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FOR MY MOTHER - POLLY KISTOWSKA

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ABSTRACT

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A distinction has often been drawn between "process" and "outcome" studies in psychotherapy research, but interest in outcome implicitly underlies virtually all research in psychotherapy, there being little point in studying what happens in treatment if these events do not, in some way, relate to outcome. In addition, since an integrative measurement of change appears to be promising in psychotherapy research (e.g. Bloch and Reibstein (1980), Cartwright et al (1963), Mintz et al (1979), Strupp and Hadley (1977), Truax and Carkhuff (1967), among others), the emphasis of the present study was on the perceptions of change by the main participants in therapy, namely the patients and therapists.

Therefore, the present study was initiated in an attempt to integrate process and outcome measures of patients' and therapists' experiences of group psychotherapy into a longitudinal study, following the participants from the start of the therapeutic contact through to termination, and six months after termination.

Bearing these considerations in mind, the aims of this research were to investigate: a) patients' and therapists' expectations and perceptions of themselves and each other before they commence therapy, and b) patients' and therapists' perceptions of themselves and each other throughout treatment, in relation to outcome. The research design employed was a repeated measures design using interviews, psychological tests (Rotter's Internal-External Control Scale, the Treatment Expectancies Questionnaire, and several semantic differentials), and observation of the participants in the group psychotherapy situation.

The main findings of the current research can be summarized as follows:

1. patients' expectations of the role the therapist played in their treatment and what they thought their impending therapy would consist of, influenced their perception of the initial stages of therapy and their participation in treatment.

2. therapists felt there was a lack of congruence between what they thought it was realistic to achieve with their group patients and what they would really like to achieve; their expectations of the patients' participation and gain from group therapy being modified considerably as a result of ongoing treatment.

3. prior to therapy, patients and therapists had differing expectations of what the process of therapy would involve; however, during therapy, patients who came to share similar perceptions of the group process as their therapists, successfully completed treatment.

4. patients became more Internal in the responses to Rotter's Internal-External Control Scale as a result of treatment ($p < .005$), although there were no significant differences between terminators and non-terminators or between males and females.

5. responses to the Treatment Expectancies Questionnaire indicated that patients showed a preference for a more behaviourally oriented treatment regime at the end of group therapy, compared to pre-therapy ($p < .01$).

6. the semantic differential data indicated that patients who successfully completed treatment viewed themselves more positively in terms of their attitude towards self and what they felt capable of achieving, attributing this, at termination to the "potency" of the group.

7. it is tentatively suggested that it may be possible to identify the potential terminator prior to commencing therapy, based on his expectations of therapy in general and his treatment in particular.

It is suggested, given the numerous limitations of the current study, further research be initiated to validate the present results.

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CHAPTER 1.

General Introduction.

The extraordinary diversity to be found in psychotherapy research parallels, and to a large extent is the product of, the amazing variety of conceptualisations and procedures that define the clinical practice of psychotherapy. There are, to name a few: psychoanalytic and neo-analytic therapies; cognitive, emotive, and body therapies; behaviourist and neo-behaviourist therapies, verbal, activity, and play therapies; as well as combinations, permutations, eclectic integrations, and idiosyncratic syntheses.

Among them all, there is no standard definition of what occurs in, or is distinctive of, therapeutic process; no concensus about the intended effects of therapy, or the criteria of therapeutic outcome. In addition, no research has, as yet, proved that psychotherapy is more effective than any other kind of help-giving. Likewise, there is no agreement concerning selection and measurement of meaningful process and outcome variables. As such, one needs a general definition of psycho-therapy to set reasonable boundaries on the field of enquiry without excluding any of the specific practices, findings, or perspectives that have been significant in clinical work.

In all forms of psychotherapy, a psychological influence is brought to bear upon the person who has enlisted, voluntarily or otherwise, an expert's help in effecting change. A person, traditionally called a "patient", is dissatisfied with some aspects of his feelings or behaviour and, having recognised his inability to rectify the situation on his own, turns to a professional person, a "therapist", for assistance, guidance, and intervention. In broadest terms, the enterprise called "psychotherapy" encompasses a person who has recognised that he is in need of help, an expert who has agreed to provide that help, and a series of human interactions, frequently of highly intricate, subtle, and prolonged

character, designed to bring about beneficial changes in the patient's feelings and behaviour that the participants and society at large will view as therapeutic. In the case of group psychotherapy, this general definition must also take into account other participants in the relation-ship, e.g. other patients and, in some instances, co-therapists, in the process and outcome of therapy.

Although behaviour therapy approaches have focused on specific targets of change, verbal insight psychotherapy approaches remain vague about change targets. Such vagueness stems from an inadequate appreciation of the implications of the basic strategy for change of insight therapy. This strategy is a two-step paradigm in which therapists' work with their patients changes patients in some way and patients use this change to make necessary changes in their broader lives. Patients are the agents of change in their lives, and therapists are like coaches that patients retain to help them do what they must (Strong (1978)). In this, is the implicit assumption that people can control their behaviour, and the assumption that people can exercise self-control is basic to psycho-therapy.

But why seek the help of a mental health professional in the first place? Bergin (1963, 1966, 1971), Gurin, Veroff and Feld (1960), and Christensen and Magoon (1974) all report that the majority of people who experience psychological disturbance do not seek mental health professionals for treatment. Many of them obtain counsel, advice and support from a variety of helping individuals such as spouses, friends, teachers, physicians and clergymen, who cannot be considered trained in these functions. It is therefore pertinent to attempt to describe systematically how attribution processes may help explain the development of emotional disorders and why a mental health professional is sought.

1.1   Attribution processes and the development of emotional disorders.

Attribution is a process whereby the individual "explains" his world. In doing so, he often uses social consensus as a criterion for validating his explanations. Indeed, when objective evidence is not available, it is the opinion of relevant others that largely determines the confidence he has in his explanations of the world. Social comparison theory (Festinger (1954) and research on affiliation (Schachter (1959)) have provided the major impetus for the investigation of conditions under which we actively seek out the opinions of others. This research, however, has identified circumstances in which individuals seem to avoid obtaining the opinions of others. To the degree that our preliminary evaluations indicate that our attitudes or behaviour are bad or shameful, we may not want to check the validity of our evaluations by discussing them with others (Sarnoff and Zimbardo (1961)).

The failure or inability to use social consensus to check shameful evaluations can lead to self-ascriptions of mental abnormality and personal inadequacy that can be profoundly debilitating. Further, under conditions in which no one else shares the individual's experiences, there is apt to be distrust of others, withdrawal from others, and the individual may develop bizarre and incorrect interpretations of his experience. In the absence of social consensus, unusual feelings and events may be explained by delusional systems - a symptom characteristic of the paranoid schizophrenic.

Nevertheless, there exists in the popular culture, ready explanations for feelings or behaviours that the individual believes to be inappropriate or wrong. Miller (1969) has referred to man's changed conception of himself as the major effect of the psychological enterprise on society.

One consequence of this is that we have all become amateur psychologists and are quite ready to infer unconscious or hidden motives to account for all kinds of behaviour. It is thus not surprising that there are individuals who are constantly monitoring their behaviour and who interpret behaviours that are common as being "abnormal". Many beliefs, however, are simply too undesirable to discuss, and in such cases, their validity is often not checked through social consensus. Under these circumstances, normal behaviours can be used incorrectly to generate a diagnosis of abnormality.

Attributions damaging to mental health are not limited to erroneous interpretations of one's own behaviour but also include interpretations of behaviour of others towards oneself. There are many life situations that regularly produce severe distress, and there are probably regularities in the damaging attributions that individuals employ to account for their tension and unhappiness in these situations. However, when an individual's self-attributions of inadequacy are not merely erroneous but severely damage his daily functioning, reassuring social comparison agents such as the therapist and other group members are often available, if the individual is motivated to seek them out. As Herzlich (1973) points out, the language of illness is not a language of the body. The language of health and illness is structured by the relation of the individual to others and to society, the representation of illness developing on three levels: that of experience itself; that of the conceptions which make sense of it; and finally, that of the norms of behaviour deriving from it.

Szasz (1974) goes further and regards the customary definitions of psychiatry as a medical speciality concerned with the study, diagnosis, and treatment of mental illness to be a worthless and misleading definition. For Szasz, mental illness is a myth. Psychiatrists are not concerned

with mental illnesses and their treatment but in actual practice, they deal with personal, social, and ethical problems in living. The notion of the person as "having a mental illness" provides professional assent to a popular rationalization, namely that problems in living experienced and expressed in terms of so-called psychiatric symptoms are basically similar to bodily diseases.

However, the concept of mental illness also undermines the principle of personal responsibility. For the individual, the notion of mental illness precludes an inquiring attitude towards his conflicts which his "symptoms" at once conceal and reveal. For a society, it precludes regarding individuals as responsible people and invites, instead, treating them as "irresponsible patients" (Szasz (1974)).

Often the meaning of symptoms is private, idiosyncratic, and only reached and understood by another person through painstaking unravelling. As such, a symptom may be regarded as a part of a person's experience of himself which he has singled out and circumscribed as in some way incongruous with the rest of his experience of himself. On account of the incongruity with the "self", it tends to be regarded as "not-self", and is offered by the person as that which requires treatment, in the form of removal of symptoms.

At the same time, it is also recognised, mainly under the influence of psychoanalysis, that a symptom is a meaningful expression of underlying personal problems, and that "treatment" should be directed towards the understanding and relief of these problems. It is of interest that both views are generally maintained at the same time, that is, symptoms have no significance except in relation to the problems they reveal, and also that symptoms are undesirable in themselves.

One might suggest that people seek help not because they are disturbed by their symptoms but because they experience feelings of distress. The symptom then becomes a "ticket of admission" (Coleman (1967)) to a treatment facility. Under such circumstances, the definition of "improvement" must be confined. Frank (1967) argues that it should be defined only as

> "explicitly reported or demonstrable favourable changes in a patient's objective or subjective state"

(Frank (1967), p.191).

This view regards other commonly used criteria of improvement, for example, greater maturity of personality reorganisation, as inferences about the causes of the observed behavioural and subjective changes, or ways of summarizing a group of these changes. However, patients' and therapists' expectancies affect any change as a result of treatment.

1.2   Patient expectations of psychotherapy.

Expectations are a major determiner of human behaviour; the confirmation or nonconfirmation of expectations having a significant effect on subsequent affective and cognitive behaviour. Expectancies are therefore not to be found in isolation but in relation to other expectations and attitudes in the individual's belief system and are coloured by a multitude of experiences - both in the past and in the anticipated future.

The anticipatory aspect of expectations is emphasised in the basic tenet held by Kelly (1955) in his theory of personal constructs. Kelly views human behaviour as basically anticipatory rather than reactive, and that new avenues of behaviour open themselves to a person when he reconstructs the course of events surrounding him. In psychotherapy, clinicians have long considered expectations to be a critical factor in predicting how a patient will behave in therapy and the outcome of therapy for that patient. People who end up in psychotherapy either volunteer for

it, are referred for it, or are selected for it and, as such, may have

differing expectations of what their therapy may involve. Sobel (1979)

points out that preference for type of therapy is not a non-specific factor,

but rather a cognitive structure which can be utilized in an assessment

of an individual's cognitive style. As such, the preference variable may

be an efficient and accurate channel for obtaining a pre-therapy assessment

of a patient's cognitive style. In addition, Corrick (1980) states that

the patient's perception of his problems often differs widely from that of

his therapist.

The construct "initial therapeutic expectancy" refers to a

patient's prediction, made before treatment begins, concerning the likelihood

that a given treatment programme will help reduce the relevant target

problem. Several types of "expectancies" can be postulated. For instance,

Cartwright and Cartwright (1958) state that patient expectations of

improvement or belief in psychotherapy is a complex concept involving at

least four different kinds of belief: belief that certain effects will

result; belief in the therapist as the major source of help; belief in

the techniques or procedures as the major source of help; and belief in

oneself (the patient) as the major source of help. Based on the fact that

there is often little resemblance between what the patient believes is wrong

with him in the initial interviews and what is eventually resolved, Cart-

wright and Cartwright (1958) hypothesized that the first three of these

classes of expectations were not linearly and positively related to

subsequent improvement by the patient. However, if the patient perceives

himself as the major source of help, and if this perception is not merely

representative of counter-dependency, then the patient could be expected to

be a serious therapeutic worker.

Likewise, Kelly (1955) has observed that there are many different

ways in which a patient may initially conceptualise his approaching psycho-

therapeutic contact. This initial conceptualisation, he states, will likely affect his behaviour during therapy, particularly in the early interviews. As this conceptualisation changes, his in-therapy behaviour should correspondingly change.

More recently, Gordon et al (1979) argue that reliance on professional authors and purveyors of the service may erroneously assume, albeit innocently, that what they create in treatment will be, ipso facto, consistent with the needs of those whom they serve. To offset this, therefore, the opinion of the "consumer" i.e. the patient, should be elicited systematically and evaluated. It is not suggested, however, that the patient's view should be regarded as the "correct" one, since his view can be unrealistic and at variance with the observations of others, but treatment procedures and systems may frequently be negated by misunderstandings and false expectations of the patient. The patient is the one with the expert knowledge about being a psychiatric patient and thus a source which must be tapped (Ballinger (1971), Gordon et al (1979)).

There are, therefore, two approaches to the study of patient behaviour early in therapy focusing on two different aspects of the therapeutic situation: one focusing on patient expectations of therapeutic gain, while the other focuses on demand characteristics as nonspecific artifacts which constrain the attribution of causal qualities to therapy procedures.

Recently, attention has been directed towards the resolution of the expectancy-versus-demand issue, as artifacts attributed to patient cognitions vie with artifacts attributed to the environment as alternative explanations of measured patient improvement (Lick and Bootzin (1975), Rosen (1976)). It is not only on a theoretical level that a difference between expectancy and demand occurs. As pointed out by Bernstein and

Wietzel (1977), their fundamental difference involves the source to which
causal qualities accounting for measured outcome are theoretically
attributed.

Studies of patient expectations have, to a large extent,
attempted to investigate what the patient wants from therapy in relation
to what he reports receiving. Clinical impressions and placebo research
have pointed to the importance of expectancy in relieving the emotional
component of any illness. As Taylor (1961) states:

> "A patient's theories about his illness and its treatment
> are as important in psychotherapy as a therapist's
> formalized and systematized theoretical speculations.
> No psychotherapy can be successful without an affinity
> between the theoretical views of the therapist and the
> patient".
> (Taylor (1961), p.34)

Equally as important, Fiedler (1950) argues that there is an
"ideal therapeutic relationship", and Heine and Trosman (1960) suggest
that therapists have "model" expectations of patients suitable for psycho-
therapy, as follows: the patient should desire a relationship in which
he has an opportunity to talk freely about himself and his discomforts;
the patient should see the relationship as instrumental to the relief of
discomfort, rather than expecting discomfort to be relieved by an impersonal
manipulation on the part of the therapist alone; and the patient should
perceive himself in some degree responsible for the outcome. But whether
these "model" expectations are necessary, or indeed, sufficient, is
debatable (Lambert et al (1977)).

How a patient perceives his forthcoming therapeutic relationship
has received much attention. For instance, Begley and Lieberman (1970)
distinguished two clusters or "kinds" of patient showing widely separated
sets of expectations of psychotherapy. At one extreme, patients expected
a tremendous amount of involvement, both as personal warmth as well as

direction, from the therapist. They expected him to approve or disapprove, to get angry, to form a friendship, to call them by their first names, to delve into their pasts and unconsciousness, to interpret nuances of behaviour, and to suggest new ways of behaving. At the other extreme, patients rejected warmth and involvement by the therapist, expecting him to be detached and objective, and to hardly interact with them at all. He was to remain silent while the patient spoke, and he was not to respond to the clues which would have hidden, unconscious meaning.

