little relation to outcome has emerged (Meltzoff & Kornreich, 1970; Parloff et al., 1978).

Much of the material to be discussed here emerged from studies investigating the phenomenon of deterioration in therapy. Yalom and Lieberman's study (1971) on ideological orientation and style of group therapists is of interest here. One approach adopted by some of the participating therapists was a very challenging, intrusive and demanding one, named by Yalom and Lieberman "the aggressive stimulator" style. An aspect of this style was that immediate self-disclosure was demanded. The "aggressive

stimulator" style was strongly related to those group participants who had negative therapeutic experiences (Yalom, 1975).

This seems very similar to one of the factors mentioned by Hadley and Strupp (1976) in their survey of therapist and researcher opinion on negative therapeutic effects. A therapist factor which respondents related to negative effects was the undercutting of symptoms that are functional for the patient's adjustment without the development of alternative coping mechanisms. This seems to be precisely the danger inherent in the "aggressive stimulator" approach.

Hadley and Strupp's respondents list the following eight therapist factors (among others) which they regarded as sources of negative effects:

(i) The entertainment on the part of the therapist of grandiose ideas about the therapy. The patient may well pick this up, leading to unrealistic expectations of the therapy.

(ii) The failure on the part of the therapist to set any / realistic goals for therapy. This may lead to lack of direction and, frequently, feelings of failure.

(iii) Negative effects may occur if the therapist fails to direct her intervention at obvious problematic behaviour or environmental difficulties, i.e. manifesting overconcern with the inner workings of the patient.

- (iv) This is a factor that has already been mentioned in relation to negative effects and involves the mismatching of technique with the patient. This is particularly problematic when reconstructive-type therapy is undertaken with a patient who is unable to assimilate such material.
- (v) Rigid adherence to a certain form of therapy may not allow for sufficient consideration of the patient's individual needs and hence lead to negative effects. Respondents generally saw this as an indication of insecurity on the part of the therapist.
- (vi) The use of dependency-fostering techniques may lead to unsuccessful outcome.
- (vii) A considerable danger of negative outcome exists when the therapist fails to recognize the patient's conflictual pattern in relationships, and allows this to be acted out in the therapy. This is an example of counter-transferential problems, of which failure to maintain professional distance is another manifestation.
- (viii) Negative outcome may occur when the therapist reacts to an impasse in therapy by prolonging it, rather than re-evaluating or referring the patient.

Gurman and Razin (1977) give a case example of a patient being treated by a therapist in training. This patient offered very interesting dynamic material, which was too quickly explored by the trainee, with insufficient awareness of the fragility of the patient's defences. The patient subsequently became psychotic. There is evidence in this

example of inadequate supervision. Similarly, all the factors cited by Hadley and Strupp (1976) above, should be taken into account and carefully monitored by supervisors of trainees.

Therapist variables in combination with patient variables:

The discussion here is confined to an examination of the role of congruent expectations and secondly, a discussion of demographic variables and some areas of patient-therapist matching. For a more comprehensive review, the reader is referred to Parloff, Waslow and Wolfe (1978).

(i) Expectations:

As has already been mentioned in the previous chapter, there is some evidence that congruent expectations of therapy on the part of the therapist and the patient is of importance. Experimental work (in which dyads with congruent and incongruent expectations are created before therapy) and naturalistic studies have generally not demonstrated a relationship between expectations and outcome, although there is some relationship between outcome and length of stay in therapy (Parloff et al., 1978).

It is really from the studies investigating the effects of preparation for psychotherapy that the most valuable results have emerged. It has been shown that preparation reduces attrition rate and bears a strong relationship to positive outcome (Hoehn-Saric et al., 1964; Parloff et al., 1978).

Parloff et al. cite an important study by Jacobs, Jacobs, Weinstein and Mann (1972) in which patients were prepared for psychotherapy and the psychiatric residents were prepared for the type of difficulties that these lower class patients might have in therapy. Substantial gain was shown in cases in which both participants were prepared.

(ii) Demographic variables and patient-therapist matching: Luborsky (1969) maintains that "factors which imply or suggest to the patient and therapist that they have something in common, facilitate gains from psychotherapy" (p.136). Interest in this area was stimulated by social concern over the adequacy of treatment given to lower class and black patients. Analogue studies on inter-racial pairing in psychotherapy suggest that black patients respond more favourably to black counsellors than to white ones (Jones, 1978). However, analogue studies are problematic in that they involve simulated therapeutic relationships, and overall the results of inter-racial studies are equivocal, with various other studies failing to find differences in outcome when black patients are paired with white counsellors and vice versa (Gurman & Razin, 1977, chap.17; Jones, 1978).

These latter findings are interesting in the light of many studies suggesting that clinicians are not free of stereotypes about members of other racial groups, and that white therapists dealing with blacks tend to be hampered by lack of knowledge about the black subculture (Parloff et al.,

1978). It certainly appears that process factors are affected by racial differences between therapist and patient, and there is some evidence that the way in which the racial issue is handled is important for outcome; Krebs (1971), for example, found that failure on the part of white therapists to deal with racial issues with black patients early in therapy, was associated with attrition (Garfield & Bergin, 1978).

This issue has particular relevance in the South African context, in which racial/ethnic issues intersect with issues of political power in a way that is more striking than in Europe and America. It is not possible within the constraints of this thesis to address the problems facing a therapist in South Africa who is dealing with a patient from another ethnic group. It is interesting to note however, that very little has been written on this topic. Nevertheless, there is some evidence in South African journals of attempts to explore aspects of the lifestyle and customs of South African blacks (Bührman, 1982; Cheetham & Griffiths, 1982a, 1982b; Griffiths & Cheetham, 1982).

The research on social class shows a similar pattern to that on race. There is a considerable body of literature on the relationship between social class and selection, process variables and various other factors, but relatively little with regard to outcome. Gallagher, Sharaf and Levinson (1965), found that responsiveness to the social

class of the patient varies with the therapeutic orientation of the therapist. It was found that therapists who valued individual forms of intervention highly were more likely to place emphasis on social class than were therapists who favoured milieu or community-based forms of intervention. This has interesting implications, and seems to correspond with some of the points made in the previous chapter. The therapist who is considering a patient for individual psychotherapy will be concerned, for example, with the degree of psychological sophistication shown by the patient. As we have seen (chapter four), the evaluation of this factor tends to disadvantage the lower-class patient.

It appears then, that from the point of view of the therapist who is considering individual psychotherapy, the social class of the patient has considerable implications for various prognostic factors, and hence for improvement in therapy, as the therapist's expectation of improvement has been found to be a significant predictor of eventual outcome (Baekland & Lundwall, 1975; Martin, Moore & Stern, 1977).

Apart from racial and social class factors, researchers have focused on the areas of cognitive factors, personality characteristics and values in attempting to discover the crucial dimensions for patient-therapist matching. Similarity is not always the goal. Some investigators maintain that dissimilarity heightens the therapist's

objectivity (Parloff et al., 1978). Others suggest that there is a curvilinear relationship between similarity and outcome, with a medium degree of similarity on certain (as yet undefined) personality variables being the most conducive situation for positive results (Meltzoff and Kornreich, 1970).

One of the better known areas of investigation of patient-therapist matching was Whitehorn and Betz's development of the A-B scale (1954). The study was a retrospective one using case records. Improvement of schizophrenic patients was related to the career interests of the therapists on the Strong Vocational Interest Blank. Improvement was associated with the Type A profile (career interests of Lawyer and Accountant); failure to improve, on the other hand, was associated with the Type B profile (career interests of Printer and Physical Science Teacher).

There was considerable interest in this work, but subsequent studies failed to replicate it (Luborsky et al., 1971; Meltzoff & Kornreich, 1970; Parloff et al., 1978). It is probable that a number of personality variables lie behind this vocational interest dichotomy and that this typology is too simplistic to be of much use (Heaton, Carr & Hampson, 1975).

#### Conclusions:

In this chapter, research examining the effects of certain therapist variables on the process and outcome of psycho-

therapy has been presented. The work in this area covers disparate topics and this review found no work offering an approach to integrating these findings. Quantitative research has confirmed certain conclusions previously made on the basis of clinical experience, but offers very little in terms of specific guidelines that can be put to practical use.

To summarise briefly: Experimental research indicates that therapists with more personal pathology are likely to promote less change in their patients, but offers no unequivocal answer as to whether personal therapy experience is of benefit. While level of experience of the therapist seems to have positive effects on the process of therapy, no firm conclusions can be drawn as to how this relates to outcome.

Research on patient-therapist matching has produced the most valuable results in the area of preparation for therapy, both in cases where the patient has inappropriate expectations, and in cases where the therapist's expectations may be inaccurate. This applies particularly to therapists embarking on psychotherapy with lower-class patients. Matching of patients and therapists on demographic and personality variables does not seem to have produced consistent results in terms of outcome.

The survey by Hadley and Strupp (1976) produced some interesting suggestions from researchers and clinicians

about the possible sources of negative effects. These were not cited as being particularly common in inexperienced therapists, although some of them related to the structuring of therapy and judgement of patient qualities, which generally appear to be more problematic for the inexperienced therapist. Such factors included the establishment of realistic goals, the appropriate and selective use of reconstructive forms of intervention, and the accurate assessment of when to deal directly with maladaptive behaviour or environmental difficulties.

The other problem-areas cited by Hadley and Strupp's respondents are also likely to pose particular difficulties for trainees. The trainee therapist is likely to feel insecure about her work and hence may tend to invest inappropriately in the patient's approval of and liking for her. The trainee needs the opportunity to discuss these feelings and obtain support and encouragement, preferably within a supervisory relationship. If this opportunity is lacking, the trainee may be unable to distance herself from the patient sufficiently to recognise the maladaptive patterns of relating that the patient brings into the therapy. As Hadley & Strupp point out, this can lead to the acting out of the patient's previous pattern within the therapeutic relationship; in addition the therapist may act out her conflicts in relation to her work. The fostering of dependency, mentioned in Hadley & Strupp's study, may be seen as an example of this.