Garfield and Wolpin (1963) found that their sample of patients appeared to be seeking a sincere, understanding, sympathetic, interested and competent person who would be unlikely to engage in criticism, anger or ridicule. They also wanted someone who would not be pessimistic about them, nor turn them away, but who would, at the same time, not deny that the patient had difficulties. However, there did seem to be some sensing, on their part, that they might not be able to adequately fulfil the role as patients required of them by the therapist and thus not get the help they were seeking.

One finding of relevance here, is that of Bruhn (1962) who, having modified Parson's theoretical components of the sick role to coincide with the mentally sick role, found that patients with more positive conceptions of their sick role had long, successful therapies. The converse, however, did not hold true. In addition, the severity of the patients' illnesses, their religious affiliation and their motivation for coming to the clinic were found to be correlated with social class and influenced patients' sick-role conceptions.

In contrast, Keithley et al (1979) in a study examining the effect of the patient's level of motivation upon process and outcome of short-term psychotherapy, found that while the patient's level of motivation

may influence the therapist's behaviour during treatment and that ratings of motivation significantly predicted both therapists' and clinicians' ratings of overall improvement, ratings of motivation did not significantly predict the patients' rating of overall improvement. Similarly, King (1977), having hypothesized that a heightened expectation of gain from therapy, motivation for therapy and perception of progress by the patient was important for continuance and successful outcome of therapy, found, on testing, that the hypothesis was not supported.

Regarding both length of time in treatment and ultimate outcome as criteria in considering assessment, Bloch (1979) states that staying in treatment and outcome are obviously not synonymous and cannot be dealt with as if they were; the patient who remains in treatment does not necessarily improve. For Bloch, the most promising patient tends to be anxious and dissatisfied with himself yet is able to meet life's basic demands. Possibly patients who are emotionally aroused when they enter therapy are manifesting a response to situational stress and their overall level of adjustment is not severely impaired. They may also be more motivated to work at lessening their distress. Bloch regards motivation as a dynamic variable, modifiable by such factors as the therapist's influence and the progress of therapy.

In an earlier study, Bloch et al (1976) concluded that the evidence for an association between expectation of improvement and actual improvement was unfounded. They speculated that the positive finding in the case of patient self-report (e.g. Garfield and Wolpin (1965), Heine and Trosman (1960) reflected an entrenched expectational set about therapy, which remained consistent whatever its course in reality. In contrast, Meltzoff and Kornreich (1970) have concluded their research evidence that motivation at the outset of psychotherapy is probably not a necessary factor for good outcome, but that its development during treatment is particularly important.

One factor which may be relevant to the findings of Keithley et al (1979), King (1977), and Bloch (et al (1976), (1979), although not mentioned, is that of the social class of the patient, which Bruhn (1962) alludes to. As pointed out by Jones (1974), much has been written about the implications of an individual's social class background for the outcome of psychotherapy. Clinical lore holds that psychotherapy, which requires of the patient, among other things, the capacity for introspection, the ability to articulate feelings and ideas freely, and a certain amount of "psychological-mindedness" (Applebaum (1973), Caine and Wijesinghe (1976), is a more appropriate treatment for people from middle-class backgrounds, who supposedly possess those characteristics to the requisite degree, than for those of lower social class backgrounds, who alledgedly do not.

However, the social class of the patient, per se, may not be the critical factor. For instance, Overall and Aronson (1962) suggest that one of the greatest problems presented by lower-class patients is their minimal involvement in therapy. In this study, about half of the patients terminated after only one or two interviews and they suggested that an important causative factor of drop-outs might be the patient's negative evaluation of the initial contact with the therapist, in terms of his expectations. The results of this study indicated that lower-class patients tend to expect a medical-psychiatric interview, with the therapist taking an active, supportive role. Those patients whose expectations were most inaccurate were significantly less likely to return for treatment. A similar finding is reported by Rapoport (1976). Hence, it may not be the social class of the patient which is important for continuance in therapy and successful outcome, but the attitudes he has towards his forthcoming treatment in relation to how he perceives his initial contact with the therapist. If his expectations are met, he is more likely to continue in therapy than if they are not.

Later, Overall and Aronson (1966) explore this topic further and suggest that one way of reducing cognitive inaccuracies is to attempt, during the initial phases of recruitment, to re-educate the patient both as to his own and the therapist's role in treatment. Moreover, it may be necessary to encourage a direct expression of expectations so that both patient and therapist can more easily view and modify their roles.

Riessman and Scribner (1965) conclude that studies which suggest that lower social class patients are not suitable for traditional dynamic long-term psychotherapy show a disregard for qualities which may indicate a positive potential for psychotherapy, e.g. a tendency not to isolate or intellectualise. They suggest that those from lower-class backgrounds may be far better therapy prospects than is generally realised (cf.Garfield (1978)).

An interesting finding (Garfield (1963), Riess and Brandt (1965), related to premature termination, is that those who terminate therapy early rarely go on and seek therapy elsewhere. Hence, it would appear that the confirmation or disconfirmation of initial patient expectations regarding the psychotherapy process are related not only to drop-out from therapy, but also future treatment. Support for this last point comes from a study by Grad and Lindenmayer (1977) of the psychiatric emergency room. They found that past treatment experiences determine, in large part, the patient's present request, and that request might not necessarily be to his benefit, as perceived by the therapist.

The findings of Grad and Lindenmayer (1977), Garfield (1963), and Riess and Brandt (1965) all point to the possibility of preparing patients for their forthcoming therapy in an attempt to reduce the number of premature terminations due to divergence between expectations and the reality of treatment.

The patient's expectations about the course and duration of therapy, the behaviour required of him, and the role of the therapist in treatment may be quite different from the expectations of the therapist. Such dyssymmetry of expectations has been shown to lead to premature termination and generally to unsuccessful outcome (Sloane et al (1970), Heine and Trosman (1960), Garfield and Wolpin (1963). Levitt (1966) proposes that there is a negative correlation between the effectiveness of any psychotherapeutic intervention and the discrepancy between the patient's expectation of the nature of the therapy process and the reality of the encounter. The more the patient finds that the therapeutic situation fails to conform to his preconception of it, the less likely it is to affect him favourably.

However, that the patient remain in treatment is a necessary but not sufficient condition for psychotherapy to be effective. The amount of time necessary for change to occur varies from patient to patient. The patient may remain in treatment and yet fail to improve. Although a patient who drops out of therapy may have derived considerable benefit, his departure may preclude any objective assessment of this benefit. The factors that determine whether a patient will remain in treatment may or may not coincide with those which determine whether he will improve if he does remain. Parloff (1961) found that patients who establish better relationships with their therapists tend to show greater improvement than those whose relation-ships with the same therapist are not so good.

As such, studies such as Zahn (1975) and Sloane et al (1970) are important as they attempted to experimentally manipulate patients' expectations prior to treatment. The purpose of the study by Zahn (1975) was to try and enhance the variables of attraction to the therapist and the expectancy for outcome by manipulating the degree of choice of therapeutic style an individual is allowed. The investigation utilised the principles of cognitive dissonance theory and predictions were made based on the rationale

that once a choice is made, the attraction of an unchosen alternative is a cognition inconsistent with the individual's knowledge that he has chosen a different alternative. It was proposed that dissonance would be reduced by making the chosen alternative more desirable and the unchosen less desirable than they were before the choice was made. Results indicated, however, that no significant differences were found among groups of subjects who were assigned to a therapeutic style, preferred a therapeutic style, or chose a therapeutic style. Similar findings to those are reported by Ziemelis (1974) and Gaynor (1976).

In contrast, Sloane et al (1970) utilised an "anticipatory socialization interview" to enhance expectations of improvement in patients. It was found at the end of treatment that patients who received an explanation of psychotherapy improved slightly but significantly more than those who did not receive it. Improvement was based on total social, sexual and work adjustment, and there was no significant difference in symptomatic change or attendance in the groups. A prediction that the anticipatory socialization interview might be enhanced by inducing expectations of improvement in four months was not borne out by the findings and it was not clear to what extent the pre-therapy preparations actually changed the patient's understanding of the therapeutic process.

As such, there was no support in this study for the suggestion that pre-therapy preparation is effective because it allows the patient to present himself in a better light to the therapist. Indeed, the patients who had received the suggestion that they would feel better in four months were found by the therapists to be less likeable than those who did not. Similar findings are reported by Roth et al (1964) who, instead of employing role preparation in sessions, controlled initial treatment conditions.

In contrast, Hoehn-Saric et al (1964) found a significant advantage at termination of relatively brief individual psychotherapy (four months) for patients who received "role induction" interviews prior to treatment. In studies of group psychotherapy, Truax and Carkhuff (1967) found "vicarious pre-training" effective with hospitalized patients; Truax and Wargo (1969) obtained similar results with neurotic outpatients; and Strupp and Bloxom (1973) reported positive findings with lower-class patients, using both interview and film as contrasting modes of preparation.

Other studies support this (e.g. Jacobs et al (1972), Warren and Rice (1972), but one limitation emerged in the five year follow-up done by Liberman et al (1972) of the patients originally studied by Hoehn-Saric et al (1964). At that later point, there were no significant differences in long-term improvement between patients who had received "role induction" training and those who had not. It would appear that such procedures may have a circumscribed effect. However, such studies do indicate that preparing the patient for the type of treatment he is going to receive can reduce the number of premature terminations and, in addition, clearly show that an explanation of psychotherapy is of greater value to the patient than mere exhortation to improve.

At this point, it is pertinent to introduce the suggestions of Goldstein (1962) discussing changes that occur in terms of a patient's aspirations. Invoking the concept of "level of aspiration" (Lewin et al (1944)) and its possible mediation on the affect of hope, or achievement motivation (Atkinson (1957), DeCharms (1968)), Goldstein (1962) argued that patients with "moderate" expectations are amenable to the greatest therapeutic change; expecting too much or too little would probably lead to a wide discrepancy between what is expected and what is actually realized. A similar argument is developed by Frank (1961) to account for the relationship between distress and outcome.

Such arguments treat distress (or the need for relief from distress) and prognostic aspirations as measures of inner processes within the patient that are accessible to external symbolic interaction. An alternative view, based on a more molecular level of analysis, might postulate a secondary, adaptive role for expectations (Helson (1941)) in which they form part of an adaptive response to the environment which, in this context, includes past experience, present distress, and treatment. Neither view necessarily excludes the other, but they emphasize different aspects and levels of a postulated causal sequence, none of which has been tied down by empirical research.

There are, however, two main conclusions to be drawn from research on patient expectations: patients with a better prognosis are those whose prognostic expectations are moderate and reality based, and whose process expectations are compatible with those of the therapist.

Such conclusions underlie the need for congruence between what the patient expects from therapy and the therapist's own goals and attitudes towards treatment; the final outcome depending on the mutual congruence of these expectations. Where they differ radically, treatment will be terminated prematurely or fail; where they coincide, it will be successful. The other part of this argument is that the patient's expectations must be realistic (Levitt (1966), Goldstein (1962))and that the final result is a reflection of the initial expectations. Zajonc and Brickman (1969) have described the lack of conceptual, empirical, and methodological clarity between expectations and aspirations, these authors noting that while the concept of expectancy places a relative emphasis on cognitive processes and the concept of aspiration implies the presence of motivational processes, both cognitive and motivational aspects are contained in each. To the degree that the expectancy-instilling procedures contain

motivational properties, a predicted outcome may function as goal,

performance standard, or criterion for the evaluation of the performance of

the individual to whom expectancy procedures are delivered.

1.3   Therapist expectations of psychotherapy.

As indicated by Cox (1978), a clear distinction exists between

facts which may be known about a patient and the other dimensions of

knowing, when he is encountered as a person. "Data about" and "meeting

with" come from different worlds of discourse, but to concentrate on one

at the expense of the other diminishes the total therapeutic resources

available for the patient. As such, the study of therapist expectancies

represents the intersection of two areas of investigation: the study of

variables contributing to effective psychotherapy and the general psychological

study of the expectancy effect.

While therapist behavioural and personality traits effect

differential therapeutic change (e.g. Kilmann and Sotile (1976), Hill

(1975), Cavenar and Spaulding (1978)), therapist cognitive variables have

been identified as contributing to the process and outcome of psychotherapy.

For instance, Temerlin and Trousdale (1969) found that even if

clinicians were asked specifically to attend to and report only observable

information, their descriptions of a patient were embellished with events

which were inferred and assumed, but not observed. Likewise Fontana

et al (1968) and Michaux and Lorr (1961) have found treatment recommendations

more consistently related to inferences which therapists have made about

the patient than they were to the complaints actually communicated by the

patient. Perhaps this is an instance of "parataxic distortion" (Sullivan

(1940)) whereby the perception of current interpersonal relationships is

distorted by previous interpersonal relationships and experiences.

In addition to therapist expectancy being one of the many therapist variables which may affect outcome, the therapy situation is one of the numerous settings in which expectancy effects may be found to occur. Rosenthal (1969) points out that it is pertinent to regard clinical interactions as a special instance in the class of general social interactions, and to consider the possibility that the principles governing general social interactions may be applied to account, in part, for events occurring in clinical interactions. Apart from the role of the therapist, there is a wide variety of applied functions served by the clinician, including those of educator, diagnostician, and institutional consultant (Wilkins (1977)).

Results of numerous early psychotherapy investigations indicated that expectancies of patient improvement were reliable across therapists and reliably correlated with some other therapist ratings. However, correlations between expectancies and measures other than therapist reports have been less consistent. Strupp (1958), for example, conducted an analogue study in which observers viewed a film of a patient-therapist interaction, rated the patient on a variety of dimensions, and judged how they would have responded to the patient at several points during the interview. He found that observers reporting favourable prognosis were more likely to accept the patient's perspective without trying to manipulate it and were less likely to respond in a "cold" manner than were observers reporting unfavourable prognosis. The prognostic ratings were most reliably associated with therapist positive attitude towards the patient, with patient emotional maturity, ego-strength, self-observation, insight, and social adjustment.

In contrast, Goldstein (1960) found therapist expectancies of patient change to be uncorrelated with patient reports of change during therapy. In spite of this, a posthoc data analysis indicated that therapists

of patients who reported improvement had significantly higher initial

expectancies than therapists of patients who reported becoming worse.   Hence,

measurement of improvement and deterioration must not be regarded as

absolute, but as relative to the patient's initial condition.   In addition,

Goldstein (1960) found that therapist expectancies of improvement measured

after the 10th and 15th sessions were correlated with duration of psycho-

therapy.   Patients whose therapists expected greater personality change

attended more therapy sessions than patients whose therapists expected

less change.   However, a general bias in the direction of being over-

optimistic about patient length of stay in therapy can result in marked

difficulty in the correct identification of the early terminator, as

cautioned by Affleck and Garfield (1961).

That the therapist's expectancies affect the amount of treatment

in relation to improvement is also suggested by Thompson's (1950) observat-

ion that frequency of sessions, over a fairly wide range, seems not to

affect either the duration or outcome of therapy.   Moreover,

> "in actual duration of treatment, in terms of months and
> years, the patient going five times a week takes about as
> long to be cured as the patient going three times".
>
> (Thompson (1950), p.235).

She concludes that the passage of time required for the patient

to consolidate new insights and incorporate them into his daily living

is a critical variable, rather than the amount of therapeutic contact.

However, an alternative conclusion might be that some therapists have changed

their expectancies as to the frequency of visits necessary to relieve

their patients but not as to the total duration of treatment required.

The interactive effect of therapist expectancies with process

events have also been investigated.   Lennard and Bernstein (1960), in a study

of therapy process variables, measured expectancies reported by both

therapists and patients prior to and during therapy, and also examined the relationship of those expectancies to other events in the therapist-patient relationship. The therapists' activity level expectancies were found to relate with actual activity level and both therapist and patient were generally agreed that the patient would do the most talking throughout therapy. Considerable discrepancy, however, was found between therapist and patient expectancies regarding the specific content of material to be dealt with in sessions. In addition, throughout therapy, the behaviour of the therapist was influenced more by the actual interaction with the patient than by the therapist's expectancies of that interaction.

Kumar and Pepinsky (1965) support this latter finding in a study of the interaction of expectancy-related, pre-therapy information about a patient and actual interaction with the patient on therapists' ratings. Presenting pre-therapy information describing a patient either as friendly or hostile was reported to have its intended effect on graduate student therapists and these initial expectancies were reinforced if the patient behaved in a manner which confirmed them. However, the authors also reported that if patient behaviour was discrepant from pre-therapy information, subsequent therapist ratings were determined by the behaviour of the patient rather than the prior information.

Summarizing the results of these investigations does not lend very strong support for the assumption that therapist expectancies function as determinants of patient change. Some correlational studies have indicated therapists expectancies, goals, and prognoses to be reliable across therapists (Affleck and Garfield (1961), Garfield and Affleck (1961)), and to be related to other therapist ratings (Strupp (1958), Strupp and Williams (1960), Garfield and Affleck (1961)), to patient attitudes towards therapy (Heller and Goldstein (1961), Hill (1969)), to duration of therapy

(Garfield and Affleck (1961), Goldstein (1960)) and to patient-reported improvement (Goldstein (1960)). However, none have shown a reliable association between therapist expectancy and symptom reduction measured independently of patient ratings. Even when expectancy information has been found to have an effect on outcome, the direction of the effect has not always been predictable; Anderson and Rosenthal (1968) and McNeal et al (1970) found reversal effects.

Despite an absence of strong empirical support, the intuitively appealing assumption that therapist expectancies explain events occurring in the therapy situation persists. Uhlenhuth et al (1959) employed the concept of expectancies to account for the results of an investigation designed specifically to prevent expectancy events from occurring. Lerner and Fiske (1973), even though expectancies were not measured in their study, invoked a posthoc expectancy effect interpretation to explain a failure to find statistical significance between patient characteristics and improvement.

Although stated in a different context, the issue, according to Bootzin (1969), is whether and under what conditions expectancy and therapy outcome are correlated because the expector actually influences the outcome or because of the expector's sensitivity to cues predictive of outcome.

In a practical sense, measurement of therapist expectancies along with other therapist characteristics, may serve as actuarial data employed only to predict probable therapy outcomes. As such, the main consideration would be the assignment of patients to therapists in an attempt to maximize the probability of patient change. Therefore, to validate the actuarial usage of therapist expectancies, it is necessary only to demonstrate a reliable and replicable correlation between the operations defining expectancy and the operations defining outcome (Wilkins (1977)).

That patient change occurs because of the expectancies held by the therapist requires that the predictive validity of the therapist expectancy construct is a necessary, but not sufficient, condition for the attribution of expectancy as a determinant of therapy outcome. Other conditions must be met which involve the operations employed to define and validate therapist expectancies and the issue of whether or not those operations occur independently of other events which may account for therapy outcome. In relation to the deterministic usage to which therapist expectancies have been put, no correlational or experimental study has both established the independence of therapist expectancies from therapy outcome and from other therapist characteristics, and validated the presence of the assumed expectancies. Indeed, once all the conditions necessary for causal attributions have been made, therapist expectancies explain no more than can be explained by appealing to observable events alone.

The importance of therapist expectancies does not appear to lie in its deterministic use; however, the actuarial usage of therapist expectancies does appear to hold significant implications for therapy research, training and practice. While there is not, as yet, definitive support for the actuarial usage of therapist expectancies, that usage appears to hold promise as a predictor of therapy outcome, as a variable to consider in the assignment of therapists to patients, and as an event the study of which may lead to heuristic identification of effective therapist conduct. The main value of actuarial usage of therapist expect-ancies appears to be as a factor interacting with other observable events, rather than as a main effect.

To the extent that therapist expectancy is prognostic of therapy outcome, the measurement of therapist expectancies is important in the identification of conditions under which patient change occurs. That

information may be of use in the assignment of patients to therapists who hold relatively high prognostic expectations, rather than to therapists who predict less therapeutic change.

While there does not appear to be enough evidence to warrant the conclusion that therapist expectancies contribute to patient improvement via being communicated to the patient (e.g. Anderson and Rosenthal (1969), Barber and Silver (1968), McGlynn and Williams (1970)), more recent findings from therapy research may be integrated with findings from the laboratory to provide an empirical foundation for hypotheses about events involved in the translation of expectancy information into patient change.

Garfield and Affleck (1961) and Strupp and Williams (1960) have shown that therapists are more interested in treating patients of whom they have relatively high expectancies of improvement. This differential selection in favour of high-expectancy patients would appear to be an instance of a more general decision-making pattern described in Feather's (1959a) theoretical model and supported by evidence presented by Feather (1959b): namely, that the probability of attempting to gain a goal increases as the probability of success increases.

If one assumes that psychotherapy is effective in inducing improvement to the extent that high-prognostic patients are more likely to receive therapy than low-prognostic patients, benefit will occur differentially in favour of high-prognostic patients simply by virtue of exposure to therapy. An implication of this is that, however, if initial expectancies are inaccurate and if, in interacting with the patient, the therapist gains information which is counter to pre-therapy information, subsequent expectancies will be arranged in accordance with the information gained through the therapist patient-interaction.

Results of studies in the therapy setting support this. Eells (1964), for example, found an overall positive correlation between therapist preferences for patient traits and selection for treatment; however, in the study by Kumar and Pepinsky (1965), when initial expectancies of an unattractive patient were disconfirmed by the patient's behaviour, not only were the expectancies of the therapist realigned to the patient's behaviour, but therapists were more willing to engage in further interaction with the patient. Accounts of diagnostic experiments reported by Sattler and Winget (1970) and Saunders and Vitro (1971) also support the interpretation that recent information has a more potent effect than prior information in applied settings.

The dimension of personal control of the therapist over expected events has also received attention. Several studies have been conducted to determine the conditions which lead one to attribute the cause of an event to oneself or to some other source. The results of these studies show that, if an intervention is followed by a change, particularly a change indicating success or improvement, subjects will attribute the cause of that change to themselves.

For example, Schopler and Layton (1972) found that subjects rated themselves as having been significantly more influential if the performance of another individual changed after their intervention than if the performance of another individual did not alter. Similar findings were reported by Johnston et al (1964), and are consistent with the trends noted by Locke (1965) in a post-experiment questionnaire in which subjects were asked the reasons for their liking or disliking of a task. The subjects who liked a task tended to attribute their liking to their own personal characteristics, such as skill while subjects who disliked the task, attributed their dislike to aspects of the task, events external to their own performance.

Applied to the psychotherapy setting, such findings would tend to suggest that if a therapist receives information that a patient has not shown improvement in the past, and if the reasons for the lack of success are attributed to patient characteristics, the therapist's expectancies and behaviour may be quite different than if the reasons for a lack of past success are attributed to characteristics of the therapists who have intervened in the past. In that expectancy information and information regarding personal control are confounded, the dimension of personal control may account, in part, for the variance previously atrributed only to expectancies.

Further, if a therapist receives information that treatment outcome for a particular patient is an event over which the therapist has little control, expectancies of improvement will be lower than if the therapist is informed that treatment outcome is within the therapist's control. As such, the dimension of personal control over therapeutic outcome also holds implications for patient selection, for therapists may be more likely to select for treatment those patients whose improvement is contingent upon intervention as opposed to patients whose change will be determined by extratherapy factors.

Regarding patient selection, Rosenbaum (1975) suggests that those who see their problems in interpersonal terms and for whom the pain of interpersonal failure provides the motivation to enable the stresses of joining a therapy group may do well in group therapy. However, not all patients describe their presenting symptoms in terms of chronic interpersonal distress. During initial contacts, the patient may describe primarily intrapsychic conflicts, acute interpersonal stress, (e.g. a failing marriage), behaviour patterns of long standing (e.g. homosexuality), all seemingly unrelated to other personality factors.

For the patient who does not formulate his problems in interpersonal terms, the therapist may offer a translation into such terms as he comes to see the interpersonal factors in the genesis of the patient's distress. How well the patient accepts and understands such translations, however, is an important part of the evaluation and of the preparatory phase of treatment. The patient may enter the group feeling vague about the interpersonal dynamics of his situation, even with the therapist's formulation, passively accepting referral to group therapy because he feels in sufficient distress to accept the suggestions of the interviewer. Rosenbaum (1975) states that it may take the patient weeks or months before he finds his goals shifting in the direction of seeking greater interpersonal fulfilment.

In addition, there are certain personality traits or configurations which are often challenged or threatened in interactional group therapy and which lead to early termination. For instance, an inability to make an initial commitment to the group to attend, patients who present with severe external stress or in crisis, or the patient who is extremely different from the others in the group in one or more major ways that he perceives himself, and is perceived by the group, as "not one of us".

According to Yalom (1970), the central issue of group deviancy is that the patient is unable to communicate on the same psychological and interpersonal wavelength as others in the group, that he cannot actively participate in the norms and the tasks which grow from the maturing group may not be applicable to his difficulties. In addition, there are those patients who would be deviant in one group, but easily accepted in another (Pokerny and Klett (1966)). Hence, choice of group is vital.

1.4   The therapeutic group.

But what constitutes a therapeutic group? Thompson and Khan (1970), argue that the number of members and degree of proximity are not sufficient to constitute a group. The common factor is a shared purpose or concern, of which all the individual members are aware; and the relationship, linking all the parts of the group together in a unique way, may be found in the psychological interaction   which follows upon the shared purpose. People may become a group through the activity of an external agent, such as a therapist, or equally they may become a group through their own recognition of each other, such as Alcoholics Anonymous.

Thus a number of people congregate, sharing some purpose, interest or concern, and stay together long enough for the development of a network of relationships which includes them all. Recognition of this network brings the concept of a group (Thompson and Khan (1970)). Each member of the group, though he may continue to behave in ways which are characteristic of him, is influenced by the behaviour of each of the others and also by the prevailing mood or climate which is present in the group at any one moment of time.

However, to understand this interaction, it is necessary to take all the individual pieces of behaviour, the contributions of each different member, and treat them as if they were parts of a meaningful whole. In order to do this, one must make certain assumptions about the nature of groups. One has to form a concept of The Group as a separate entity, to ascribe forces to it, and even to endow it with capacitites for decision and action. However, if treated too concretely, this concept of the group can lead to the naive transfer of properties, which belong to the individual, to the group as a whole.

Assuming that some connection exists between all the events

taking place in a group, one must also assume that, at some level, forces exist and exert an influence over every single thing that happens. These group processes must belong to the group situation itself; they are created by the group, and they occur inevitably whenever several individuals meet and form a relationship with each other. Therefore, to understand the meaning of the behaviour of any particular person in a group context at a moment in time, an exhaustive knowledge of that person is not enough; one must also look for the processes operating in the group which will have played a part in eliciting that behaviour.

In order to consider the processes taking place in any particular group situation, it is necessary to consider initially the expressed purpose for which the group is meeting. This purpose supplies a reason for meeting, establishing a framework and a context, and providing members with roles to play and expectations about the behaviour of other members; it may also impose a considerable degree of control over the proceedings.

Likewise, the structure of a group can impose some control over what may take place and set some limits to the behaviour of the participants. Within the group structure, which may be weak or firm, explicit or implicit, are the individual members, each with his own psychological make-up, needs, and problems.

As such, different needs will be activated by different circumstances. When a person is with a group of other people, the situation in itself and his feelings towards the other people present, will determine which of his habitual needs he will experience and how he will endeavour to satisfy them. His behaviour will also be influenced by his feelings towards the group itself, and the relationship prevailing between the group and the outside world.

There is, therefore, constant adaptation and change in the group situation as each member tries to influence the others to behave in a way favourable to his own particular and personal needs. The more structured the group, and the more stereotyped the roles that the members are expected to play, the less apparent will be the tensions and needs that each individual brings into the group. The needs will be more and they will exert some influence, but they will be masked by the formal procedures and there will be less opportunity for them to obtrude into personal relationships.

However, the aim of all therapeutic groups include the promotion of a degree of change in their individual members. This change is not something that takes place through the influence of any external factor, nor is it change in some determined way, although improvement in "mental health" (Wolman (1976)) is usually sought, or reduction of presenting symptoms. The agent of change is participation in the group itself, and in its processes, operating under exceptional and disciplined conditions. However, change in therapy does not come about by merely willing it. But whatever may happen in the group to help or hinder the development of this process, the safety of the group is ultimately the responsibility of the group leader.

1.5   The therapeutic relationship.

While it is possible to report specific outcome and change effected by group psychotherapy independent of process, it is essentially meaningless to discuss process without specifying the specific changes to which it refers. Kiesler (1973), in his critique of the dichotomy of "process" and "outcome" research, argues that the traditional process-outcome distinction has perpetuated the relatively exclusive use of pre-post designs in outcome studies, with the effect that information about the

form of the function that represents the improvement between the two end points, as well as for follow-up periods, has not been clarified. In addition, the use of only two measurement points entails the likelihood that any differences observed may be only chance fluctuations due to unreliability of measures. For Kiesler, patient in-therapy improvement manifested in his interview behaviour, is just as legitimate an outcome as extratherapy change.

Despite the existence of numerous theories and approaches to the practice of psychotherapy, all major viewpoints have emphasized the importance of the therapeutic relationship. Thus, it was not surprising that Fiedler's (1950a, 1950b, 1951) early studies of the dimensions of an "ideal therapeutic relationship" found that experienced therapists of different orientations concurred in their characterization of such a relationship as warm, accepting, and understanding, and that experienced therapists of different persuasions agreed with each other more than they did with inexperienced therapists of similar orientations. While Fiedler's results have been challenged on methodological grounds by Meltzoff and Kornreich (1970), subsequent investigations (Gonyea (1963), Parloff (1961), Raskin (1965))have supported his findings.

Largely on the basis of Truax's (Truax and Carkhuff (1967), Truax (1961)) unequivocal position, it has been argued that, by virtue of the very fact of their patienthood status, patients are unable to perceive accurately the nuances and affective qualities of interpersonal relationships, perhaps especially those of an intimate nature, as in psychotherapy. It follows from this premise that patients, therefore, will "distort" their perceptions of their therapists; hence, the argument goes, assessments of the thera-peutic relationship from the patient's point of view or phenomenological experience are poor indices of how facilitative therapy "really" is.

Even granting the likelihood that such perceptual distortions may occur

with a wide variety of patients (see, for example, Rosenbaum (1975)),

does not invalidate the proposition that these therapeutic conditions must

be perceived by the patient for change to occur.

It should be pointed out that Truax does not reject the usefulness

of the patient's perspective in all cases. Rather, he asserts, such assess-

ments are of

> "Little value with severely disturbed or psychotic individuals"

> (Truax and Carkuff (1967),p.73).

but may be

> "Valuable with juvenile delinquents, outpatient neurotics, and
> a wide variety of vocational rehabilitation clients".

> (Truax and Carkuff (1967),p.73).

In fact, there exists evidence that the use of patient ratings is not

inappropriate in psychotherapy research with chronically hospitalized

schizophrenics (Rogers (1967)) and with hospitalized alcoholics (Lierly (1967)).