The last two areas of difficulty that emerge from Hadley and Strupp's study are (i) insufficient flexibility in the use of approaches or techniques, and (ii) failure to re-evaluate a case when an impasse in the therapy is reached. Once again, the supervisory relationship is crucial, particularly in terms of providing the support needed by a trainee in order for her to tolerate the uncertainty inherent in flexibility. In addition, it is vitally important that the trainee learns, within the supervisory relationship, that difficulties in therapy can be acknowledged without implications of inadequacy.

five), a marked lack of integration of experimental findings is characteristic of this area, and hence it cannot offer substantial elaboration of other research findings.

It seems, therefore, that many of the more meaningful factors in the area of psychotherapy are too subtle and complex to be reflected in quantitative research as generally practised. One possible conclusion is that this body of work operates within a paradigm that is inappropriate to its subject matter; this is a topic that falls beyond the scope of this thesis.

An alternative conclusion is that the research designs generally employed are too simplistic (Strupp & Bergin, 1969). One interesting approach to this problem is that of Beutler (1979), who examined patient-symptom dimensions in terms of response to different treatment modalities. The results of this study are interesting in themselves, but it is Beutler's model that is of particular relevance here.

Beutler extracted three independent patient-symptom dimensions from a literature review. They are the following:

- (i) Symptom complexity: The patient may present with either a circumscribed or complex problem.
- (ii) Defensive style: Using MMPI profiles, Beutler

distinguished patients who use internal defences such as intellectualization and compartmentalization from those who rely on external defences such as projection and acting out.

(iii) Reactance: This refers to the way in which the patient copes with external demands. Beutler divided patients into those showing a high degree of reactance, which would manifest in a tendency to resist external influence, and those showing a low degree i.e. those who are more susceptible to external demands. This variable was measured using Rotter's Internal-External Locus of Control Scale.

Beutler then drew up well-founded hypotheses based on these dimensions. He hypothesizes, for example, that insight-oriented forms of intervention would be most successful in cases where the presenting problem is complex in nature, the patient tends to employ internal defences and has a high degree of reactance (Beutler, 1979, p. 884).

Beutler found tentative support for these hypotheses after doing a review of comparative studies, unfortunately using many that were based on non-clinical populations. In a later study (Beutler & Mitchell, 1981), some support was found for using an experiential approach (involving active techniques that focus on feelings and current experience) rather than an analytic approach with patients who were described as "impulsive-externalizers" using MMPI

profiles. Interestingly, the Temple Study (1975) found that patients with "acting-out" tendencies did better in behaviour therapy than in analytic therapy (Garfield & Bergin, 1978). This would be compatible with Beutler's model, which predicts that patients with external defensive styles would do better in behaviourally-based treatments than in insight-oriented ones.

Beutler's work offers an interesting avenue for investigation but he is somewhat isolated in his attempt to develop a model sufficiently complex to offer the potential of a really meaningful contribution to the issue of assessment for psychotherapy. It is clear that, given the current status of quantitative research, this body of work cannot provide comprehensive answers to clinical questions. In the following chapters, therefore, extensive use will be made of work based on clinical experience, while results emerging from quantitative research will be integrated wherever possible.

SECTION III: THE GUIDELINES

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CHAPTER SEVENEXCLUSION CRITERIA FOR PSYCHOTHERAPY

The first step in establishing guidelines for assessment is to clarify under what circumstances therapy should be withheld. This chapter addresses this issue specifically, and in the following two chapters indications and requirements for various forms of short-term therapy are presented.

As stated in chapter one, the decision to withhold psychotherapy from a prospective therapy candidate is rarely made. It is certainly a difficult decision; the therapist (particularly a trainee) is likely to feel that she cannot withhold therapy from a patient while there is some chance, however slight, of the patient being helped. Nevertheless, there is considerable evidence that psychotherapy can be detrimental or unnecessary, and therefore some guidelines for appropriate exclusion from psychotherapy are provided here. The literature in this area is sparse, and very few authors address the issue of exclusion in a direct and extensive way. Those authors utilized here appear to cover the material comprehensively. The material presented here is based mainly on clinical work although results of quantitative research from previous chapters is included where appropriate.

Criteria for exclusion from psychotherapy obviously are dependent upon the definition and requirements of the form of psychotherapy in question. It has been noted in

previous chapters that an exclusion criterion relating to reconstructive therapy does not necessarily apply to other forms of intervention, e.g. a patient who has recently had a severe psychotic episode would be excluded from reconstructive modes of psychotherapy, but may benefit considerably from social skills training or supportive therapy.

Initially, it is important to establish the criteria that indicate exclusion from all types of individual intervention. This will be dealt with in the first part of this chapter. In the second section, factors will be outlined that indicate exclusion from more ambitious forms of intervention (reconstructive types of therapy) but which do not necessarily apply to approaches with more limited goals (re-educative and supportive modes).

#### Exclusion criteria:

Patients for whom no treatment is the best option, can be divided into three groups (Francis & Clarkin, 1982):

##### i) Patients at risk for negative response:

Various studies have suggested that more disturbed patients tend to deteriorate in therapy (Garfield & Bergin, 1978), but many of these studies are poorly controlled and the patient may well have benefitted from a form of therapy other than the one employed in the particular study.

What does emerge is a tentative conclusion that negative response may be related to patient personality factors such as masochistic personality traits, low ego-strength and low motivation. (Francis and Clarkin do not provide any detail here. Ego-strength and motivational factors are concepts which are more fully elaborated by Bloch, 1979a). Previous unsuccessful therapeutic experiences must be carefully examined for indications of such problems.

Patients with borderline personality traits (Diagnostic and statistical Manual of Mental Disorders, 1982, 3rd ed.,) may respond negatively, especially when the patient has previously shown poor tolerance of the ambiguities and frustrations of the relationship to the therapist and who may act out transference fantasies, often in a self-destructive manner (Francis & Clarkin, 1981; Wolberg, 1977). If the patient has not been in therapy before, a trial of therapy will help to establish whether such negative responses are likely. In the case of previous unsuccessful therapy with this type of patient, therapy should not be undertaken unless there are clear reasons to expect a different outcome. Examples of such reasons are evidence of considerable change in the patient since the previous therapy experience, or the presentation of a circumscribed problem that is more amenable to therapeutic intervention.

There are other patients, often referred to as "therapist defeaters", who may have what Francis and Clarkin (1981)

term "severe negative therapeutic reactions" (p.543). These tend to be patients with self-destructive and oppositional traits who, in response to an appropriate technique or intervention, inexplicably deteriorate. In other patients similar reactions can be dealt with as resistances but in these individuals such reactions take a more serious form and may be life-threatening. In such patients psychotherapeutic interventions appear to exacerbate rather than ameliorate problems and are therefore better withheld. (For a case example, see Francis and Clarkin, 1981, p.543).

Another type of patient at risk for negative response would be one whose motivation is highly suspect e.g. a patient who enters therapy primarily to justify a claim for compensation or to support a lawsuit. With such patients there is a considerable risk of the development of secondary gain and chronic invalidism.

ii) Patients at risk for no response:

True non-responders must be clearly differentiated from those patients who appear to have remained the same but who would have worsened but for the beneficial effect of treatment. Such patients may be termed "veiled positive responders" (Francis & Clarkin, 1981, p.543). Similarly, one may find "veiled negative responders", i.e. those patients who appear to be unchanged but who would have improved but for the noxious effects of psychotherapy. Non-responders are therefore those patients who show no

effect of psychotherapy.

Various categories of patients may fall into this group. Firstly, patients who in fact have an organic disorder (e.g. a subdural haematoma or endocrine disorder) will not show the expected response to psychotherapy. Obviously it is of considerable importance to screen out such patients prior to considering psychotherapy.

The second category of patients includes those chronically dependent patients who have had extensive therapy previously without any real change. As mentioned above, in such cases the therapist has to have real grounds for expecting a different outcome if he/she decides to take on such a patient.

Thirdly, patients who have been referred with antisocial or criminal behaviour have to be very carefully assessed in terms of whether a psychiatric disorder exists, and in terms of whether the problem is amenable to therapeutic intervention. The problem of secondary gain from treatment may be considerable in these cases, and therapy should be provided within, rather than as an alternative to the legal system.

The fourth category comprises those patients who are poorly motivated, especially those without incapacitating symptoms. In such patients, the symptoms may be "strongly protective in nature and yield positive dividends, such as support,

attention and monetary compensation" (Wolberg, 1977, p.430). Frequently the patient does not see the need for therapy and is not self-referred. Finally, patients with factitious illness must be excluded.

The above categories of patient may be seen as lacking in the quality of openness to therapeutic influence (Strupp & Bergin, 1969). This covers such basic requirements as a desire for help, some sense of personal responsibility for problems, a liking for the therapeutic process and a willingness to express feelings, on however unsophisticated a level.

iii) Those patients who are likely to improve spontaneously: This refers to patients who might have a positive outcome with therapy, but who would do just as well independently. Into this group would fall individuals experiencing a crisis, such as a grief reaction, who do not display pathological symptoms, and who have adequate psychological and social resources. In such cases the expenditure both of time and money, does not seem warranted; in addition the patient may be given the message that she is "sick" and unable to cope. This obviously does not apply in cases when the person is seeking therapy for training purposes. Finally, therapy may be withheld temporarily, to allow a patient to experience and integrate the termination of a previous period in therapy before beginning another, unless the patient is unable to cope without maintenance therapy.

Francis and Clarkin (1981) make the important point that recommending no therapy can be an important therapeutic intervention; for example, in the case of a person who can function adequately but wants therapy to justify regression, such a recommendation is a communication to the patient that he is healthier than he thinks. The same authors point out that making a recommendation of no therapy is a difficult task, and they suggest that a senior colleague be brought in to share the responsibility of the decision. They note that it is frequently more acceptable to the patient to be given a small amount of contact (such as a follow-up interview) rather than none at all.

Factors indicating limited therapeutic goals:

Certain criteria have been related statistically to drop-out rates. Important in this regard are Hildebrand's Excluding Factors, which comprise the following: Serious suicide attempts, chronic alcoholism or drug addiction, long-term hospitalization, more than one course of E.C.T. (the last two would exclude patients with chronic psychotic disorders), a confirmed homosexual who would like to be heterosexual, patients with chronically incapacitating phobic or obsessional symptoms or gross destructive or self-destructive acting out (Malan, 1979, p.225).

It was noted in chapter four that these criteria relate to the selection of patients for analysis carried out by trainees. They may therefore be seen as exclusion

principles for reconstructive modes of therapy, while not necessarily excluding patients from re-educative or supportive types of intervention. Other factors that indicate that therapeutic goals should be limited are the following: Limited intelligence, considerable difficulty in communicating, or a situation where the patient has to live in a disturbed or depriving environment and therefore would have difficulty in dealing with the additional stress of exploratory therapy (Malan, 1979).

#### Conclusions:

As was found in chapter four, psychiatric diagnosis is important to take into account for the purposes of exclusion. It is particularly important that organic disorders are accurately diagnosed. Exclusion should be considered with some patients who manifest borderline personality traits, particularly those who have acted out in previous therapeutic relationships. The importance of careful investigation of the course and outcome of any previous therapy cannot be overemphasized. Such investigation may alert the therapist not only to the possibility of negative reactions, but also to cases in which there is a risk of no response to therapy.

Lack of motivation to change is considered in a somewhat broader context than in previous chapters. The therapist should be alert to this problem not only in patients who

lack severe symptomatology and are not self-referred, but also in patients who stand to gain financially from the maintenance of symptoms. Those patients who avoid legal action through entering into psychotherapy are also at risk for no response and should not be considered for psychotherapy under these circumstances.

The patient who is distressed but actually able to cope presents a particular assessment challenge to the neophyte therapist. It will be recalled that Hadley and Strupp (1976) regarded overconcern on the part of the therapist with the inner workings of the patient as a potential source of deterioration. This has relevance for the kind of patient being discussed here. Psychological problems can be found in every individual, and it is probably most difficult for the inexperienced therapist to weigh up the difficulties the patient is experiencing against her strengths and resources. The therapist who focusses too narrowly on the internal life of a distressed patient will find reason to take her into therapy, possibly not always appropriately.

The intern in the local hospital setting has limited time both for individual psychotherapy and for supervision. These limitations of resources underline the value of considering exclusion. The recommendation of no therapy can be important not only in preventing potential harmful effects or wastage of resources, but also as an important statement of confidence for an individual who can,

in fact, cope alone. While the principles outlined above are tentative and require further examination, they underline the fact that the decision to withhold therapy is a legitimate and important option. The recommendation of no therapy should be seen not as an admission of failure on the part of the therapist but as a recommendation based on informed assessment.

CHAPTER EIGHTASSESSMENT FOR SHORT-TERM PSYCHOTHERAPY

As stated previously, the primary focus of this thesis is on assessment for short-term forms of intervention. The rationale for this choice is that the local clinical psychology intern's experience of individual psychotherapy is based mainly on work with inpatients, for a limited period of six weeks to a few months. They are also expected to undertake "long-term" therapy with two patients. This may theoretically continue for one year, or in rare cases, even longer. Most frequently, however, these "long-term" patients are seen for about nine months (Appendix II). It will be shown that this time period is considered by some authors to be short-term; certainly the bulk of the intern's individual work falls into the category of short-term psychotherapy.

The importance of short-term psychotherapy does not, however, relate only to the circumstances of the local training environment. Strupp and Bergin, in their 1969 review of research in psychotherapy, stated that "fewer therapists continue to grapple with the task of reconstructing the 'total personality', which tends to be seen as an extravagant if not impossible endeavour" (p.23). Many individuals in an expanding patient population do not want, or are unsuitable for long-term psychotherapy (Clarkin & Francis, 1982). There is evidence that time-limited therapy can be at least as effective and efficient as unlimited

therapy (Luborsky, Singer, & Luborsky, 1975; Marmor, 1979; Schlien, Mosak, & Dreikurs, 1962). Nevertheless, the relationship between short-term and long-term therapy, and the appropriate range of application of short-term therapy have been subjects of controversy. The issues involved in this controversy will be briefly addressed in a historical context.

Marmor (1979) points out that some of Freud's early psychoanalytic treatment tended to be short, i.e. limited to a period of a few months and that the length of treatment increased with the growth in complexity of the theory and the development of more ambitious goals. In about 1918 Ferenczi began to experiment with "active therapy" - a modification in analytic technique aimed at shortening the treatment. He collaborated with Rank, who had been working in a similar direction independently, and in 1925 they published The Development of Psychoanalysis. In this book they put forward the view that the technique of psychoanalytic treatment need not parallel the investigative methods out of which the theory evolved; propounding in other words, the view that a good research technique is not necessarily a good therapeutic one.

In 1946, Alexander and French presented results that emerged from seven years of research into short-term approaches to therapy at the Chicago Institute of Psychoanalysis. This work was extremely important in evaluating the evidence for the prevailing negative attitude towards

short-term psychotherapy. Alexander and French did not find evidence to support the psychoanalytic dogmas that (i) depth of the therapy is proportional to the length of treatment and the frequency of interviews; (ii) therapeutic results achieved in brief work are superficial and temporary, while those achieved in long-term work are stable and profound, and (iii) that the desired therapeutic results are more likely to be achieved in prolonged analysis (Marmor, 1979).

Marmor (1979) maintains that traditional psychoanalysts adopt a closed-system model, believing that a recurrence of symptoms will occur unless all aspects of the unconscious conflicts of the patient are worked through. Proponents of an open-system model, on the other hand, would contend that modifications in the patient's dynamic structure can occur without therapy. According to such a model, a brief psychotherapeutic intervention may allow a patient to function better and thus to experience greater self-esteem. These changes lead to positive feedback from the environment, which act to maintain the changes.

It appears, therefore, that short-term therapy can result in profound and sustained changes and that it should be seen not as a second-best alternative to long-term therapy, but as an approach in its own right, with its own indications (Castelnuovo-Tedesco, 1970; Marmor, 1979; Sifneos, 1967; Ursano & Dressler, 1974). Traditionally, short-term therapy has been seen as applicable only to mild,

acute disorders and certain more recent authors still seem to maintain this view (e.g. Castelnuovo-Tedesco, 1970). It is strongly argued, however, (for example, by Malan, in Davanloo, 1978), that mild problems of recent onset are not the only disorders amenable to brief interventions. Severity and duration of the disorder may be useful in excluding obviously unsuitable patients, but are not seen as the main criteria determining applicability of short-term work.

Short-term work does, nevertheless, have certain limitations. The therapist's dynamic understanding of the patient is likely to be less extensive when the intervention is time-limited, but it appears that many patients undergo significant change nevertheless; it is certainly inappropriate to advocate long-term intervention for the sake of dynamic understanding alone.

Furthermore, while it is vital that the therapist works on the basis of an adequate understanding of how the patient's symptoms relate to his underlying conflicts, it is frequently not useful to convey this dynamic understanding to the patient. In previous chapters, it was argued that certain patients cannot integrate such material and hence may react adversely, and that others may simply be unable to make use of such material; such patients are therefore not suitable for reconstructive therapy. More appropriate would be re-educative and/or supportive modes

of intervention which do not attempt to facilitate change through dynamic insight. Before presenting the specific selection criteria for each category of therapy, the concept of short-term therapy needs further definition.

Short-term therapy is defined primarily by deliberate limitation of therapeutic time and planned ending. This is different from crisis intervention; in short-term psychotherapy one is dealing with people in conflict, not necessarily in crisis, although crises may be involved (Marmor, 1979). The primary goal is the modification of coping mechanisms; the relief of stress is of secondary importance.

It has been noted in previous chapters that extremely adverse life circumstances hamper psychotherapeutic work. In cases where a patient presents in the context of an acute crisis (for example, having been ejected from her home because of family friction) a crisis intervention approach is more appropriate. Once the crisis has been ameliorated, the patient can be assessed for psychotherapy. It is clear, therefore, that short-term therapy and crisis intervention must not be confused.

The disparate approaches incorporated under the heading of short-term therapy will be categorized into reconstructive, re-educative and supportive approaches. The reconstructive approach comprises, among others, the work of Malan, Davanloo, Sifneos, Mann and Wolberg. The re-educative approach incorporates behavioural techniques and problem-solving

approaches such as those of Browne (1964) and Clarkin and Francis (1982). The supportive approach includes what Sifneos calls "brief anxiety-suppressive psychotherapy" (1967).

As the latter two approaches are less controversial, they will be dealt with first. The reeducative type of therapy has as its characteristic goal the definition and resolution of a specific presenting problem. Various techniques can be utilized such as advice-giving, role-play and behaviour modification techniques. The goals are symptom relief, reintegration and the development of better problem-solving skills. Interpretation of unconscious processes are generally not made and goals do not include insight or profound personality change.