Frank (1951) believes that the customary methods, such as those of

social psychology, which involve classifying and categorizing patients'

behaviour, are inappropriate in group therapy research, since in psycho-

therapy, the underlying meaning and attitudes of any behaviour need to be

understood. He also believes that behaviour can only be understood in the

light of the total group situation, and has therefore developed a method of

study which he calls "situational analysis" but this method remains essen-

tially descriptive and not replicable.

The key preposition that remains is that it is the patient's

perception of the quality of the therapeutic relationship that mediates

therapeutic change. Several studies (e.g. Heine (1953),Feifel and Eells (1963), Strupp et al (1964), Hathaway 1948)) indicates that the patient's perception of the relationship between himself and his therapist seems to be crucial. This appears to be true whether the therapy concerned is psycho-analytic or behavioural. More recently, Ryan and Gizynski (1971) and Sloane et al (1975) studied patients who had undergone behaviour therapy, and both reports conclude personal interaction with the therapist is reported as having been highly important. It is frequently assumed that the fact of a patient's remaining in treatment may be interpreted as evidence of the "goodness" of the relationship and therefore of the probability of an ultimately successful outcome.

1.6 The dynamics of the therapeutic process.

Despite their differences, all therapeutic rationales and rituals have certain effects in common. They heighten the patient's sense of mastery over the inner and outer forces assailing him by labelling them and fitting them into a conceptual scheme, as well as by supplying success experiences. Behaviour therapies do this by stressing progress in conquer-ing symptoms, insight therapies by helping the patient to gain new under-standing. Since the therapist represents the larger society (Birch (1979), Kendall (1975), Szasz (1976)), all therapies help to combat the patient's isolation and re-establish his sense of connectedness with his group, thereby helping to restore meaning to life (Frank (1974)). However, the question still remains of what is the nature of the therapeutic process.

Fundamentally, it is a kind of learning experience that takes place in a number of different ways (Marmor (1966)). One basic difference between psychotherapeutic learning and any de novo learning situation, however, is that in psychotherapy, the previously learned behaviour (the neurotic pattern), is particularly resistant to change. It was this fact that forced Freud to abandon his initial hopes that insight

alone could dramatically cure his patients, and to emphasize instead
the more difficult process of "working through"; this process of
working through being the core of the long-term psychotherapeutic process.

   In similar fashion, Rogers (1961) addressed himself to the
task of discerning the common elements in the process of psychological
change, particularly with reference to psychotherapy. Having found the
study of outcomes unsatisfactory, he found that the effects of therapy
is not moving from fixity to changingness. For Rogers, how the patient
discusses his feelings and problems is the clue to where he stands
on a continuum characterized at one extreme by rigidity, remoteness
from and lack of awareness of feelings, and at the other extreme by
fluidity, closeness to feelings and immediate awareness of them. While
the patient may function at somewhat different stages with respect to
different areas of his life, on the whole, his behaviours cluster within
a narrow range.

   Rogers (1961) describes the continuum in terms of several
stages, but the stages are not sharply demarked, and the conception
appears to be more a polar variable than a true stage conception. At
the first stage, personal constructs, in Kelly's (1955) sense, are rigid
and fixed. At the second stage, feelings are unowned or described in the
past. At the third stage, there is some conceptualization of self, and
personal choice of conduct are often seen as difficult to enforce on
oneself. Feelings not currently present are talked about; feelings mostly
are not accepted but considered bad, shameful or abnormal. Roger's
fourth stage has current feelings experienced but often not accepted;
there is recognition of personal constructs and beginning of questionning
of their validity. In the fifth stage, present feelings are expressed
freely, but the immediacy of feelings is surprising and frightening
rather than pleasant, and there is interest in self-discovery. At the

sixth stage, there is greater acceptance of immediate, intense feelings, and meanings are sharply differentiated. The incongruence between experience and awareness is vividly experienced as it disappears into congruence, and the relevant personal construct simultaneously disappears. The seventh stage is described in terms similar to those of the sixth stage, but it represents a more advanced state; in addition, the choice of courses of conduct become real and effective because the elements of experience are available to the individual.

Most of psychotherapy, according to Rogers (1961), is concerned with his fourth and fifth stages. Cases judged to be successful by other criteria show more movement on this scale than do less successful cases (Loevinger (1976)); moreover, the more successful cases begin higher on the scale. However, how to help those at the lowest stages is not yet fully understood. In addition, a vulnerable aspect of Rogers' position is the equation in some of his writings of maturity with adjustment and of both with congruence between self and experience. Likewise, it is open to debate that Rogers' fourth and fifth stages form the basis of most psychotherapy.

For instance, Andrews (1972) argues that therapy (he does not distinguish any particular kind), is directed towards a reconstruction or dissolution of neurotic or characterological patterns of the personality which are dominant in their relationship with others. This reconstruction or dissolution involves the following basic elements of psychotherapy: transference, catharsis, insight, reality testing, and sublimation in working towards this goal - these elements forming a temporal sequence. Andrews (1972) argues that certain therapeutic dynamics work hand in hand with these elements to produce the therapy for each of the group members. These dynamics may be defined as the forces which produce effective action in the field. In this instance, the field is the group of patterns

and the effective action is the elements of psychotherapy. The group is at all times seen as the vehicle of treatment for its individual members and, as such, the dynamics do not constitute the therapy but, instead, act as a facilitating agent for effective therapy.

The importance of group balance has already been alluded to for the initial formation of a group. The therapist has the responsibility of achieving the most effective group balance through careful selection of group members. Once the group is meeting, he can affect the maintenance of the balance somewhat through his verbalizations, but this can never substitute for an initially adequate group balance. The interaction produced by a planned, heterogeneous group balance acts dynamically to facilitate the elements of psychotherapy, in that it operates in the promotion of affective verbalizations to encourage catharsis, to serve as a comparative sounding board for reality testing, and to stimulate transference reactions.

Another therapeutic dynamic is that of group task orientation which is the assumption by the group members of their involvement in their interpersonal disturbances and their acceptance of the value of affective expression of their anxieties, conflicts and characterological patterns as a method of working towards a solution of these disturbances. This basic orientation is at first the responsibility of the therapist, but when accepted by the group members, it becomes a characteristic aspect of the group's functioning. What can appear at first a problem in the clinical management of the resistive patient can become a valuable dynamic in the form of the group task orientation (Bauer (1980), Pinto and d'Elia (1980), Bloom and Winokur (1972)).

The presence of group balance and the group task orientation become fundamental properties of the group's interaction. The therapist's

role is paramount in their establishment but, once established, their effect is group-originated. Without these two basic dynamics, the group would not function as a therapeutic experience but would only be a social experience.

A third dynamic is that of universalization, whereby patients become aware of the fact that almost everyone entertains similar negative and ambivalent feelings. The prior establishment of group balance and group task orientation lays the base for significant universalizing experiences within the group. The experience of the universalization of certain feelings, moods, and experiences seems to counteract the feeling of isolation many patients have and the consequent conviction that many of their feelings and experiences are completely unique (Birtchnell(1978)).

When the dynamic of universalization is present in the group, several elements of psychotherapy are given impetus. Initially, universalization relieves guilt, which permits certain beginning insights and gives a base for reality testing, which opens the gates for extensive emotional support from other group members. As guilt is relieved, members are able to admit to and talk freely about the underlying feelings, and further catharsis ensues. They then begin to realise and to see how these feelings are related to their actions, usually towards a series of recipient figures, such as parents, siblings, and spouse.

A fourth dynamic is that of extensive emotional support, which entails the positive reinforcement of a member's self-esteem by the verbal and/or nonverbal acceptance of that patient's feelings by other group members. Although this is essentially the same support given in individual therapy by the therapist, in a group, the support is extensive in nature, and in many ways it seems to be more meaningful coming from several concurrent sources. The experiencing of extensive emotional support from other members of the group can act as a prop to the self-image.

Several elements of therapy are facilitated by extensive emotional

support.   Though frequently stimulated by catharsis, this dynamic often

triggers off further and deeper catharsis.   Feelings that others are on his

side and will not criticise,unjustly reprimand, or slough off his feelings,

the patient is able to talk about many guilt - and anger - laden experiences.

Positive transference may form between the recipient of the support and the

group members who give the support, the positive transference stimulating,

through identification, positive avenues of sublimation. The energies released

through catharsis and stimulated by the positive transferences permit growth

of a more positive self-image.

However, the direct challenging of defenses by other group

members is equally important.   Before the other group members "confront" each

other, extensive support must be prevalent in the group interactions so that

the "confrontation" will not be perceived as criticism or ridicule.   The

extensiveness of the confrontation coming from several members, plus the

perceived supportiveness of the group, breaks down the necessity for the

defenses without overwhelming anxiety.   This seems to be a particular instance

in which group therapy works more effectively than individual therapy

Yalom (1970).   The extensive confrontation of defenses usually occurs increas-

ingly directed over a period of time, building up to a firm refutation of the

defensive elaboration by several group members.

The final dynamic is that of experiential validation, which is

usually defined either as the abandonment of inappropriate behavioural

responses through experiencing their inappropriateness in interpersonal

relations within the group, or as the establishment of appropriate behavioural

responses through experiencing their appropriateness in interpersonal relations

within the group.   Essentially, this dynamic is the learning process embodied

in working through the multiple transferences which emerge between one member

and the other members.   The appropriateness or inappropriatness of a

patient's behaviour responses is validated by the group's response to
the behaviour both in their actions and in their verbalizations regarding
the patient's behaviour. The unlearning of negative responses facilitated
by experiential validation precedes the learning of more positive,
appropriate responses, this being the last hurdle the individual has to get
over in order to develop a realistic and appropriate relationship with others.

As such, the group serves as an experiential arena for the
reality testing of behavioural patterns;   intellectual insights are exposed
as being realistically ineffectual without subsequent emotional translat-
ion into appropriate action and gradually, emotionally meaningful insights
develop (Brady (1967)). The presence of negative transferences indicates
that the old responses have not been extinguished sufficiently.

Usually, these six therapeutic dynamics develop in the sequence
in which they have been discussed, although at times, universalization
and extensive emotional support can occur during the development and
acceptance of the group task orientation (Andrews (1972)). Four dynamics-
group balance, group task orientation, universalization, and extensive
emotional support - are characteristic of the formative stages of the
interpersonal interaction within the group, and three dynamics - extensive
emotional support, extensive defense confrontation, and experiential
validation - are more prominent in the later stages of the interaction
within the group. Each dynamic highlights one aspect of the process of
group therapy but also represents one of the interrelated aspects of group
process considered as a whole, and these aspects can be conceptually
synthesised to provide a comprehensive, integrative view of what happens
in group therapy interaction.

Nevertheless, it cannot be assumed that affective and effective
changes will occur simultaneously. For some patients, affective changes

may occur more readily than improvement in areas of social effective-
ness. Moreover, the course of change in subjective comfort and manifest
effectiveness may follow quite different patterns. The patient may increase
in comfort and even reach peak experiences quite early in the course of
therapy, while his effectiveness may not observably change until much
later in treatment. As a result of such differential rates of change,
the association between criteria of change in affective and effective
states may vary greatly at different points in time.

In addition, what individuals report as having experienced in
therapy need not correspond with these dynamics, and, when asked to
describe what has been happening in therapy, the report given can depend
on who is asked - patients'therapists, or observers. Patients may use
the experience quite differently and see themselves as deriving different
kinds of benefit.

For instance, Mintz et al (1973) found there was a reasonable
consensus in descriptions of several aspects of a psychotherapy session.
In particular, good agreement was noted across all views in descriptions of
the patients' emotional states. However, evaluation of the goodness of the
session did not correlate significantly with patient emotions for all views.
On the other hand, consistently poor agreement was noted in evaluation of
the quality of the therapist's relationship within a session, and the
goodness of the session itself.

In an earlier study, Mintz and Luborsky (1971) reported that
agreement in evaluation of the quality of therapist relationship style
may be particularly difficult to obtain. In that study, raters who
listened to whole hours of therapy and raters who heard only brief segments
from the same hours agreed on most descriptive ratings, with the notable
exception of an Optimal Therapist Relationship factor, for which poor

agreement was found. Unfortunately, this factor appears to be crucial in understanding the experience of "good therapy". This observation about judgments of goodness of sessions appears to parallel a finding for judgments of the outcome of an entire treatment - patients, therapists, and external observers tend to have only low agreement (Cartwright et al (1963), Luborsky (1971)).

However, the data of Mintz et al (1973) confirmed what kinds of events are experienced as good therapy (Auerbach and Luborsky (1968), Mintz and Luborsky (1971))- on this, there is reasonable consensus. Primarily, it implies an involved, understanding therapist and secondly, an involved, active patient. But this apparent "agreement" on the verbal level as to what effective treatment is like does not negate the fact that their raters did not agree as to when, in fact, effective treatment was happening.

Weaver (1975) attempted to meaningfully quantify some of the more subjective aspects of therapy and relate those to the quality of therapy. This research aimed to measure the impressions of patient and therapist about the various aspects of the therapy experience, and assess the quality of agreement between various observers, both participant observers and outside observers. Measures were also included to determine if areas varying in the quality of agreement could be delineated and explained.

Results indicated that agreement between all raters on all variables varied over an extremely wide range from highly positive to highly negative. Discrepancies appeared to be particularly related to the quality of the therapy session: the better the session, the better the quality of agreement. An important side outcome of this study, however, was the demonstration that while each individual measure or observer may be suspect, the inclusion of several diversified measures on a phenomenological event

increases the appreciation of the uniqueness of the event and decreases
the probability of this interpretation and over-generalization.

Similarly, Hill (1975) found that evaluations of the therapy
process by patients, therapists, judges using frequency data, and judges
doing ratings, produced conflicting results. Patients judged according
to a "halo effect"; therapists were more accurate in their reports as
compared to behavioural data, but were, in general, less satisfied with the
sessions than were the patients; frequency counts gave an accurate and
quantitative unbiased view of the process; and judges' ratings were
unrelated to either therapists' or patients' perceptions. Yet again, the
conclusion was drawn that it is important to know who makes the evaluat-
ions of effectiveness of therapy.

However, an explanation that is consistent with both clinical
experience and a growing body of empirical research (Bednar and Lawlis
(1971)) suggests that a group member's perception of the quality of
"therpeutic conditions" offered by the group as a whole may be more salient
in mediating therapeutic change than is the member's perception of those
conditions in the group therapist alone.

1.7   The therapeutic experience.

The experience of psychotherapy highlights the occurring
involvement in the therapeutic process as it is viewed internally from the
perspective of the participants, which may include not only their perception
of self, but also their perceptions of others and of the social and physical
milieu. The individual's perception in a social situation is generally
divided in a shifting, fluid way between self-awareness and a typically more
salient awareness of the "object world" that is comprised of co-participating
individuals and the current situation in which they are mutually involved.

Two things, however, differentiate psychotherapy from most other
social situations. First, the therapist is likely to be an unusually
influential focus of awareness for the patients, especially in individual
therapy where the therapist is virtually the sole occupant of the patient's
"objective world". Second, the patient's own self-perceptions are likely
to be brought more forcefully into the foreground of awareness than in
most other social situations. As such, both of these factors heighten
sensitivity to the impact of the experiential aspects of the relation-
ship on the patient.

Just as the individual's perception is generally divided between
"self" and "other", so the individual's self-perception is, in turn,
typically divided between the externalization of self in conduct and
appearance, and the internal milieu of feeling and identity (Goffman (1971a),
(1971b)). Surprisingly, there are only a few studies involving either
the patient's or therapist's self-perception of his own participation
in the process and outcome of therapy.

Turning attention first to the therapist's experience and
therapeutic outcome, process-outcome research utilizing the therapist's
perceptions of process have focused primarily on the therapist's view
of the patient, the therapist's self-experience, and, to a very slight
extent, on perceived qualities of their relationship.

The patient's instrumental participation includes both role
engagement and goal attainment, related to the therapist's view to
the "means and ends" of the patient's conduct. Certain qualities of
patient role engagement, as observed by therapists, have been associated
significantly with therapeutic outcome. Gendlin et al (1960) found that
therapist reports of patients' movement from talking about to experienc-
ing feelings, were positively associated with improvement in individual

client-centred therapy while Roether and Peters (1972), studying sex offenders in group therapy, found that therapist perceptions of patients' expression of hostility was positively related to outcome. These limited findings suggest that therapist awareness of patients' freedom in experiencing feelings is indicative of successful therapeutic outcome.

Likewise, there are only two studies to date that give data relevant to therapist perceptions of patient ongoing goal attainment in relation to eventual outcome, and their findings are somewhat conflicting. Saltzman et al (1976) found that therapist ratings of patient improvement or progress in problem resolution, judged from the third session, were unrelated to outcome, while Malan (1976) found that therapists' intercurrent impressions that therapy was "going well" did positively relate to eventual outcome in brief psychotherapy.

A number of process-outcome studies focus on the patient's "inherent" attributes rather than the patient's self-externalization in conduct as a target of therapist perceptions. These attributes may be split into role attributes and personal attributes and, within the former category, into attributes of role investment and role ability. The therapist's perception of the patient's motivation is one role investment variable examined in several process-outcome studies (e.g. Prager (1971), Malan (1976), Strupp et al (1963)),but the results are in conflict.

Therapist ratings of patient prognosis seem pertinent to both the role attributes and the personal attributes of the patient, as these strike the therapist. Of three process-outcome studies which include this variable, Prager (1971) found no correlation between improvement and good prognosis early in treatment; Saltzman et al (1976) found a significant positive association between outcome and prognosis rated in the third

session; and Strupp et al (1963) found that therapists' retrospective assessments of patient prognosis also correlated positively with outcome.

Patient likeability, as seen by therapists, is the personal attribute most often included in process-outcome studies. Gotteschalk et al (1967), investigating extremely short-term emergency therapy, found no correlation between therapist liking for a patient and outcome. Similarly, Prager (1971) found no association between outcome and patient likeability as rated by therapists early in treatment. However, at termination, he did find a significant positive correlation, suggesting that therapists may experience an increasing sense of liking towards more successful patients over the course of treatment. Likewise, Ryan and Gizynski (1971), Strupp et al (1964) and Sloane et al (1975), all report significant positive associations between outcome and terminal or retrospective therapist assessments of patient likeability. However, they offer no answer to whether the more likeable patients improve or the more success-ful patients are better liked by the therapist. As such, there remains a presumption of some relation between patient likeability and therapeutic outcome but precisely what the connection is, is open to question.

Although the therapist is not the focus of therapeutic concern, and may enter his own awareness most often in a subsidiary way, there is some clinical research, and much lore, to suggest that the therapist's self-perceptions are an especially interesting aspect of therapeutic process (e.g. Howard et al (1969), Orlinsky and Howard (1975)). Two studies have focused on therapists' awareness of their instrumental participation with patients, both indicating positive findings in relation to to outcome. Ryan and Gizynski (1971) found in behaviourally oriented therapy that therapists of more improved patients were more likely to report after treatment that they had deliberately fostered positive expectations. Similarly, Malan (1976) studying brief psychoanalytically

oriented treatment, reviewed therapists' reports of their interpretive

interventions and found that transference interpretations, which

indicated similarities between patient reactions towards the therapist

and earlier familiar reactions, gave strong, positive correlations with

outcome, while interpersonal interpretations were found to be negatively

related to patient improvement.

Regarding the therapist's sense of his own role investment,

Rosenthal and Levine (1970) found that for brief individual therapy with

children, poor therapist motivation for the procedure was associated

with poorer therapeutic outcome. In contrast, Saltzman et al (1976)

found no correlation between patient improvement and the therapist's sense

of involvement or "emotional availability" defined in terms of concern

and attentiveness. While these two studies are not very similar, there

are no others bearing on this point, and, as such, the issue is left in

some doubt.

Similarly, there are only a few studies of patient's self-

perception of his own participation in the process and outcome of therapy,

as will now become clear.

In most therapies, the patient's participation consists of

engaging in a specialized kind of conversation.Saltzman et al (1976)

found that patients who perceived themselves as expressing their thoughts

and feelings with greater "openness" early in treatment had significantly

better outcomes than patients who perceived themselves as less open in

talking with their therapists. Consistent with this finding, patients

who felt they had a better "understanding" of what their therapists were

trying to communicate to them also had significantly better outcomes than

their less comprehending fellow patients. The attainment of self-

understanding through sincere encounters with others, and the chance for

self-expression and emotional catharsis, were also instrumental

qualities of participation in group psychotherapy stressed by success-

fully terminated patients (Yalom et al (1975)).

Another aspect of instrumentality that is salient in perceptions

of conduct is goal attainment. Saltzman et al (1976) found that the

patient's sense of "movement" or progress in problem resolution, even

as early as the third session, was significantly and positively correlated

to patient improvement, as judged by the therapist at termination. Tovian

(1977) supports this finding in that "experienced benefit" and the attain-

ment of catharsis, encouragement and a sense of mastery and insight by

patients in their therapy sessions was predictive of patient improvement

at termination.

Relational aspects of participation are also prominent in the

individual's perception of his own externalization of self, in this

instance, taking the form of the patient's awareness of relating to the

therapist. Patients who see themselves as acting in an "accepting" (i.e.

friendly, attentive, consenting) manner towards their therapist were

found by Tovian (1977) to be rated as improved than those who did not

see themselves in this way. Consistent with this, is the report of Lorr

and McNair (1964), whose data indicated that patients perceiving themselves

as acting in a "hostile-controlling" manner had significantly poorer

outcomes than others.

These two studies also provide some information on a related

aspect of patients' self-perception of their conduct towards their

therapists. Tovian (1977) found that patients who reported behaving in a

"structuring" (i.e. actively initiating) manner with their therapists had

better outcomes, while Lorr and McNair (1964) reported no significant

correlation between outcome and patient self-perceptions as relating

in a "dependent" or in a "controlling-resistive" manner towards their

therapists, but indicated that patients who perceived themselves as

"actively involved" were significantly more improved.

Of the few findings available on patients' internal self-

experience, Saltzman et al (1976) found, in terms of patients' sense

of role-identity, a tendency towards better self-rated outcome among

patients who felt a greater sense of "responsibility" for solving their

own problems and altering their behaviour, as compared to those who

placed the responsibility for this more on their therapists. Likewise,

Jeske (1973) found that patients in group therapy who more often

"identified" with the experiences reported by other patients appeared to

have more favourable outcomes than those who felt less identification.

Such findings would tend to suggest that the patient's experience of

active and passive involvement in his treatment is predictive of success-

ful outcome in diverse terms of psychotherapy.

As in the case of self-perception, it would seem natural to

differentiate between the patient's view of the therapist's appearance

and conduct,and the therapist's seemingly "inherent" attributes, as an

individual. The therapist's relational participation, as perceived by the

patient, can be viewed in terms of value contact and status contact. The

majority of studies focus on the patient's experience of the therapist's

value contact in relation to outcome; these studies including perceptions

of the therapist's nonpossessive warmth, positive regard, acceptance,

respect, and positive valuing, but while fine distinctions might be drawn

among those constructs, their commonality appears to outweight the nuances

of difference. Moreover, the evidence of many studies, ranging in focus

from the idealized "moment" of process to the whole course of treatment,

is unanimous in showing that the patient's perception of the therapist's manner as affirming the patient's value is positively and significantly correlated with successful therapeutic outcome (e.g. Board (1959) Strupp et al (1964) Martin and Sterne (1976), Saltzman et al (1976), Sloane et al (1975)). Given the diversity of samples, measurement instruments, and analytical strategies represented in these studies, the convergence of results is striking.

Considerably less attention has been devoted to patient perceptions of the status contact implicit in the therapist's manner in connection with outcome. However, Lorr (1965) found that patients who saw their therapists as "independence - encouraging" had significantly better outcomes than others, while those who perceived their therapists as "authoritarian" in manner, had significantly poorer outcomes. Martin and Sterne (1976) were able to confirm the positive correlation of outcome with patients' perceptions of their therapists as "independence - encouraging", using the same instrument but with a rather different type of patient and treatment setting. But they found no association between outcome and "authoritarian" manner.

Perceptions of the therapist's relational participation inevitably overlap, to some degree, with perceptions of the therapist's "inherent" attributes as an individual. Nevertheless, it is possible to separate the two in experience, as indicated by the fact one often feels an individual's actions are "out of character", i.e. the qualities attributed to his conduct are incongruent with the qualities attributed to the person. Further, it is possible to differentiate the individual's perceived attributes into personal attributes and role attributes.

Among the perceived role attributes of the therapist is his therapeutic skill or ability, and chief among the skills that have been

studied in relation to outcome is the therapist's empathy or empathic understanding. Whether focusing on the idealized average "moment" of process (e.g. Lesser (1961), Lorr (1965), Cain (1973)), the early phase of treatment (e.g. Saltzman et al (1976), Tovian (1977),Kurtz and Grumman (1972)), or considering process over the course of therapy (e.g. Martin and Sterne (1976), Sapolsky (1965)), these investigations generally support the notion that the sense of being understood by the therapist is a fairly consistent feature of beneficial therapy, as experienced by patients.

Other aspects of perceived therapeutic skill are reflected in the patient's experience of the therapist as "helpful" (Tovian (1977)), as "competent and committed to help" (Saltzman et al (1976)), as "credible" (Beutler et al (1975)), as "confident" and able to induce positive expectations of treatment (Ryan and Gizynski (1971)) - all of which were found to be positively related to therapeutic outcome.

In addition to responding to the therapist's apparent skillfulness, patients also respond to their sense of the therapist's personal investment in his role functioning. Strupp et al (1964), for instance, found that patients' retrospective perceptions of their therapists as really "interested" over the course of therapy was positively correlated with successful outcome. Bent et al (1976) reported that patients who perceived their therapists as "active" and "involved" also had significantly better outcomes, although patients who saw their therapists early in treatment as being "detached" (i.e. bored or distracted), tended to deteriorate rather than improve in therapy (Toyian (1977)).

Finally, Horenstein (1974) suggests that perceived therapist qualities are not simply related to outcome, as such, but are influential as confirmations or disappointments of prior expectations; the confirmative

perception being positively associated with patient improvement. As
such, the core portion of the patient's perception of the therapist is
composed of personal attributes, as distinct from the skills or invest-
ment he manifests in the role of therapist. It would therefore appear
that it is the interpersonal perception of the therapy process which is
vital for successful therapeutic outcome and, as such, the effects of
therapy must be delineated.

1.8   The effects of psychotherapy

Reviews of the effects of psychotherapy have been
debated and highly influential. It is therefore pertinent to review
studies of therapy outcome in the context of the controversy surrounding
their implications for practice.

The ambiguity of the data in question has been a crucial
contributor to the debate. This deficiency is best illustrated by
reference to the Eysenck-Rachman surveys and reactions to them (Eysenck
(1952), (1960), (1965), (1966), (1967), Rachman (1971), (1973))·Eysenck
purported to show that about two-thirds of all neurotics who enter psycho-
therapy improve substantially within two years and that an equal proport-
ion of neurotics who never enter therapy improve within an equivalent
period. Eysenck originally based his conclusions on the percentages of
improvement in 8053 cases from 24 outcome studies, but a review of those
studies reveals the ambiguity of the original data in that different
percentages of improvement may be derived, depending on what criteria
and what method of tabulating the reviewer uses.

As such, many therapy researchers disagree with these findings
and interpretations. Bergin (1971) has a comprehensive appraisal of the
numerous publications on this, but it is possible to summarize the
conclusions from these studies. First, studies do not generally specify

the precise nature of treatment or the limits of applicability. They are tests, for the most part, of whether therapy has any effect at all and, as such, it is impossible to conclude very much from such studies except that psychotherapy "works". Second, most studies do not seem to provide strong evidence that psychotherapy has, on average, more than modestly positive effects, but the number showing positive results is clearly greater than chance. Third, there is a slight tendency for more adequately designed studies to yield more positive results. Likewise, it seems evident that something potent or efficacious is operating in some portion of the therapy routinely offered; even though average effects are only moderately impressive when diverse cases, therapists, and change scores are lumped together. Fourth, there does not seem to be a relationship between duration of therapy and outcome, nor is there any relationship between type of therapy and outcome. Experienced therapists fare better that inexperienced therapists and, finally, at least two factors operate which may make the observed effect of therapy seem more limited: the fact that a number of neurotic patients improve without treatment, and the fact that a number of patients deteriorate.

The issue of spontaneous remission is of major interest as it is presumed to confound the success rates that are attributed to participation in psychotherapy. Numerous authors have attempted to determine which, if any, baselines are suitable (Bergin (1971), Rachman (1973), Lambert (1976)),but have been unable to distinguish clearly those studies that include subjects who had minimal treatment but not extensive psychotherapy from those studies that include subjects who for the most part were untreated. However, Bergin and Lambert (1978) quote a median spontaneous remission rate of 43%, with a range of 18% to 67%, which is far from the original statement of two-thirds suggested by Eysenck (1952) and supported by Rachman (1973).

Bergin and Lambert (1978) note that a two-thirds estimate is

not only unrepresentative but is actually a most unrealistic figure for describing the spontaneous remission rate or even rates for minimal treatment outcomes. They do, however, indicate that anxiety and depressive neuroses have the highest spontaneous recovery rates, followed by hysterical, phobic, obsessive compulsive, and hypochondriacal disorders; but no study has attempted to describe recovery rates by diagnostic classification while holding constant other important variables such as degree of disturbance, type of onset, and past history of disturbance.

The term "deterioration effect" was proposed by Bergin (1966) to describe the general finding that a certain number of psychotherapy patients are worse after treatment. Such an effect was suggested by the tendency for treated groups to show an increase in variance compared with control groups on outcome measures. Deterioration implies an impairment of vigour, resilience, or usefulness from a previously higher state. Generally, it has been regarded as a worsening of the patient's symptomatic picture, the exaggeration of existing symptoms, or the development of new symptoms, as assessed before and after treatment.

Hadley and Strupp (1976) have, in addition, suggested that the negative effects of therapy may include a sustained dependency on the therapist or therapy and the development of unrealistic expectations which result in patient activities that are beyond his capability. These may lead to guilt, self-contempt, and possibly contribute to disillusionment with therapy and a corresponding general loss of hope and depreciation of all helping attempts. These latter possible negative effects are, of course, more subtle, and to them might be added the lack of significant improvement when it can be realistically expected.

Examination of the empirical literature leads to the conclusion that deterioration can, and does, occur in a wide variety of patient

groups with an equally wide variety of treatment methods. It occurs in

severely disturbed patients (Fairweather et al (1960)), in normals

(Lieberman et al (1973)), in predelinquent boys (Powers and Witmer (1951)),

as well as in neurotic outpatients (Barron and Leary (1955)). It seems

to be reported in studies that employed therapists who differ in training

and experience, such as medical students (Uhlenhuth and Duncan (1968)),

paraprofessionals (Carkhuff and Truax (1965)), psychiatric residents

(Gotteschalk et al (1967)), and combinations of experienced and inexperienced

therapists (Fiefels and Eells (1963), Rogers and Dymond (1954)).