Supportive therapy within the short-term framework has as its goal the strengthening of defenses and restoration of equilibrium. Such an approach relies strongly on technique of guidance and environmental manipulation, with or without medication. (A useful discussion of the techniques of supportive psychotherapy is provided by Bloch, 1979b, chap.9)

Considerable variation is contained within these three broad headings, a fact which becomes most clear when those approaches classified "reconstructive" are examined. For example, Malan (1979), Wolberg (1977), Davanloo (1978) and Marmor (1979), consider 15-40 sessions to be appropriate (depending on the patient), James Mann has a fixed limit

of 12. Marmor (1979), Sifneos (1967) sets no time limit but makes it clear to the patient that treatment is not expected to last more than a few months, Pumpian-Mindlin (1953) sets an upper limit of 50 sessions. Generally the sessions are once a week and are conducted face-to-face.

A key factor on which writers in the field seem to agree is that in short-term reconstructive psychotherapy the therapist must delineate and concentrate on a circumscribed area of conflict. Bellak and Small (1978) underline this: "The effectiveness of brief psychotherapy derives from the clarity of conceptualisation necessary for its practice" (p.11). According to Pumpian-Mindlin (1953) this is done through a process of "skillful neglect" (p.647), i.e. issues not clearly and directly related to the focal problem are not followed up. Entrenched problems and character traits are not dealt with.

To maintain this focus the therapist must assume an active role. This means that the therapy is intense, with considerable interaction. Marmor (1979) points out that a high level of therapist activity must not be confused with being directive and maintains that the therapist doing dynamic short-term therapy, should be non-directive while using persistent confrontations and interpretations. It would seem, however, that a degree of directiveness is unavoidable, in order to prevent the focus becoming diffuse.

The role and nature of interpretation in short-term reconstructive therapy is another area in which divergent opinions occur. Certain workers, notably Malan and Sifneos, consider the interpretation of links between the past, present and the transference to be of vital importance. The parent-transference link (Malan, 1979, pp.79-81) is seen as one of the most important therapeutic tools and is regarded as being primarily responsible for successful outcome (Sifneos, 1978, p.40). Pumpian-Mindlin, on the other hand, maintains that interpretation should deal with more superficial material and should not aim at uncovering childhood material. While there is agreement that the development of a transference neurosis should be avoided, Pumpian-Mindlin suggests that attention be diverted off the therapist onto an important figure in the patient's life - an approach which differs considerably from that of Malan and Sifneos. Similarly Bellak and Small (1978) recommend a restricted approach to the transference with active encouragement of positive feelings only.

Early termination is almost by definition a common factor although differing amounts of emphasis is placed on this. Generally treatment is stopped when some insight is developed into the focal problem and when there is evidence of change. An important point in deciding on termination is when the therapist feels he can no longer restrict the work to the original focus (Pumpian-Mindlin, 1953).

In conclusion, conceptions of short-term reconstructive

therapy vary considerably. It would probably be generally acceptable to say that reconstructive short-term therapy aims to develop the patient's insight through interpretation into a circumscribed area of conflict, with early termination occurring with the development of insight and evidence of change.

#### Indications for brief psychotherapy.

The criteria presented here have been drawn from a number of sources (Bellak & Small, 1978; Davanloo, 1978; Clarkin & Francis, 1982; Francis & Clarkin, 1981; Gillman, 1965; Hoch, 1965; Malan, 1979; Marmor, 1979; Pumpian-Mindlin, 1953; Sifneos, 1968, 1978). First, general indications for all forms of brief psychotherapy will be presented, and secondly, criteria specific to certain forms of brief therapy will be discussed.

##### 1. General indications for brief therapy:

The primary criterion is that the individual is sufficiently disturbed to require intervention. Secondly, there must be a clearly defined focus. This is an extremely important criterion given the limitations of brief psychotherapy. Thirdly, sufficient motivation must be apparent. This involves at very least, the willingness to attend, to cooperate and to make some changes.

Fourthly, the patient must generally function at an adequate

level (for Sifneos, 1968, this involves the ability to maintain a job), and must be assessed as able to separate after relatively brief treatment. Finally, it is necessary that no other form of intervention is indicated; examples are crisis intervention with a patient in acute crisis, long-term treatment for patients with numerous or pervasive difficulties, or no individual psychotherapy at all, as discussed in chapter six.

## 2. Indications for specific forms of short-term therapy:

In this section, criteria for inclusion in brief reconstructive therapy will be presented first, followed by indications for brief reeducative and supportive approaches.

### a. Indications for brief reconstructive psychotherapy:

(i) The patient's presenting problem can be understood as a manifestation of a focal intrapsychic conflict. This places a requirement on both the patient and the therapist. Firstly, the patient is required to choose the problem that is bothering him most. This requirement of choice is important in that it fosters the awareness that all his problems will not disappear as a result of the therapy. Secondly, the requirement is made of the therapist to decide whether he can understand the problem in a way that is amenable to brief, dynamic work. Differences exist among therapists as to what type of conflict is most suitable for short-term dynamic work - Sifneos emphasizes Oedipal conflicts,

others do not specify. Davanloo discusses the focal conflict explicitly with the patient and will not continue until there is agreement about this. Malan does not make his understanding explicit in this way (Marmor, 1979).

(ii) The goal of treatment is character change, at least in one circumscribed area.

(iii) The patient relates quickly and flexibly in the initial interview/s and can express feelings.

(iv) The patient responds productively to interpretations dealing with the focal conflict.

(v) The patient is motivated to change and not merely to obtain symptom relief.

(vi) The patient shows evidence of high ego-strength. Aspects of the history are important to take into account here, such as educational, occupational and sexual performance, as well as the patient's ability to form and sustain relationships. (Francis and Clarkin, 1982, require that the patient have had at least one significant interpersonal relationship in childhood.)

The ability to tolerate frustrations and painful feelings are also important aspects of ego-strength, as is the ability to accept responsibility. Marmor (1979) includes intelligence here; this is controversial however, with certain researchers finding no relationship between intelligence

and outcome (Davanloo, 1978; Haskell, Pugatch & McNair, 1969). The concept of ego-strength is clearly both central and complex, and will receive further attention in the next chapter.

(vii) A reasonably favourable environmental situation exists, i.e. one offering a fair degree of stability and support.

(viii) The therapist can forecast possible difficulties in the therapy, and has considered ways of dealing with them.

b. Indications for brief reeducative and supportive approaches.

In addition to the general indications outlined in section 1, the following conditions should be fulfilled:

The individual is either:

(i) a fairly well-integrated person who has reacted adversely to a severe stress and requires help purely to facilitate restoration of equilibrium, or

(ii) an individual who requires stabilization but refuses to undergo reconstructive therapy or would be unable to tolerate such work. Such individuals may derive a great deal from supportive work or from re-educative techniques such as anxiety management or assertiveness training.

The following points provide examples of circumstances under which supportive or reeducative methods are appropriate:

(iii) the patient has a circumscribed phobia, sexual dysfunction or social skills deficit that is amenable to a behaviour modification approach.

(iv) the patient requires reconstructive therapy but temporarily requires supportive work for a preparatory period.

(v) the individual is unsuitable for reconstructive work but has symptoms that are potentially dangerous and affect functioning severely, such as suicidal/homicidal impulses, or drug addiction, and hence requires monitoring and containment.

(vi) the patient requires intervention but is of low intelligence, is excessively rigid or only responds to directive and authoritarian instructions.

There is far less written on assessment for reeducative and supportive forms of intervention compared to reconstructive therapy. There can be no doubt, however, that the ultimate effectiveness of all forms of intervention bear a strong relationship to rigorous assessment and planning of therapy.

Concluding comments:

Short-term therapy should be regarded, not as a degraded form of longterm therapy, but as a viable approach based on autonomous theoretical principles. While expediency should not be the sole basis for recommending short-term

therapy, limited resources on the part of the hospital system or the patient may mean that short-term intervention is all that is feasible (Clarkin & Francis, 1982). It certainly appears that within the local hospital setting, brief psychotherapy is the most appropriate form of intervention for the majority of patients.

It is argued in this chapter that the traditional conception of short-term work as being appropriate only for mild problems of recent onset, is not supported by empirical evidence. Selection criteria based mainly on clinical work are presented, for brief forms of therapy in general and specifically for reconstructive, reeducative and supportive modes of intervention.

It is evident that therapist-related factors are very important in these forms of therapy. Schlien (1957) points out that a time-limit gives the therapist a framework within which to work. It is also evident however, that short-term therapy requires considerable activity on the part of the therapist, especially in the assessment period. There is little time to experiment; decisions often have to be made on incomplete data and particularly in short-term reconstructive work, the therapist must be able to tolerate the lack of definitive psychodynamic formulations.

Furthermore, while the criteria presented in this chapter may appear straightforward, a thorough theoretical understanding of the patient is required to assess many of the

areas that are included. Many of the concepts that have been discussed require elaboration; this applies particularly to the concepts of motivation and ego-strength. In the next chapter an attempt will be made to place these concepts in a theoretical framework.

CHAPTER NINETHE ASSESSMENT OF EGO FUNCTION

In this chapter, certain important factors to be taken into account during the process of assessment will be discussed in detail. Criteria related primarily to reconstructive therapy will be examined here. This choice is motivated, firstly, by the fact that inappropriate application of reconstructive therapy has the most serious potential dangers of all forms of therapy. Secondly, the process of assessment for reconstructive therapy is more challenging than assessment for reeducative and supportive therapy. It is important to note, however, that evaluation of the patient according to these criteria will also benefit reeducative and supportive forms of intervention.

The material presented here is based on work within the psychodynamic framework. Although reconstructive therapy can obviously be undertaken within other theoretical frameworks (for example, Personal Construct Theory), most of the available literature has emerged from the psychodynamic approach.

A primary aim in this chapter is to concretize various important concepts as far as possible. It is clear from previous chapters, for example, that motivation is important for positive outcome in psychotherapy. The aim here is to operationalize this concept and thus to facilitate meaningful evaluation. An attempt is also made to relate

various important prognostic indicators to one another.

The context of the assessment process:

Assessment takes place in the first few interviews with the potential therapy candidate, and no matter how thorough this assessment is, there is a strong argument for a trial period of therapy as an additional evaluative step (Bloch, 1979a; Crown, 1979). Malan (1979, chap.17) describes graphically the complexity of the assessment interviews, in which the therapist has to operate flexibly at various different levels.

As has been shown, psychiatric diagnosis is extremely important, as deterioration effects appear to be more likely in patients who have been diagnosed as having psychotic or borderline features. "In intensive psychotherapy, a therapist always runs the risk of making a patient as disturbed as she (or he) has ever been in the past, or more so" (Malan, 1979, p.220). Malan calls this the law of increased disturbance, and while it does not necessarily apply to every patient, it underlines the importance of a careful and accurate psychiatric diagnosis, since deterioration can have more grave consequences in some conditions than others. The one mode in which the therapist has to operate, therefore, is the psychiatric mode.

Malan's second level is the psychodynamic one. It is clearly

important to understand the presenting problems in a way that identifies the forces in conflict within the patient, and between her and the environment. A psychodynamic formulation places the present problems in historical and developmental context, and illustrates the precipitating factors of the current conflicts and how these repeat past situations. From such a formulation should emerge a clear theme according to which the therapy can be structured: In short-term therapy a circumscribed focus is crucial. Far more could be said about the development of a psychodynamic formulation of the patient's problems. Malan (1979), Bellak and Small (1978, chap.4) and Davanloo (1978, chap.2) provide detailed examination of this aspect.

Another important level on which the therapist operates is the psychotherapeutic level. This involves the process of forecasting likely phenomena in the therapy and is informed by the information obtained from the psychiatric diagnosis and the psychodynamic formulation. For example, one might forecast that the patient will experience intense hostility towards the therapist. The likelihood of this leading to acting out between sessions needs to be evaluated. This can be seen as the core area of the assessment, because it is here that information should be integrated to permit the patient's strengths to be weighed up against her weaknesses. The likely risks and benefits of psychotherapy for the patient are considered here, and the decision made as to which level of work - reconstructive, reeducative or supportive - would be ideal.

The conclusions reached through this process must then be evaluated on the level of practicality. This involves the question of what is actually available that would most closely approximate the ideal form of intervention. This must take into account the resources available, such as the time at the therapist's disposal. Potential problem areas must be taken into account, particularly in terms of the need for containment. The intern also has to consider whether she has adequate supervision for the form of intervention she considers ideal.

As Malan points out (1979, pp.210-211), the therapist must also concern herself with the interview itself, i.e. she must maintain rapport while eliciting sufficient information. Finally, the patient and her expectations, anxieties and fears cannot be neglected.

It is clear that the process of assessment, involving, as it does, so many levels of functioning, is an extremely challenging task. Certain areas will not be given attention here. These include Malan's first level, that of making a psychiatric diagnosis and the last two, dealing with the interview and the patient. These areas are given considerable attention in the course of the intern's clinical training. The aspects of assessment to be examined here have to do with the psychodynamic and psychotherapeutic levels of enquiry, and centre around the assessment of ego-function.

The assessment of ego function:

Several important factors, such as motivation, quality of interpersonal relationships, response to interpretation and ego-strength were briefly mentioned in the previous chapter, and require elaboration. These factors can all be considered as aspects of ego function assessment. This topic is clearly of considerable importance. In chapter four, ego function was postulated as an important interactive factor. Furthermore, exclusion criteria draw considerably on this concept. A long history of psychotic breakdowns, for example, indicates poor ego function. In this chapter, therefore, detailed consideration is given to the concept of ego function and its assessment.

The concept of ego-strength is generally considered to reflect past adaptation and functioning (Bloch, 1979a); adequate ego function is the integrating force that allows the individual's adaptive resources to be used (Wolberg, 1977). Relatively strong ego function is required in therapy, in that the patient is required to cope with the ambiguities of the therapeutic relationship, to relinquish the secondary gains that may have accrued from her pathological behaviour and, in reconstructive therapy, to face inner conflicts and tolerate strong emotions.

Assessment of ego function involves an examination of a number of areas. First of all, the clinician, having taken a detailed history from the patient, should be aware of

important aspects of his/her early environmental influences and developmental history. "Severely traumatizing influences in early childhood may have impoverished ego development so drastically as to limit the extent of its potential growth" (Wolberg, 1977, p.425). Conclusions about the patient's ego functioning cannot be made on the basis of early history alone, but important early events and influences should form the basis of the clinician's initial hypotheses. (Wolberg, 1977, chap.26, provides a detailed discussion of this area.)

An important basic indicator of adequacy of ego function is the ability to gratify vital biological and social needs in an acceptable way and without aggression, self-punishment or guilt. In addition, assessment of previous levels of functioning is important, in that good adjustment at any one time is a much better sign than continued maladaptive functioning.

Possibly one of the most important areas for the assessment of ego function is the quality of the patient's relationships. The therapist needs to establish whether the patient is capable of meaningful emotional relationships with others. The word "meaningful" is important and refers to altruistic relationships, in which the patient can trust, can give and receive affection (Crown, 1979), and can make tangible sacrifices (Sifneos, 1978). This can be assessed in terms of the patient's relationship with people in authority, with friends and colleagues, in groups and in intimate relationships.

The evaluation of the patient's tendency to polarize people can be a valuable indicator of how she functions in relationships. For example, the more she sees her parents as having positive and negative qualities, the more adequate is her ego functioning. Tendencies to polarize in terms of all good and all bad are signs of poorer ego functioning (Pumpian-Mindlin, 1953).

An important test of the quality of the patient's relationships is an evaluation of how she interacts with the therapist during the initial interviews. The ability to trust through confiding feelings and thoughts should be assessed; another important consideration is whether the patient's emotional interaction appears appropriate to the clinician (Davanloo, 1978; Sifneos, 1978).

The last point leads to another important area of assessment, the affective functioning of the ego. Accessibility and tolerance of affect needs to be established. Historical material can be valuable here, for example, the patient's previous responses to anxiety can be examined. The key question is whether anxiety has a stimulating effect on the patient, allowing her to use her resources fully and remain alert while experimenting some uncomfortable physical sensations, or whether it has an inhibiting function, paralyzing the patient and preventing her from coping (Davanloo, 1978). Within the interview situation the therapist needs to assess the extent to which the patient is capable of experiencing and communicating reflective

awareness of her feelings (Luborsky, Chandler, Auerbach, Cohen & Bachrach, 1971).

A further aspect of ego function has been mentioned at several points in previous chapters: "Motivation is considered a major ego function of primary importance in psychotherapeutic work and very closely related to the psychotherapeutic choice" (Davanloo, 1978, p.17). Motivation is rated highly by therapists as a selection criterion; for some, in fact, it is the most important single patient variable (Bloch, 1979). Motivation for change must be distinguished from simple desire for symptom relief, and from motivation based on neurotic needs. The latter includes for example, a desire to enter into therapy based primarily on a wish to convert the therapist into a parental figure and thus to satisfy dependency needs (Wolberg, 1977). An aspect of motivation for change is preparedness to relinquish the secondary gain elements involved in the symptoms.

Many investigators have tended to regard motivation as a static, measurable personality trait. However, it is far more usefully conceptualized as a dynamic quality that changes with the progress of therapy and with the influence of the therapist (Bloch, 1979; Crown, 1979). Motivation may be seen as the product of the continual conflict between the patient's conscious desire to understand and resolve his underlying problems and his resistance to the painful affects involved. This balance changes, depending

on the progress in therapy; an early success may boost the motivation of a patient who at the outset showed only moderate levels of motivation. Similarly, high initial motivation may reduce with disappointment in the therapy.

Once motivation is conceptualized as a changing quality it becomes clear that it is the development of motivation, rather than high initial levels, that is of importance for assessment. With this in mind, some detail on what constitutes "motivation" will be discussed.

Wolberg (1977) maintains that factors supporting good motivation include suffering from symptoms, awareness, that these problems affect functioning adversely, and a desire to be more like others rather than unique. Sifneos (1968, 1978) developed criteria specifically for dynamic psychotherapy according to which motivation could be assessed. The first of these is an ability to recognize that symptoms are psychological in nature, rather than physical. The second criterion is somewhat less straightforward. It refers to the tendency to be introspective, and to give an honest and truthful account of emotional difficulties. Sifneos unfortunately does not go into detail as to how the honesty and truthfulness of the patient's account can be evaluated; the tendency towards introspection can presumably be gauged from the patient's account of his problem and how he has dealt with emotional difficulties in the past.

The third criterion that Sifneos uses is eagerness to participate actively in the therapeutic process, as opposed to a tendency to abdicate responsibility and be a passive participant. Two further criteria are related to this: Curiosity and willingness to put effort into understanding himself, and willingness to change, explore and experiment. This factor has been mentioned in previous chapters in terms of appropriate expectations of the therapy process.

Another factor that has been mentioned previously is realistic expectations about the therapeutic outcome. "Unrealistic expectations may be vague, world-wide in scope, nonspecific, exaggerated and magical". (Sifneos, 1968, p.274). Extremely unrealistic expectations are an indication of poor contact with reality. Realistic expectations, particularly for short-term interventions, need to be specific and circumscribed.

Sifneos' final criterion is an extremely important one: Willingness to make reasonable and tangible sacrifices in order to achieve the goals of the therapy. The patient may be required to change her schedule so as to fit in with appointments, or to take an extra job so as to be able to pay. The patient's response to these specific tasks is a very important test of motivation. It is crucial, of course, that any such sacrifice be reasonable, taking into account factors such as distance the patient must travel and her economic situation (Meltzoff & Kornreich, 1970).