The treatment techniques for which some deterioration can be

identified are likewise very diverse and not exclusive to psychotherapy.

Reports of psychotic episodes precipitated by ECT are not uncommon(Elmore

and Sugarman (1978)). Questions about psychosurgery have been raised,

and deterioration from drugs are not unknown (Shader and DiMascio (1970)).

Some of these methods, in fact, may be destructive enough to cause

permanent negative behaviour change. Likewise, the hypothesis that

differing approaches and theories of change show marked tendencies for

differential effects on patients and that these effects would be apparent

in patient deterioration rates has not been supported by the empirical

evidence (e.g. Rachman and Teasdale (1969), Bruch (1974), Marks (1971),

Blinder et al (1970)).

Regarding group treatment in particular, the controversy over

casualities in experimental groups became apparent in the late 1960's

when Campbell and Dunette (1968) reviewed the research literature regard-

ing the effectiveness of T-group experiences and alluded to several

studies that showed some negative outcomes. More recently, Hartley et al

(1976), have specifically examined the empirical evidence on encounter

groups with regard to the question of deterioration. Having summarized

nine studies appearing since 1966, Hartley et al (1976) report a large

variation in estimated casualty rates across studies from less than 1% to
almost 50%, the median casualty rate being about 6%. Those varying rates
are a function of the casualty criteria employed, varying member character-
istics, and perhaps the diverse nature of the treatments studied.

From the research literature, it is difficult to identify
deteriorative variables that relate exclusively to group treatment. Lieberman
et al (1973) indicate that generic labels identifying the groups they studied
did not have differential process or outcome correlates. For example, one
of the Gestalt groups evaluated was found to produce the most casualties,
whereas another Gestalt group was among the most beneficial. However, they
were able to identify some group process variables that were related to
negative effects, namely the encouragement of confrontation, expression
of anger, rejection by the group or leader,and feedback overload.

There is a growing body of knowledge that confirms the value
of psychotherapy, but differences in outcome between various forms of
intervention are rare. While behaviour therapies and their cognitive
variations, sometimes show superior outcomes, this is by no means the
general case. Even when it is the case, the criteria of change are often
biased in the direction of being sensitive mainly to behavioural changes,
despite the fact that changes in both behavioural and internal states are
important.

Truax and Carkuff (1967), for example, utilized the distinction
between dynamic and symptomatic criteria when reviewing a number of studies
of patient characteristics and patient change, reporting that certain
apparent contradictions in outcome could be resolved by distinguishing between
these two types of criteria. For instance, they pointed out that initial
level of inner disturbance is positively correlated with outcome, while initial
level of behavioural disturbance is negatively related to outcome. Taking

this concept one step further, Malan (1976) has devised what he calls an assessment of internal or dynamic changes as opposed to symptomatic or behavioural change. In addition, it is too simplistic to expect patients to show consistent and integrated improvement as a result of therapy. The fact that change is multidimensional has lead to the practice of applying multiple criterion measures in research studies.

For instance, Ross and Proctor (1973) and Wilson and Thomas (1973), using multiple criterion measures, found that a specific treatment used to reduce seemingly simple fears resulted in a decrease in behavioural avoidance of the feared object while not affecting the self-reported level of discomfort associated with the feared object. Likewise, a physiological indicator of fear showed no change in response to a feared object as a result of treatment while improvement in subjective self-report was marked. This suggests that divergent processes are occurring in therapeutic change; that individuals themselves embody divergent dimensions of phenomena; and that divergent methods of criterion measurement must be used to match the divergency in individuals and in the change processes that occur within them.

Factor analyses of multiple change criteria used in complex psychotherapy outcome studies yield generally similar findings (e.g. Cartwright et al (1963), Nichols and Beck (1960), Gibson et al (1955), Forsyth and Fairweather (1961)). The main factors derived from these studies tend to be closely associated with the measurement method or sources of observation used in collecting the data rather than being identified by some conceptual variable that would be expected to cut across techniques of measurement. Among the most typical factors are patient self-evaluations, therapist evaluation, TAT or other fantasy evaluation, independent clinical judgment, indices of concrete overt behaviours, and a limited bag of factors associated with specific instruments.

A more recent investigation (Berzins et al (1975)), addressed

itself directly to the issue of consensus among criterion measures. Studying the relationship among outcome measures in 79 patient-therapist dyads, using the MMPl, Psychiatric Status Schedule, the Current Adjustment Rating Scale, and the sources of outcome measurement involving the patient, therapist, and trained observers, it was found that data from all three sources, and a variety of outcome measures, showed generally positive outcomes for the treated group as a whole at termination. Their primary hypothesis, however, was that problems of intersource consensus could be resolved through the appreciation of alternatives to conventional methods of analysis. When subjected to principle components analysis, their data showed four components; changes in patients' experienced distress as reported by patients on a variety of measures; changes in observable maladjustment as noted by patient, therapist, and psychometrist; changes in impulse expression; and finally, changes in self-acceptance. Underscoring the obvious complexity and wealth of knowledge that may be hidden from view by a limited analysis of data, the findings of Berzins et al (1975) are supported by Mintz et al (1979).

Strupp and Hadley (1977), in a discussion of therapeutic outcomes, emphasize the multiple effects of psychotherapy and the need for a conceptual model in evaluating the diverse changes that result from psychotherapy. As such, they present a tripartite model which suggests that outcome be viewed from the vantage point of society (behaviour), the individual himself (sense of well-being), and the mental health professional (theories of healthy mental functioning), suggesting also that these three views be assessed simultaneously.

Such a model indicates that interpersonal and nonspecific or nontechnical factors still loom large as stimulators of patient improvement and, therefore, it should come as no surprise that helping to deal with their inner conflicts, to form viable relationships, to become less threatened and

defensive, or to engage in more productive behaviours can be greatly

facilitated by an interpersonal relationship that is characterized by

trust, acceptance, warmth and human understanding. However, while it appears

that these personal factors are crucial ingredients even in the more technical

therapies, this is not to say that techniques are irrelevant, but that their

power for change diminishes when compared with that of personal influence.

Technique is crucial to the extent that it provides a believable rationale

and congenial modus operandi for the change agent and the patient.

CHAPTER 2.

The Present Investigation.

2.1.   Problems of research in psychotherapy.

The programmatic investigation of participants' contributions
in psychotherapy is clearly more than simply establishing a few classes for
each component (therapist, patient, treatment and outcome) and studying
each of the many combinations of one instance from each component. There
are obviously interactive effects, such as the highly relevant interactions
for certain combinations of therapists and patients (e.g. Betz and Whitehorn
(1956), Bednar (1970)). As such, it must be recognised that while a single
empirical study has value, it does not establish any fact or principle. It
may provide strong suggestions as to possible relationships, it may increase
by one step subjective confidence in some general propostion, or it may
point to variables which appear to make substantial contributions to the
variance.

For instance, while the remission of a single symptom may be
judged with adequate agreement among observers, the assessment of overall
symptom relief requires an integrative judgment. After all, how a person
is seen by others is highly relevant to decisions about the desirability
of treatment and evaluations of outcome. These others include not only
those involved in his treatment, such as the therapist, but also signifi-
cant people in his life, such as spouse, friends, and colleagues. And
the patient's perception and cognition of himself is, of course, fundamental.

The importance of an integrative judgment of symptom relief
arises out of the fact that almost instantly, when someone perceives
another person, he begins to form impressions of that person. Even if
these impressions are not verbalized, they undoubtedly affect how he
interacts with the other. Subsequently, these impressions are put into
words when one thinks about the other or when one describes the other to
a third person.

To test the hypothesis that an effective treatment effects a positive change would appear to be a simple matter. At first thought, the measurement of change appears to be an easy matter - make a measurement before treatment and a measurement after treatment and take the difference. However, while this simple approach may be satisfactory when the measurement is quite free of errors and is perfectly reliable, there is no agreement concerning the selection and measurement of meaningful process and outcome variables. Moreover, measurements of change associated with psychotherapy possess limited reliability.

The measurement of change in an individual, using fallible procedures, turns out to be a highly technical matter and there is still no consensus among experts on the best way to do it, despite what is now decades of investigation. Therefore, researchers are caught up in an impossibly complex situation and can only survive by restricting investigations to limited fragments of the total situation.

Over and above this, Birtchnell (1978) and Garfield (1978), among others, argue that there still exists within psychiatry, and especially within psychotherapy research, a conviction that simple causal relationships can readily be elicited and are there for the taking. Thus, researchers continue to concern themselves with the crudest of variables with little concern for the total life situation of the people under scrutiny. What tends to be overlooked is that no single experience or even group of experiences is so powerful an influence that it overrides all others such that it consistently gives rise to the same consequences, either in the short- or long-term.

Not only has no research, as yet, proved that psychotherapy is more effective or ineffective than any other kind of help-giving, but a

point stressed by Laing and Esterson (1964) is that different facets

of a person show according to the people with whom he relates. One might

even say that he is a different person for each person he is with. In

addition, there is no social situation in which one could say one has

isolated the individual: one would only have isolated that part of

him which is brought out by that particular situation.

As such, measurement of the effectiveness of psychotherapy

cannot be regarded as a unitary variable; it is an appraisal from some

perspective. It can be judged by the therapist who is involved in therapy,

or it can be judged by someone who is not, such as an observer; it can

be judged from the perspectives of those who know the patient in his

everyday life; and it can be reported by the patient himself. However,

there is a considerable degree of consensus in reports of therapy research

on the distinctiveness and the relative independence of outcome judgments

from those several perspectives. The crucial consequence of distinctive-

ness among outcome measures is that they are not interchangeable.

Measured gain or deterioration differs with the measure used, each

measure having its own pattern of relationships.

Independent of the categorization of outcome measurements by

perspective is the classification by content. Among the relevant areas

are work or occupational adjustment, interpersonal relationships, sexual

adjustment, symptom status (with special reference to target symptoms and

to amount and intensity of negative affect), and insight into one's own

cognitive processes. As it may not be possible to assess all of these

areas from all perspectives, the researcher faces the difficulty of

choosing those combinations he feels are most pertinent to his purposes;

in other words, those he suspects are most influenced by the therapy

experience.

As already alluded to, the conditions for assessing outcomes must also be given serious attention. While measures can be derived from the therapy sessions themselves (e.g. Stiles (1980), Tolor and Kissinger (1965), the researcher cannot be assured that such measures relate highly to measures taken elsewhere. Diagnostic appraisals made from separate sessions within the same institution (e.g. Tyson and Reder (1979), Trauer (1977)) may be affected by the patient's reactions to the institution or measurements can be made in outside settings. It is, however, difficult to see how fully comprehensive assessments could be both unobtrusive and ethical. The implementation of any applied psychotherapy research is open to the criticism of being obtrusive, altering the therapeutic milieu to focus attention on certain aspects of the situation.

The reliability of measures of the therapist, patient, and of outcome must also be a matter of strong concern for the researcher. One kind of unreliability is associated with the particular observer; each observer tending to contribute some individuality to his judgments, through his interpretation of wordings in judgment scales and his particular interpretations of the behaviours being judged.

The use of extended observations is also a potential source of unreliability. Longer periods provide opportunities for manifestations of variations in the behaviours of the therapist and the patient, but whether the final data be a rating or the average of several observations, the more variations in the behaviours observed, the less dependable the data summarizing them. If the final score is the mean of very varied observations, it is less typical or representative than the mean of a narrow range of observations and, therefore, may have lower relationships with other measures than would a more reliable measure. The sources of unique determinants for each particular observation may be too strong

relative to the source of common influence at which the final score is aimed. In other words, the common variance may be only a small proportion of the total variance.

Therefore, the relationship between agreement and length of observation period is not a simple one. Outcome ratings made by people who see the patient in different situations may not agree closely, entirely aside from the attribution associated with the kind of relationship that the observer has with the patient.

Apart from the reliability of measuring procedures, the validity of measuring procedures must also be considered. Agreement between observers, stability of measurements over periods for which consistency is expected, and consistency among subscores combined into the final data are of interest primarily because such kinds of reliability set limits to the expected validity of the measurements. Measures specifically created for psychotherapy research have, for the most part, only face validity, appearing to get at whatever is to be measured.

Among the various usages of validity, the one of primary importance is construct validity. Unfortunately, the phrase "construct validity" tends to be foreign to psychotherapy research. At least as much as in other personality areas. The theoretical statements are at such a level of abstraction that one cannot derive unambiguous statements about expected relationships among operational indices. The impression one tends to get from the literature is that researchers are preoccupied with the search for measuring procedures that will have reasonable linkages with their concepts, and do not aim for very close degrees of coordination. In addition, much effort has been devoted to trying to clarify and

explicate constructs, researchers having a label for a certain set of
impressions and searching for common features among these impressions.

As well as the fallibility of the methodologies employed in
psychotherapy research, there also exist several problems which hamper
comparison of studies. For instance, there is a lack of precisely
comparable cases across studies, as researchers often provide an inadequate
appraisal of the patient's circumstances. Likewise, there is a lack of
equivalent criteria of outcome attributable to the unreliability of the
measures used. Related to this problem is the fact that, given the
variable nature of psychotherapeutic process, if it is possible to
conduct analogue studies, they often produce contradictory or inconclusive
findings, which lead to further confusion (e.g. Rakover (1980), Kazdin
(1978), (1980)). Regarding the process of therapy, there are large
variations in the amount of therapy received and in its quality, as well
as differences in the duration and thoroughness of follow-up after termin-
ation. A criticism levelled at psychotherapy research is that many
studies do not employ a follow-up of any kind at all. The process of
change need not halt with the termination of therapy. Another problem is
that of variation in the nature of onset and in duration of disturbance
in the patient and finally, there is the problem of definitions of disorder
and criteria for improvement to the extent of rendering reliability
questionable.

Such problems exist in studies of both individual and group
psychotherapy. In the latter instance, however, any analysis of group
treatment is further complicated in that one must not lose sight of two
related facts: the incredible complexity of the group phenomenon and the
relatively primitive state of theoretical development apparent in the
area of group treatment. In addition, there is the fact that the concept

of causality has no absolute meaning in group treatment as it can only be defined in a multidimensional context.

Admittedly, the experimental laboratory has been of great assistance in teasing out which variables may be of more importance in the face-to-face interaction in group treatment, but the bulk of applied research still emphasises the importance of the dynamics of the therapy situation itself. Also, the prevailing strategy of research is extraspective. In this way, the subject's frame of reference is disregarded, while the investigator's frame of reference is given validity of a superior kind (Garfield(1978)). Because of this, the researcher must ask himself if he is investigating the participants' experiences of therapy or whether he is predisposing the participants to report certain experiences which they feel are consistent with what they think he is looking for. As such, the role of the investigator, as seen by the participants in the therapy he is studying, must be carefully delineated.

Last, but not least, is the question of whether the results of any psychotherapy study are clinically significant or statistically significant. Several authors (e.g. Gough (1963), Sawyer (1966), Holt (1970)) have traced the importance of deciding whether clinical or statistical predictions are more accurate to the allegedly fundamental role of prediction in science. According to Sawyer (1966) "it underlies explanation", following Polanyi's (1964) argument that the aim of science is explanation through understanding. Though prediction may be the best way to verify the validity of a concept, rather than a self-deception, it is a means and not an end in itself(Holt (1970)). It is possible to predict and control without understanding, a state of affairs that leads to empiricism rather than science. However, it is commonplace that the scientific process begins with an empirically observed regularity or rule of thumb, which makes prediction possible as well as stimulates the

curiosity of the researcher to find out how it works. In psychotherapy research, there has been a tendency for statistically significant findings to be given more credence than studies with clinically significant results. Hence, a potentially valuable source of data is neglected and whether the former studies give psychotherapy research an appearance of respectability is open to question (Birtchnell (1978)).