Many of the factors subsumed by Sifneos under motivation are also seen as indications of psychological-mindedness which Davanloo defines as "the capacity for introspection" (Davanloo, 1978, p.17). The psychologically-minded patient has appropriate expectations of therapy, shows the ability to reflect on her emotional reactions and can see how these relate to past experience. To these Davanloo adds the capacity for verbal communication of thoughts and feelings.

It is not surprising that there is an overlap between motivation and psychological-mindedness. The therapist assessing for individual therapy is assessing motivation for a particular process, which involves clarification of problems through a verbal exchange. Sifneos compiled his criteria of motivation with short-term anxiety-producing (or reconstructive) psychotherapy in mind, and hence emphasizes the motivation to introspect and to recognize the psychological basis of problems. It is important to note that an excessive degree of rumination may reflect resistance. As discussed before, the psychological content of this rumination may be very interesting to the neophyte therapist, who needs to remain alert to the issue of how the material relates to the changes that are necessary in the patient's life. Given the difficulties involved here, it nevertheless appears that anything other than supportive therapy will be extremely difficult to undertake unless the patient is in some way able to relate her symptoms to conflicts within herself and to her relationships with

others.

Hollender (1964) maintains that it is of considerable importance to focus on how the patient addresses herself to her problems. Once again, it is the degree of psychological sophistication that is being evaluated. The therapist should assess whether the patient is able "to make connections between seemingly unrelated situations, to inquire into the meaning of paradoxical occurrences, and to scrutinize difficult and painful interactions" (Sifneos, 1978, pp.37-38).

The question of how the patient construes her role in the therapeutic relationship is part of the criteria of psychological-mindedness. The more sophisticated patient will expect mutual participation, while the less sophisticated patient may want a "guidance-cooperation type" relationship (Hollender, 1964). Very basic misapprehensions about therapy, such as the belief that there will be immediate improvement, need to be corrected. A Role Induction interview may be useful here (see chapter four). It is not, of course, being argued that psychologically unsophisticated patients must necessarily be "changed" before they are suitable for therapy. An intervention based on guidance and advice may be extremely valuable to such a patient. What is important is that the therapist is clear about the framework she is employing, and is consistent in applying this.

An important aspect of psychological sophistication is the evaluation of the patient's response to interpretations. As Malan rather neatly puts it, "the best way of assessing the patient's capacity to use psychotherapy is to try it" (Malan, 1979, p.211). Davanloo (1978) suggests that the therapist might give an interpretation of what he considers to be the central focus of the patient's difficulties. He then evaluates how the patient responds, whether she is receptive to the interpretation or disregards it, and whether she elaborates on it at any stage. The therapist must of course be critically aware that the accuracy and appropriateness of the interpretation is being put to the test as well.

Davanloo makes the important point that a positive response to an appropriate interpretation, particularly one that connects the current problem to past experience and to the transference, may well bring about an increase in motivation. This underlines the relationship between motivation and progress in therapy. In addition an accurate interpretation may increase the patient's spontaneity and deepen rapport.

The use of interpretation in the first few interviews should, however, take into account the potential dangers inherent in making interpretations at this stage (Malan, 1979). An accurate interpretation encourages strong attachment to the therapist, raises hope that help will be forthcoming, and may increase disturbance. The therapist

must be reasonably certain that he can take the consequences of his interventions. Malan points out the contradiction here: One should not make interpretations without knowing the kind of patient one is dealing with and hence what one can offer, but it is difficult to find out what kind of patient one is dealing with without making interpretations. The only way around this contradiction is to make limited interpretations initially and proceed according to the information that emerges, the patient's response and the availability of the form of intervention that is likely to be the most suitable.

Wolberg (1977) and Davanloo (1978) include intelligence as an ego function to be assessed. As has been discussed previously, high levels of intelligence do not necessarily imply that the patient is highly suitable for therapy. A borderline level of intelligence or mental handicap, however, will make it difficult to use interventions other than supportive therapy and some forms of behavioural therapy.

The final aspect to be discussed with reference to ego function assessment is evaluation of the patient's defence mechanisms. The most important issue here appears to be whether the patient utilizes a number of defence mechanisms in a flexible manner, or whether there is evidence of reliance on one specific mechanism. The question here is whether the patient is able to flexibly combine various defence mechanisms so as to appropriately deal with various

emotional problems. The more the patient is able to do this, the more suitable she is for therapy (Davanloo, 1978). Davanloo did a retrospective analysis of the defence mechanisms predominantly used by patients who were deemed suitable for supportive work. These include intense reliance on projection, acting out and denial, and the general tendency to rely on a limited range of rigid ego defence mechanisms.

An alternative, rather technical model for assessment of ego function is provided by Bellak and Small (1978, chap.4). These authors provide a list of the components of reality testing, judgement and thought processes. Unfortunately little detail is provided and hence this model will not be discussed here. It is worth consulting, however, particularly for factors relevant to incipient psychotic states. The patient who is becoming psychotic may show a fluctuating level of ego strength, may report some confusion such as memory impairment and perhaps impairment of body boundaries, and almost always experiences extremely high levels of anxiety.

The evaluation of the possibility of psychotic decompensation is an important aspect that emerges out of ego function assessment. A related risk that requires evaluation is the possibility of suicide, particularly in depressed patients. A suicide attempt may reflect the inability to tolerate painful affect without acting out.

This was mentioned above as part of the definition of ego-strength. Some aspects of the assessment of suicide risk will be briefly discussed.

First, the degree of depression is obviously of primary importance to assess when there is any evidence of suicidal ideation. The extent to which the patient has formulated plans for suicide and/or tends to ruminate on the idea of suicide must be explored. Any previous suicide attempts must be carefully investigated. Malan (1979) points out that there are two important aspects to consider:

(i) The degree of suicidal intent. The circumstances surrounding the attempt need to be explored in order to establish whether the patient's motivation was actually to die or not. An alternative motivation for example, is the desire to manipulate or take revenge on another person.

(ii) The actual risk to life. A number of factors are involved here. First, one needs to know whether the patient carried out what he considered to be a fatal action. Secondly, one needs to establish whether the attempt was carried out under circumstances that made discovery unlikely.

The question of how likely the individual is, at the present time, to commit suicide is problematic to assess. Bellak and Small (1978) suggest that the administration of a Thematic Apperception Test (TAT) may be useful in providing

information. It may emerge from the TAT whether a considerable amount of denial of suicidal ideas exists and whether the suicidal ideas are ego-syntonic or ego-alien. Given the crucial nature of this evaluation, the therapist should obtain a second opinion on this matter, particularly if he/she is inexperienced.

### Conclusion:

In this chapter, aspects of the assessment of ego function have been discussed. A further word needs to be said about the time period involved. First, the complexity of the process of assessment, and the sheer amount of information that needs to be accumulated mitigates against the viability of allocating one or two interviews for assessment. Secondly, it has been made clear that certain of the factors involved have a dynamic rather than static nature. To accurately assess motivation and response to interpretation for example, the therapist must allow sufficient time in which the patient can react to the therapeutic interventions, and hence can demonstrate his/her capabilities.

On the other hand, it has been strongly suggested in previous chapters that assessment for short-term forms of intervention cannot be protracted. Certainly, it is not feasible to suggest a six-week assessment period for an inpatient in the local hospital setting, given that the average period of stay is about two months. In order to

assess satisfactorily within these constraints the intern needs an intensive period of initial contact with the patient - several interviews, for example, within the first week. Hollender (1964) makes the important point that the therapist must respect the purpose for which the patient seeks psychotherapy. This point serves as a caution. The process of assessment for psychotherapy should not develop into an attempt, on the part of the therapist, to provide the patient with goals that she, the therapist, regards as admirable. By implication, the therapist must seriously consider the goals that the patient presents however limited.

This leads to a practical point of considerable relevance to the local hospital setting. Interns frequently carry a considerable case-load and have limited time for assessment. Many patients present with highly circumscribed goals, for example, a desire to cope better with anxiety or to be more assertive. The needs of the intern to gain exposure to complex dynamic material must be carefully weighed up against the patient's own goals. It is clear that frequently these goals should be accepted, their limitations acknowledged and a more limited assessment process undertaken.

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CHAPTER TEN  
IMPLICATIONS FOR TRAINING

The truth is that the assessment of a patient for psychotherapy is probably the most complex, subtle and highly skilled procedure in the whole field. (Malan, 1979, p.210)

In this thesis, some guidelines for assessment for psychotherapy relevant to the local training hospital setting are presented. The process of assessment, however, like all aspects of psychotherapy training, cannot be meaningfully taught outside a clinical training setting. Therefore, the guidelines compiled here cannot be seen as more than an integration of pertinent aspects of the literature, which could serve as a basis from which the intern can develop assessment skills.

The thesis began with an examination of the importance of assessment for psychotherapy. The early experimental work in the area of psychotherapy centred primarily around the issue of the effectiveness of psychotherapy. Evidence has in fact emerged that psychotherapy is a powerful intervention with the potential of facilitating both improvement and deterioration in the patient. In the light of this, the issue of which patients will benefit most from which types of intervention becomes a central one.

First, the quantitative work in the area was addressed in order to derive guidelines for assessment. While the

review was necessarily limited, it is evident that many of the most crucial issues cannot be easily investigated in an experimental manner. For example, research investigating the differential effectiveness of various treatment modalities has provided remarkably few useful conclusions. It is likely that the research designs commonly employed are insufficiently sophisticated to allow the emergence of more subtle differences between treatments.

In addition, the complexity of the field mitigates against the emergence of clinically valuable conclusions from experimental work, which frequently addresses itself to the relationship between one variable and an outcome measure. This became particularly apparent when research on patient variables was examined. For example, it emerges clearly from this body of work that diagnostic considerations are important when assessing for psychotherapy; that certain personality traits, particularly borderline traits, are associated with potential deterioration in therapy. This conclusion, however, lacks clinical usefulness unless it takes into account the type of psychotherapy in which this deterioration effect is more likely to occur. Many of these diagnostic considerations, most notably Hildebrand's Excluding Factors, have particular relevance for reconstructive forms of intervention and do not necessarily imply that negative effects may occur with such patients if they are taken into other forms of psychotherapy. Similarly, intelligence, motivation and the state of the patient's life circumstances have a different relationship to outcome, depending

on the type of intervention employed.