2.2. The Present Study

2.2.1. Formulation of the research topic.

There are two main themes common to all the divergent types of psychotherapy, namely that all psychotherapy is about people as human beings and secondly, psychotherapy is concerned with the problems people have in living their lives and in living with each other. The justification for psychotherapy is personal change-change in the aspect of life that has the potential to be under one's control, the assumption being that people have the potential to be responsible for their lives and have choice.

As an integrative measurement of change appears more promising in psychotherapy research, the emphasis of the present study was on the main participants in therapy, namely the therapists and patients. Despite the fact that reports of what happens in therapy depends on who one asks, the patients and therapists are the principle contributors to the inter-action.

The present study was initiated in an attempt to integrate process and outcome measures of patients' and therapists' experiences of therapy into a longitudinal study, following the participants from the start of the therapeutic contact through to termination, and six months after termination. As indicated in Chapter 1, there has been a distinct

lack of research into how patients and therapists experience the same therapy and this is particularly the case in group psychotherapy. Reasons for this are not hard to find when one considers the complexity of the group psychotherapeutic process, the many contributions participants bring to this process, as well as the limited reliability of measures in psychotherapy research.

No apologies are made for the fact that the present study, in common with previous psychotherapy research, employs fallible procedures in terms of design reliability; however, that does not detract from the potential validity of the measurements used. In addition, the principle concern of the current research was to investigate participants' experiences of group therapy at different points in time during treatment. This does not, however, necessarily assume that there is a causal relationship between events at one time and events at another time. This does not assume that there was a relationship between how the participants experienced events in the temporal sequence of therapy.

Bearing these considerations, in mind, the general aims of this research were to study:

1. patients' and therapists' expectations and perceptions of themselves and each other before they commence therapy, and

2. patients' and therapists' perceptions of themselves and each other throughout treatment, in relation to outcome.

Given the difficulties of completing psychotherapy research, and the fact that the aim of the present investigation was to study a small number of patients and therapists "in-depth", as it were, it was felt that it would not be profitable to formulate a prior hypotheses. As it subsequently transpired, such an approach yielded more information than was originally anticipated.

2.2.2. The subjects.

Initially, there were 22 patients drawn from three outpatient psychotherapy groups, with no inpatient members. Although the therapists preferred to describe these patients according to their presenting problems rather than symptoms, these patients had the diagnosis of anxiety neurosis and no patient received concurrent medication. The characteristics of the sample are indicated in Table IIa.

Groups 1 and 2 met weekly at a psychiatric hospital near Stirling for 1½ hours, while group 3 met for 2½ hours every week at a Psychiatric Outpatient Clinic in Glasgow. All three groups had a treatment term of approximately 18 months and were of the "slow-open" type, i.e. when a member left, his place was filled if there was a suitable candidate available. These latter patients did not form part of the sample but their contribution to the therapy process was noted.

The therapist of each group was the Consultant Psychiatrist to whom the patients had been referred by their General Practitioner. Discussions with these therapists, prior to commencing the study, indicated they had similar aims in group work. Each therapist saw his group as being to encourage the individuals to question and attempt to resolve their current difficulties in the light of their previous life experiences with others similar to themselves. As such, the therapists emphasised the importance of achieving group balance and group task orientation as well as a need for minimal participation on their part to allow the group to work together.

2.2.3. Theoretical orientation of the therapists.

In addition to having comparable aims in their groups, the therapists also had similar theoretical orientation to their group work.

Table IIa: Characteristics of the sample

	Group 1		Group 2		Group 3	
Therapist						
1	*					
2			*			
3					*	
Sex of patient						
male	5		6		5	
female	2		3		1	
Number of patients						
	7		9		6	
Age of patients(years)	mean	range	mean	range	mean	range
male	29	26-36	35.3	26-42	38.2	21-57
female	43.5	35-52	28.6	25-32	36*	-
male and female	33	26-52	33	25-42	37.8	21-57

* note only one female patient.

They saw the group as being the therapeutic medium and their own task

as being to nurture its therapeutic potential by allowing the individuals

in it to function increasingly as active and responsible agents themselves.

Hence, the individual is treated in the context of the group with the active

participation of the group.

Such "analysis through the group" is particularly associated

with S.H. Foulkes ((1964), Foulkes and Anthony (1957)) who was deeply

impressed by the way in which a context affects not only what is seen,

but also what happens within it. Foulkes maintained that in group-analytic

psychotherapy, it was psychotherapy by the group and of the group, including

its "conductor", as he called the therapist. Therefore, Foulkes came to

perceive the individuals as at a nodal point in a network of relationships,

and illness as a disturbance in the network that comes to light through

the vulnerable individual. This awareness of transpersonal phenomena

anticipated many developments in current understanding of family processes

and therapy.

Furthermore, Foulkes discerned the many levels at which groups

function, often simultaneously: 1. the level of current adult relationships;

2. the level of individual transference relationships; 3, the level of

shared feelings and fantasies, often from early pre-verbal stages of

development; and 4. the level of archetypal universal images, somewhat

reminiscent of Jung's Archetypes of the Unconscious. Foulkes and Anthony

(1957) and Foulkes (1964) indicated that these levels range from more

conscious objective "everyday" relationships to increasingly subjective

and unconscious fantasy relationships, and likewise, from more to less

clearly differentiated and individual relationships. It is also of note

that these levels can be successfully linked with the idea of Parent,

Adult and Child parts of the personality as suggested by Berne((1961),(1966)).

Within such a model, there are three essential preconditions for group psychotherapy, namely: that the group relies on verbal communication; that the individual member is the object of treatment; and that the group itself is the main therapeutic agency. Therefore, group psychotherapy uses the group and its power for therapeutic purposes, and, as such, constitutes group treatment. However, it does not treat the group for the group's sake or to improve its working efficiency. The group is treated for the sake of its individual members as all psychotherapy is, in the last resort, treatment of the individual.

In practice, this type of group therapy is rooted in the experiences fed into and emerging from the group, thus building up into a unique developing culture with its own history and memory, as members relate more deeply and intimately. Foulkes calls this the group matrix. In it, the individual can immerse himself in experiences which are personal, interpersonal and transpersonal. That is, they spring from each individual's unique past and present outside the group, from fresh engagements "here and now" in the group, and from deep shared responses which transcend their separate individualities. As he immerses himself in the group matrix, each individual can question his own preconceptions, boundaries and identity; he can regain aspects of himself that he has disowned and projected, and re-emerge with fresh insights and ways of relating.

However, as Balint and Balint (1961) are quick to point out, after a successful treatment by group methods, the patient may not necessarily be less neurotic, but will be inevitably more mature. This difference probably results from the greater availability of non-transference factors in group therapy compared to individual treatment, and the greater similarity of the setting in group therapy to the natural groups in which people live, in the family and in society.

2.2.4. Research design

The research design employed in this study was a repeated

measures design using interviews, psychological tests, and observation

of the patients and therapists in the group therapy situation from the

start of the therapeutic contact, through to termination and a six month

follow-up, as indicated in Figure 2,1.

As shown in Figure 2,1. patients and therapists were interviewed

prior to the first group meeting and, thereafter, at intervals of eight

weeks, until the end of the treatment term. If the patient left the

group within the treatment term, he was interviewed as having terminated

therapy and, in addition, all patients were interviewed six months after

terminating treatment.

The interviews used in this study were semi-structured in an

attempt to allow the respondent as much "freedom" in his responses as he

felt necessary and they were developed with the aim of assessing various

aspects of patients' and therapists' experiences which were thought based

on previous research and study of "group notes" kept by the therapists

of their previous groups, might be relevant to the process and outcome of

therapy. As can be seen in Figures 2,2 and 2,3, the topics covered in

these interviews were diverse in an attempt to obtain an integrative

appraisal of the participants at the various points in time, while the

interview schedules employed are detailed in Appendix B1 to B7.

With reference to the research design depicted in Figure 2,1

several psychological tests were administered to both patients and

therapists at different times in therapy. The tests used were Rotter's

Internal-External Control Scale, the Treatment Expectancies Questionnaire

and several semantic differentials, and are discussed fully in Chapters

6, 7, and 8 respectively.

Figure 2,1. Research design for group therapy patients and
their therapists.

<u>Group therapy patients.</u>   <u>Group therapists.</u>
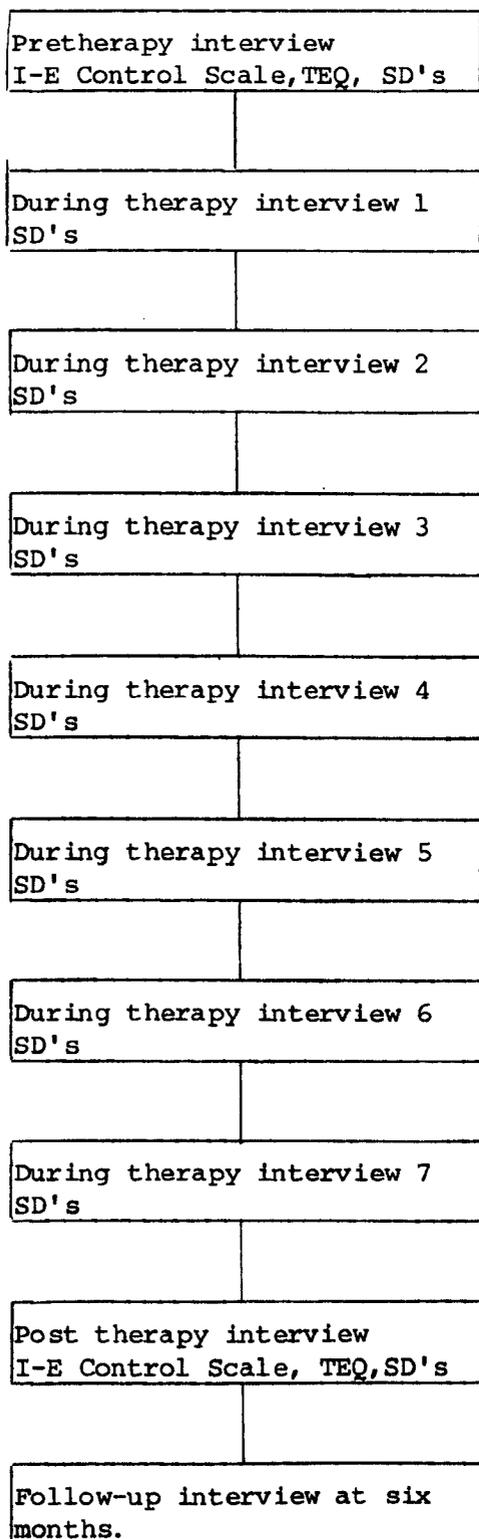
| Pretherapy interview I-E Control Scale,TEQ, SD's |

| During therapy interview 1 SD's |

| During therapy interview 2 SD's |

| During therapy interview 3 SD's |

| During therapy interview 4 SD's |

| During therapy interview 5 SD's |

| During therapy interview 6 SD's |

| During therapy interview 7 SD's |

| Post therapy interview I-E Control Scale, TEQ,SD's |

| Follow-up interview at six months. |
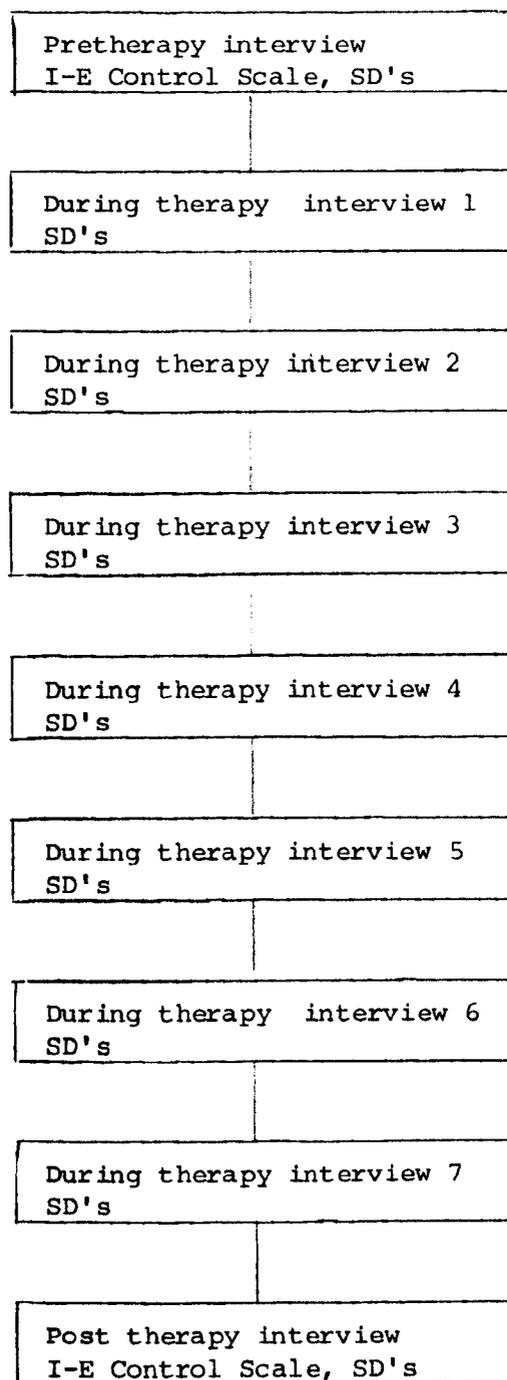
IF PATIENT TERMINATES DURING THERAPY

| Pretherapy interview I-E Control Scale, SD's |

| During therapy interview 1 SD's |

| During therapy interview 2 SD's |

| During therapy interview 3 SD's |

| During therapy interview 4 SD's |

| During therapy interview 5 SD's |

| During therapy interview 6 SD's |

| During therapy interview 7 SD's |

| Post therapy interview I-E Control Scale, SD's |

Figure 2,2. Topics covered in group psychotherapy patients' interviews.

	Treatment		
	Before	During	After
Knowledge of group psychotherapy	*		
Expectations of group therapy	*		
Subjective adjustment	*		*
Future	*		*
Locus of control	*		*
Freedom	*		*
Decision making	*		*
Responsibility	*		*
Independence and dependence	*		*
Problem handling	*		*
Expectations for after therapy	*		*
Satisfaction with information prior to treatment			*
Fulfilment of initial expectations		*	*
Perception of what has elapsed in the group		*	
Perception of what has happened to them personally		*	
Any gain from the group experience		*	
Leadership pattern in the group		*	
Enjoyment of the group meetings		*	

Figure 2,3. Topics covered in group psychotherapy therapists' interviews.

	Treatment		
	Before	During	After
Expectations of the patient	*		
Perception of the patient's presenting problems	*		
Suitability of treatment and alternatives for the patient	*		
Possibility of premature termination by the patient	*		
Hopes for the patient as a result of treatment	*		
Realistic expectation for the patient as a result of treatment	*		
Training of the therapist	*		
Approach to therapy	*		
Role to be adopted in the group and with the patients comprising it	*		
Personal expectations of therapy	*		*
Locus of control	*		*
Perception of change in the patient			*
Satisfaction with the outcomes			*
Therapist's perception of his role in the group			*
Expedience of group therapy for the patient and future prognosis			*
Fulfilment of anticipated and realistic expectations of change in the patient		*	*
Perception of the patients' participation in group process and attribution at termination		*	*
Perception of what has elapsed in the group		*	
Perception of what has happened to him personally		*	
Leadership pattern in the group		*	
Enjoyment of the group meetings		*	

2.2.5. The role of the researcher

In an attempt to minimise any notion of therapeutic "power" which may have been attributed to the researcher by the patients studied, it was made clear at the outset that the researcher was not employed by the Health Authority and, therefore, would not supplement any of the therapeutic work done in the group. In addition, the patients were assured of the confidentiality necessitated by the research and that neither the therapist nor other group members would be informed of their views.