Furthermore, there is evidence that various patient factors are interrelated. For example, it appears that severity of maladjustment has to be considered in the light of the patient's relationship skills before one can attempt to predict outcome. It appears that it is the severely maladjusted patient, with poor relationship skills who is likely to deteriorate in therapy. Similarly, high initial levels of anxiety or depression are frequently considered to be good prognostic signs; in fact, it appears that the type of anxiety/depression and the context of its manifestation has to be borne in mind, and that the presence of these affects in the context of a general ability to cope is indicative of positive prognosis.

The situation is further compounded by the fact that certain characteristics attributed to the patient may well reflect therapist attitudes. This became particularly clear when the variable of social class was discussed - the tendency for fewer lower-class patients to be recommended for psychotherapy compared to middle/upper-class patients may well be a function of (middle-class) therapists' stereotypes about this group.

In view of the complexity of the factors involved there are considerable difficulties with the application of an experimental model, which requires that the situation be broken down into isolated components. The ultimate aim

of such research, of course, is to build up a complete picture from the pieces. Given however, that one is working with people rather than things and that incomparability of definitions and goals characterize the area, one wonders whether different researchers are working on the same jigsaw puzzle.

An attempt to address these problems is evident in the work of Beutler (1979), who related three patient-symptom dimensions to various forms of intervention. This work indicates that with greater complexity of design, more worthwhile information emerges. In addition, it is important to investigate patient variables that relate clearly to the process of therapy. Beutler's dimensions of degree of symptom complexity, type of defences used by the patient, and the patient's pattern of reacting to external influence, all have a direct and obvious relationship to therapy; far more so than factors such as age, sex or even diagnosis. There should be a theoretical foundation, therefore, for questions that are put to experimental investigation.

Given the lack of integration of quantitative work in the area of psychotherapy, literature drawing largely on clinical work was used to develop inclusion and exclusion criteria for therapy. In view of the fact that the therapy undertaken by the intern within the local hospital setting is almost always short-term in nature, the guidelines presented in this thesis relate specifically to brief forms

of intervention. Some implications of these guidelines will be discussed.

In chapter eight, guidelines for specific forms of short-term intervention were presented. It emerged that in short-term work in general, and particularly in short-term reconstructive therapy, the therapist has to operate at a high level of activity and has to make decisions quickly and sometimes on the basis of inadequate information. In chapter nine, the crucial area of ego function assessment was addressed. This process is a complex one requiring considerable skill. Information has to be integrated from sources as diverse as the Maudsley history-taking schedule and the patient's reactions in the interviews. This process requires considerable academic knowledge well grounded in practice.

The implications of these points for the trainee are considerable. In chapter five it was argued that various therapist factors associated with deterioration in therapy are more likely to be characteristic of the inexperienced therapist. These factors include the failure to maintain realistic expectations and goals for the therapy, the tendency to undercut defences that are important for the patient's adjustment, inappropriate choice of approach or inappropriate focus within the therapy, and various aspects of counter-transference.

The psychology intern is therefore faced with a highly

problematic situation. She has to avoid all the pitfalls of therapy outlined above (and cope with an unfamiliar and threatening situation) while engaging in a form of therapy (short-term) which requires a high activity level and decisiveness, and does not allow time to reflect and experiment. The process of assessment for psychotherapy, which is complex under any circumstances, becomes even more demanding and intense in the context of short-term psychotherapy.

The intern is therefore placed in a situation in which she is most likely to make mistakes associated with deterioration in therapy. The only way in which this situation can be ameliorated (unless the role of the psychology intern within the training units is considerably altered) is through intensive supervision of brief inpatient therapy. When the supervision of short-term therapy is examined, however, it is clear that very little time is allocated to this area (Appendix III). Although there is variation across the Units, the time allocated to short-term therapy is almost, 15 minutes per patient per week.

In addition to these 15 minutes, it must be borne in mind that the intern receives more intensive supervision on at least one "long-term" patient. Furthermore, there are contexts other than supervision in which inpatient short-term therapy is discussed, particularly ward rounds and daily staff meetings. While each patient is regularly

discussed in these meetings, detailed and ongoing examination of how the intern is conducting the assessment or therapy is left to the supervisor.

Fifteen minutes per patient per week (which reflects the most favourable circumstances) certainly cannot offer the opportunity to examine transcripts or to review video- or audiotapes of the intern's sessions with patients. Under these circumstances, the supervisor can give only cursory attention to the details of the intern's work in sessions.

When an intern experiences difficulty in assessing a patient it is no doubt possible for her to obtain closer supervision. One of the major functions of supervision, however, is to pick up problems that are not perceived by the intern herself. It is certainly not the case that such problems are always manifest ones. Patients may well experience relief once they are admitted to a unit and have the opportunity to talk about their problems, and they may show symptomatic improvement despite problems that exist in their individual sessions. Without intensive ongoing supervision, therefore, the intern may fail to develop appropriate skills for the process of assessment and may persist in the use of techniques or approaches that are associated with patient deterioration. This has the most potential danger when assessment for reconstructive therapy is being carried out.

The issue of the adequacy of supervision available in the hospital setting is clearly related to the low ratio of trained staff to patients in psychiatric units. It is beyond the scope of this thesis to comment on whether reconstructive therapy should be undertaken by interns at all, given the available resources. An examination of this question and the related issue of allocation of financial resources to mental health services in this country would be a worthwhile topic of further research.

It is important to note, however, that an offshoot of reconstructive therapy is that it facilitates the development of a dynamic understanding which interns need in order to function as therapists. There seems to be an implicit assumption that psychology interns will develop such an understanding during their training. This is reinforced by the tendency among interns to value highly the acquisition of these skills, and to aim to practice reconstructive forms of therapy after the internship. The literature presented here makes it clear that the process of training interns to assess for, and to undertake reconstructive forms of psychotherapy, is a highly demanding and complex task. Whether this can in fact be accomplished within the limitations of the local training setting is another area which needs careful investigation.

Certainly, given the current situation, considerable responsibility devolves onto the intern who emerges from the training program. It is essential that she regards

her training in psychotherapy as a basic one. Should she undertake reconstructive therapy as part of her clinical work, it is crucial that this occurs within the context of ongoing supervision and training.

APPENDICES

Information reported in the appendices cover the time period February 1982 to July 1983, except where otherwise indicated.

APPENDIX I

1. Survey questionnaire sent to psychologists in charge.
2. Survey questionnaire sent to intern psychologists (1983).
3. Survey questionnaire sent to intern psychologists (1982).

PSYCHOLOGISTS-IN-CHARGE

This questionnaire is part of an M.Sc. thesis.

The goal of this research is to formulate a set of guidelines to facilitate the effective selection of clients for individual psychotherapy. These guidelines are to be designed for the psychology intern in the local hospital setting. In view of this specific emphasis, accurate information about available resources is vital to the research. Your cooperation in this respect would be very much appreciated.

Questionnaires are being directed to each unit in which psychology interns are trained. The questions on each questionnaire should be answered with respect to one particular unit. This may take up to 30 minutes to complete.

Should there be any queries contact me at 55-1920 or 71-3578 (a/h).

*Bev. Dickman*

1. Indicate the members of staff involved in the unit:  
(Give numbers if there is more than one member of any category)

Consultant psychiatrist.

Registrar.

Psychologist.

Psychology Intern.

Social Worker.

Occupational Therapist.

Trained nursing staff who are actively involved in therapy.

If a staff member is not assigned specifically to this unit, specify, and estimate what proportion of his/her workload this unit constitutes:

Over 75%

50%

25%

Less than 25%

2. Range of pathology presented by inpatients of this unit: Assign (1) to the largest category, (2) to the next largest, etc. Categories that are not represented should not be numbered.

Mental Handicap

Personality Disorder

Neurosis

Functional Psychosis

Organic Psychosis

a) Acute

b) Chronic

3. Number of inpatients at any one time:

Range:

Average:

(Give detailed comment if necessary)

4. Period of time as an inpatient:

Range:

Average:

(Give detailed comment if necessary)

5. Primary goals of intervention in this unit:

Choose 3 of the below ranking them in order of importance:

(i) crisis counselling

...4/(ii)

- (ii) short-term intervention with the goal of stabilization of behaviour or medication
- (iii) change in the patient's social situation
- (iv) rehabilitation
- (v) long term personality change
- (vi) assumption of responsibility for the patient on a permanent basis, i.e. institutionalization.
- (vii) Assessment/observation
- (viii) Other: specify

6. Types of intervention undertaken by the psychology intern: It may be useful to describe these in terms of theoretical model/s, goals and timespan.

- (a) Individual
- (b) Other (specify)

7. How many hours per week does the psychology intern spend in:

...5/a)

- a) Structured discussion time with other members of this unit, including ward rounds
- b) Supervision:
  - i) within the unit: individual  
other
  - ii) outside the unit: specify (eg. long-term psychotherapy supervision)
- c) Academic sessions
- d) Other activities on the unit eg. group, psychometric testing (specify)
- e) Other eg. outpatient management (specify)

8. What is the average caseload of the psychology intern in this unit?

9. Any other comments:

INTERN PSYCHOLOGISTS

This questionnaire is part of an M.Sc. thesis. The aim of the research is to formulate a set of guidelines to facilitate the effective selection of clients for psychotherapy. These guidelines are to be designed for the psychology intern in the local hospital setting. In view of this specific emphasis accurate information about available resources is vital to the research, and your cooperation in this respect would be very much appreciated.

Kindly answer the questions with respect to the unit in which you are currently placed. The most valuable way in which you can assist is to draw on your personal experience in answering these questions. You are not expected to research your answers. Your responses will be entirely confidential and the manner in which the information will be integrated into the thesis will in no way compromise this confidentiality.

The questionnaire may take up to 30 minutes to complete. Should there be any queries, contact me at 55-1920 or 71-3578 (a/h).

*Bev. Dickman*

1. How much time do you have available per patient per week for individual sessions (apart from clerking or assessment)?

If there are marked discrepancies in the amount of time spent with different patients, include the proportion of patients seen for the time periods in question (e.g.,  $\frac{3}{4}$  caseload: 30 mins. per week;  $\frac{1}{4}$  caseload:  $1\frac{1}{2}$  hours per week).

2. What proportion of the patients you see in individual sessions are also involved in any of the following: Specify in each case who leads/facilitates the sessions. If you have facilitated any sessions at any time, specify.

- (i) Group Therapy

Specify if there is more than one type of group therapy involved.

(ii) Family Therapy

(iii) Occupational Therapy

Specify the activities undertaken

(iv) Any other form of intervention that does not fall under the above categories, e.g. sessions specific to role play, projective art, etc.

3. How is it decided whether to include patients receiving individual therapy in any of the sessions mentioned in (2): what is your role, if any, in this decision.

4. Supervision/Discussion with other team members: detail the number of hours per week (approximately) that you spend in formal and informal discussion with other members of the team. Specify the other team members involved.

	FORMAL	INFORMAL
ASSESSMENT		
THERAPY: LONG TERM		
SHORT TERM		
CASE MANAGEMENT (INCL. WARD ROUNDS)		

5. In what context is the decision made to undertake psychotherapy with any particular patient:

Supervision:

Ward Round:

Other (specify):

What information is regarded in this unit as necessary for the above decision e.g. initial interview, psychometrics, family interview.

Any comments:

6. How frequently do you receive requests to assess out-patients for psychotherapy (specify e.g. two a month, one every three months, one a week etc.)
  
7. How many patients are you required to see in long-term psychotherapy? What is the minimum period that you are expected to see such patients?
  
8. Any other comments

1982 INTERN PSYCHOLOGISTS

This questionnaire is part of an M.Sc. thesis. The aim of the research is to formulate a set of guidelines to facilitate the effective selection of clients for psychotherapy. These guidelines are to be designed for the psychology intern in the local hospital setting. In view of this specific emphasis accurate information about available resources is vital to the research, and your cooperation in this respect would be very much appreciated.

Kindly answer the questions with respect to the unit in which you were last placed. After each question you are asked to compare the information you have given with your previous two placements. Please do this with as much detail as you can confidently recall. The most valuable way in which you can assist is to draw on your personal experience in answering these questions. You are not expected to research your answers. Your responses will be entirely confidential and the manner in which the information will be integrated into the thesis will in no way compromise this confidentiality.

The questionnaire may take up to 30 minutes to complete. Should there be any enquiries, contact me at 55-1920 or 71-3578 (a/h).

Rev. Dickman

1. How much time did you have available per patient per week for individual sessions (apart from clerking or assessment)? If there were marked discrepancies in the amount of time spent with different patients, include the proportion of patients seen for the time periods in question (e.g.  $\frac{3}{4}$  caseload: 30 mins. per week,  $\frac{1}{4}$  caseload :  $1\frac{1}{2}$  hours per week).

How does this compare with your previous two placements?

2. What proportion of the patients you saw in individual sessions were also involved in any of the following: specify in each case who led/facilitated the sessions. If you facilitated any sessions at any time specify.
  - (i) Group Therapy

Specify if there is more than one type of group therapy involved.

(ii) Family Therapy

(iii) Occupational Therapy

Specify the activities undertaken

(iv) Any other form of intervention that does not fall under the above categories, e.g. sessions specific to role play, projective art, etc.

How does this compare with your previous two placements?

3. How was it decided whether to include patients receiving individual therapy in any of the sessions mentioned in (2): what was your role, if any, in this decision.

Compare with previous two placements.

4. Supervision/Discussion with other team members: detail the number of hours per week (approximately) that you spent in formal and informal discussion with other members of the team. Specify the other team members involved. (See over)

...5/

	FORMAL	INFORMAL
ASSESSMENT		
THERAPY: LONG TERM		
SHORT TERM		
CASE MANAGEMENT (INCL. WARD ROUNDS)		

Compare with previous two placements.

5. In what context was the decision made to undertake psychotherapy with any particular patient:

Supervision

Ward Round

Other (specify)

What information was regarded in this unit as necessary for the above decision e.g. initial interview, psychometrics, family interview.

Compare to previous two placements

Any comments

6. How frequently did you receive requests to assess outpatients for psychotherapy (specify: e.g. two a month, one every three months, one a week etc.)

Compare with previous two placements

7. With respect to your entire internship: How many patients did you see in long-term psychotherapy (i.e. extending beyond the period of one placement.) Over what period did you see this/these patient/s and how frequently?

8. Any other comments

APPENDIX II

General characteristics of local  
psychiatric training units.

UNIT	Cape Town Neuroclinic: Valkenberg Hospital (White Side)	Pinelands Firm: Valkenberg Hospital (Black Side)	Ward D 12 Groote Schuur Hospital	Avalon Treatment Centre *
RANGE OF PATHOLOGY <sup>+</sup>	1. Functional psychosis 2. Organic psychosis 3. Personality disorder 4. Neurosis 5. Mental handicap	1. Functional psychosis 2. Organic psychosis (acute) 3. Personality disorder 4. Neurosis 5. Organic psychosis (chronic)/ Mental handicap	1. Neurosis 2. Personality disorder 3. Functional psychosis 4. Mental handicap	1. Neurosis 2. Personality disorder 3. Functional psychosis
STAFFING COMPLEMENT: <sup>+</sup>				
Consultant psychiatrist	1	1	1	1
Clinical psychologist	1	1	1	1
Registrar	3	3	1	1
Intern psychologist	2	1	2	1
Social worker	3	1	1	1
Occupational therapist	1	1	1	1
Trained nurses involved in therapy	2	0	5	3/4
AVERAGE NUMBER OF INPATIENTS <sup>+</sup>	45	200	13	14
AVERAGE LENGTH OF STAY <sup>+</sup>	2 months	4 months	3 months	6 weeks

\* February 1982 - May 1983 only.

+ Informant: Clinical psychologist in charge.

° Informant: Intern psychologist.

UNIT	Cape Town Neuroclinic	Pinelands Firm	Ward D 12	Avalon
PRIMARY GOALS OF INTERVENTION <sup>+</sup>	1. Short-term stabilisation of medication/behaviour. 2. Crisis counselling. 3. Assessment/Observation.	1. Short-term stabilisation of medication/behaviour. 2. Crisis counselling. 3. Assessment/Observation.	1. Long-term personality change. 2. Assessment/Observation. 3. Short-term stabilisation of medication/behaviour.	1. Short-term stabilisation of medication/behaviour. 2. Crisis counselling. 3. Change in patients' social circumstances.
FORM OF INDIVIDUAL THERAPY EXPECTED OF INTERN <sup>+</sup>	Eclectic.	No detail given.	Brief psychotherapy: Eclectic. Involves support, crisis work, behaviour therapy and dynamic therapy.	Brief Rogerian or "mild" dynamic therapy.
SIZE OF CASELOAD <sup>+</sup>	10	16	4	5/6
TIME PER PATIENT <sup>o</sup>	$\frac{1}{2}$ - 1 hour per week	20 minutes per week	1 hour per week	1 hour per week
CONTEXT OF DECISION FOR PSYCHOTHERAPY <sup>o</sup>	Ward round and supervision.	Non-applicable.	Automatic inclusion. Form of therapy discussed in ward round and supervision.	Virtually automatic inclusion. Form of therapy discussed in ward round
"LONG-TERM" PATIENTS: NUMBER DURATION OF CONTACT	2 6 months minimum	2 6 months minimum	2 6 months minimum	2 6 months minimum

+ Informant: Clinical psychologist in charge.

<sup>o</sup> Informant: Intern psychologist.

APPENDIX III

Interns' estimates of time per week  
spent in supervision / informal  
discussion.

UNIT	Cape Town Neuroclinic		Pinelands Firm		Ward D 12		Avalon	
	Formal	Informal	Formal	Informal	Formal	Informal	Formal	Informal
ASSESSMENT	Under $\frac{1}{2}$ hour	-	$1\frac{1}{2}$ hours	-	$\frac{3}{4}$ to 1 hr.	-	-	-
SHORT-TERM IN-PATIENT THERAPY	Under $\frac{1}{2}$ hour	$\frac{1}{2}$ hour	Under $\frac{1}{2}$ hour	-	$\frac{3}{4}$ hour	-	1 hour	-
"LONG-TERM" THERAPY	GS: $1\frac{1}{2}$ hrs.	$\frac{1}{2}$ - 1 hr.	GS: $1\frac{1}{2}$ hrs.	-	GS: $1\frac{1}{2}$ hrs.	-	GS: $1\frac{1}{2}$ hrs.	$\frac{1}{2}$ hr.
CASE MANAGEMENT	WR: 2 - 4 hrs.	$\frac{1}{2}$ - 1 hr.	WR: $1\frac{1}{2}$ hrs. DSM: $7\frac{1}{2}$ hrs.	$\frac{1}{2}$ hr.	WR: 3 - 4 hrs. DSM: $2\frac{1}{2}$ hrs	-	WR: 4 hrs. DSM: 4 hrs.	-

KEY:

GS : Group supervision.  
 WR : Ward rounds.  
 DSM : Daily staff meetings.

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