In exchange for the co-operation of the therapists and patients, the researcher was asked to join the groups as a participant-observer. The researcher attended every session for each group during the 18 month treatment term, and her verbal participation in the group was restricted to only occasionally asking for an explanation of a comment she did not understand. Therefore, an attempt was made to minimise any effect of the researcher's presence on the therapeutic milieu. It is suggested that this was successful in that, at post-therapy, 80% of the patients inter-viewed had perceived the researcher to have been a participant-observer, while the remaining 20% felt she had made a minimal contribution to the group by simply being there.

2.2.6. Unanticipated events

As must be anticipated in any applied research, the course of therapy was influenced by several events, not always contingent on treatment.

Of the 22 original patients, one was lost due to accidental death in the second week of therapy, eight patients (three in Group 1 and five in Group 2) terminated within the first nine months of the treatment term, and Group 3 was disbanded following the sudden death of the group therapist after 12 months of therapy. Subsequent to the therapists's

death, a study was completed of the patients' reactions to his death and adjustment to their new situation, and this is detailed in Appendix **A** . Therefore, seven patients of a possible 15 patients completed the full treatment term.

2.3. Treatment of the interview data.

Since the interviews employed in this study were of a semi-structured design allowing for a great deal of variation in the quantity and quality of responses by the therapy participants, much of the data was found to be suitable for scalogramme analysis. Although scalogramme analysis is not a method for constructing or developing an attitude scale, in practice, it can be most accurately described as a procedure for evaluating sets of statements or existing scales to determine whether or not they meet the requirements of a particular kind of scale as described by Guttman((1944), (1945), (1947a), (1947b)),and referred to as a Guttman Scale. As such, it is perhaps pertinent to summarize the theoretical assumptions of this type of analysis.

Guttman (1944) assumed initially that a variable, whether qualitative or quantitative, be used in its conventional logical or mathematical sense as denoting a set of values, these values being either numerical or non-numerical. Using the term "attribute" interchangeably with "qualitative variable", the values of an attribute (or of a quantitative variable, for that matter) may be called its subcategories, or simply categories. For a given population of objects, the multivariate frequency distribution of a universe of attributes is called a scale if it is possible to derive from the distribution a quantitative variable with which to characterise the objects such that each attribute is a simple function of that quantitative variable. Such a quantitative variable is called a scale variable.

Since perfect scales are not to be expected in practice, the deviation from perfection is measured by a coefficient of reproducibility, which is simply the empirical relative frequency with which the values of the attributes correspond to the proper intervals of a quantitative variable. While Guttman (1944) states that 85% perfect scales or better can be used as efficient approximations to perfect scales, Edwards (1957) suggests that 90% perfect scales or better are more realistic.

The ordering of objects according to the numerical order of their scale scores are called their scale order; scale scores simply being a value of a scale variable. An individual with a higher score than another individual on the same set of statements must also rank as high or higher on every statement in the set as the other individual (Guttman (1950)). Thus, if the responses of subjects to the same statements are in accord with the theoretical model of a unidimensional scale of state-ments, one would have confidence in interpreting scores of subjects, based upon the statements, as also falling along the same unidimensional continuum, representing the universe of content.

The universe of content simply consists of all the attributes that define a concept; those attributes have a common content and may be classified under a single heading which indicates that content. Since an attribute belongs to the universe by virtue of its content, the investigator indicates the content of interest by the title he chooses for the universe, and all attributes with that content belong to the universe. Guttman (1945) believed that the selection of a small number of statements from the large number of possible statements representing a universe of content should be done upon the basis of intuition and experience. He also said that the statements selected should be those that seem to have the most homogeneous content; however, there arises in practice, borderline cases

where it may be hard to decide whether or not an item belongs to a universe.

An important point is also that a criterion for an attribute to belong in the universe is not the magnitude of the correlations of that item with other attributes known to belong to the universe, and one need not have knowledge of which is a right answer or wrong answer beforehand to establish a proper order among the individuals (Guttman (1944)). In addition, the point correlation between two dichonomous items may be anything from practically zero to unity, and yet they may be both perfect functions of the same quantitative variable.

It might be asked how can one know the universe forms a scale if all one knows is a sample from the universe, but Guttman (1944) insists that it is acceptable to infer that, if a sample of attributes is selected without knowledge of their empirical interrelationships and is found to form a score for a reasonable sample of individuals, then the universe from which the attributes are selected is scalable for the entire population of individuals.

However, finding that a universe of attributes is scalable for a population means that it is possible to derive a quantitative variable from the multivariate distribution such that each attribute is a simple function of that variable and, as such, it is important to distinguish between two closely related topics, namely scaling and prediction. This is the converse of the usual problem of prediction. In an ordinary problem of prediction, there is an outside variable, independently defined, that is to be predicted from the attributes.

An outstanding property of scaling is that it provides an invariant of quantification of the attributes for predicting any outside variable. In scaling, the interest is in each and every attribute in

the universe on its own merits. The attributes are the important things; and if they are scalable, then the scores are merely a compact framework with which to represent them. In addition, if a compact framework is found, it has the additional property of being an efficient device for predicting any outside variable in the best manner possible from the given universe of attributes and such scale analysis will also pick out the deviants or non-scale types for further investigation.

While Guttman scale analysis has not been used in previous psychotherapy research, it was felt to be the most suitable method of analysing the present interview data and was therefore adopted. Subsequently, the content of the interviews was subjected to this method of analysis and it was possible to subject   scales obtained to further analysis. The Kolomogorov-Smirnov two-sample test was employed to compare responses to the interviews at pre- and post-therapy in an endeavour to see changes in response pattern as a result of group psychotherapy.

CHAPTER 3.

Patients' and Therapists' Expectations
of Group Psychotherapy

General Introduction
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The study of participants' expectations of therapy have been approached from many perspectives, each suggesting a relationship between expectations, the process of therapy, and outcome of treatment. It is, however, difficult to differentiate between what each participant expects and what he hopes for from therapy, as both cognitive and motivational aspects are contained in each. Nevertheless, therapists have long considered how a patient's expectations of his forthcoming treatment contribute to his participation in therapy and what he gains from the experience. Treatment procedures and systems may often be invalidated by misunderstandings and false expectations (Ballinger (1971), Gordon et al (1979)).

There are, however, two main approaches to the study of patients' behaviour early in treatment: one emphasises the patient's expectations of therapeutic gain, while the other focuses on the demand characteristics of therapy procedures. Studies of patient expectations have concentrated mainly on how the patient interprets his difficulties and how the experience of therapy fulfills his need to cope with these difficulties.

For instance, Garfield and Wolpin (1963) found that their sample of patients sought a therapist who would be sincere, sympathetic and competent, as well as realistic about the problems of the patient. In contrast, Begley and Lieberman (1970) found two clusters of patients having widely separated sets of expectations of psychotherapy, at one extreme, expecting the therapist to be personally committed to helping them develop new ways of behaving, while at the other extreme,

expecting the therapist to be objective and detached.

Several investigators have examined the patient's level of motivation upon the process and outcome of therapy. Keithly et al (1979) and King (1977) found that ratings of motivation did not significantly predict patients' rating of overall improvement. However, the patient's level of motivation influenced the therapist's behaviour during treatment and clinicians' ratings of overall improvement. The conclusion of Meltzoff and Kornreich (1970) and Block (1979) is that motivation at the outset of therapy is probably not a necessary factor for successful outcome, but its development during treatment is particularly important. Such conclusions tend to suggest that, if the reality of the therapeutic situation fails to conform to the patient's preconception of it, it is less likely that he will be affected favourably by it. However, his experience of the therapeutic situation can influence his motivation to continue treatment.

In addition, the patient's expectations regarding the duration and process of therapy, the therapist's role, and what is expected of himself may differ considerably from the expectations of the therapist. Such lack of congruence in expectations has been found to be productive of unsuccessful outcome of therapy and premature termination (Sloane et al (1970), Garfield and Wolpin (1963), Heine and Trosman (1960)). Because of this, Overall and Aronson (1966) suggest that it may be necessary to encourage a direct expression of expectations so that both patient and therapist can more easily view and modify their roles. Several attempts have, however, been made to manipulate patients' expectations prior to treatment to prepare him for the impending therapy.

Sloane et al (1970) used an "anticipatory socialization interview" to enhance expectations of improvement in patients but, although it was found at the end of treatment that patients who received an explanation of psychotherapy improved slightly but significantly more than those who did not receive it, it was concluded that there was no support, in this study, for the hypothesis that pre-therapy preparation is effective because it allows the patient to present himself in a more favourable light to the therapist. A similar conclusion is reached by Roth et al (1964) who utilized controlled initial treatment conditions.

Nevertheless, several investigators have countered such findings. Truax and Carkhuff (1967) found "vicarious pre-training" effective with hospitalized patients; Hoehn-Saric et al (1964) found "role induction" interviews for patients prior to treatment of advantage; and Strupp and Bloxom (1973) report positive findings using both interview and film as contrasting modes of preparation. The long-term effect of such preparation is, however, questioned by Liberman et al (1972) who suggest that such procedures may have a circumscribed effect, but do support the view that preparing the patient for the type of treatment he is going to receive not only reduces the number of premature terminations but also an explanation of psychotherapy is of greater value to the patient than mere encouragement to improve.

Such preparation would appear to be particularly useful for potential patients of lower-class background. Although Garfield (1978) and Jones (1974) suggest that lower social class patients are not suitable for traditional, dynamic long-term psychotherapy, Overall and Aronson (1962, 1966), Rapoport (1976) and Riessman and Scribner (1965) indicate that one of the greatest problems presented by lower-class patients is

their negative evaluation of the initial contact with the therapist and
their minimal involvement in treatment, expecting a medical-psychiatric
interview, with the therapist taking an active role.   Patients whose
expectations are most inaccurate are significantly less likely to return
for treatment,and Overall and Aronson (1966) suggest that one way of
reducing cognitive inaccuracies is to attempt, in the initial phases of
treatment, to re-educate the patient born to his own and the therapist's
role in treatment.

Regarding patient selection for psychotherapy, Rosenbaum (1975)
suggests that patients who describe their presenting symptoms in terms
of chronic interpersonal distress and are prepared to endure the stresses
of joining a therapy group may be successful therapeutic workers.   There
are, however, certain personality traits or configurations which are
often challenged or threatened in interactional group therapy, such
as patients who present with severe external stress or the patient who
is sufficiently different from the other group members such that he
perceives himself, and is perceived by the group, as a "deviant".   Never-
theless, this is not to say that he would be unsuitable for another group.
Hence, the assessment made by the therapist and his expectancies of the
patient prior to commencing treatment must also be considered.

Therapist cognitive variables have been consistently indentified
as contributing to the process and outcome of psychotherapy, although
exactly how they contribute is not clear.   For instance, Temerlin
and Trousdale (1969), Fontana et al (1968) and Michaux and Lorr (1961)
found treatment recommendations more consistently related to inferences
made about the patient than they were to the complaints actually made by
the patient.   If one accepts the position of Rosenthal (1969) that

clinical interactions are a special instance in the class of general
social interactions and that the principles governing general social
interactions can be applied to account for events occurring in clinical
interactions, the manner in which the patient presents himself may greatly
influence the therapist's willingness to interact with the patient and
his expectancies of patient improvement.

Strupp (1958) found that observers reporting favourable
prognoses were more likely to accept the patient's perspective without
trying to manipulate it and were less likely to respond in a "cold"
manner than those observers reporting unfavourable prognoses. In contrast,
Goldstein (1960) found therapist expectancies of patient change to be
unrelated to patient reports of change during therapy. However, a post
hoc data analysis indicated that therapists of patients who reported
improvement had significantly higher initial expectancies than therapists
of patients who reported becoming worse. Nevertheless, Affleck and
Garfield 1961) caution that a general bias in the direction of being over-
optimistic about patient length of stay in therapy can result in marked
difficulty in correctly identifying the early terminator, while Bloch (1979)
points out that the patient who remains in treatment does not necessarily
improve.

Garfield and Affleck (1961), Strupp and Williams (1960) and
Eells (1964) have shown that therapists are more interested in treating
patients of whom they have relatively high expectancies of improvement,
there being an overall positive correlation between therapist preference
for patient traits and selection for treatment. In contrast, Kumar and
Pepinsky (1965), Sattler and Winget (1970) and Saunders and Vitro (1971)
argue that recent information has a more potent effect than prior
information in applied settings; namely, if a therapist's expectancies

of a patient are disconfirmed, the therapist will realign his expect-
ancies according to the patient's behaviour.

A further difficulty is that expectancy information and
information regarding personal control are confounded in that, if a
therapist receives information to the effect that treatment outcome
for a particular patient is an event over which the therapist has little
control, his expectancies of improvement will be lower than if the
therapist feels that treatment outcome is within his control.

The interactive effect of therapist expectancies with process
events have also been investigated (e.g. Lennard and Bernstein (1960),
Kumar and Pepinsky (1965), Affleck and Garfield (1961), Strupp (1958),
Heller and Goldstein (1961), Goldstein (1960)). However, the results of
these investigations do not lend strong support for the view that
therapist expectancies function as determinants of patient change, as
none have shown a reliable correlation between therapist expectancy and
symptom reduction measured independently of patient ratings.

The issue, according to Bootzin (1969), is whether and under what
conditions expectancy and therapy outcome are correlated because of the
expector's sensitivity to cues predictive of outcome or because the
expector actually influences the outcome. While there is not, as yet,
definitive support for the actuarial usage of therapist expectancies,
that application appears to be more promising than the deterministic
usage of therapist expectancies, as a predictor of therapy outcome. The
measurement of therapist expectancies would appear to be important in
the identification of conditions under which patient change occurs.

In summary, such conclusions support the hypothesis that there must be congruence between what the patient expects from treatment and the therapist's own goals and attitudes towards treatment; the final outcome depending on the mutual congruence of these expectancies. Where they coincide, treatment will be successful; where they differ completely, treatment will fail or be terminated prematurely.

3.2. The Present Study

3.2.1. Patients' expectations of group psychotherapy:

Subjects:

There were 15 patients drawn from two outpatient psychotherapy groups. As the third group was terminated following the therapist's death, their results were excluded from the main study. The characteristics of the present ssample are indicated in Table IIIa. All patients had the diagnosis of anxiety neurosis and none received concurrent medication.

Procedure and treatment of the data:

Each patient participated in an interview before they attended their first group meeting. The interview was semi-structure with, in total, 70 questions (see Appendix B.1), designed to cover various aspects of their situation which, on study of the literature and "group notes" kept by the therapists of previous groups, were considered relevant to patients' expectations of group psychotherapy. Figure 3.1 shows the areas covered in this interview. Each interview was tape-recorded, to be transcribed and analysed at a later date.

The amount of data collected from these interviews was immense and found to be suitable for Guttman scale analysis. From the 11 initial sections of the pre-therapy interview for patients shown in Figure 3.1 , 28 possible scales were determined and subjected to Guttman scale analysis. As can also be seen in Figure 3.1 , 20 of these scales were found to have 90% or greater consistency. (Appendix C.1 contains detailed Guttman scale

Table IIIa:Characteristics of the patients who were interviewed
prior to group therapy.

	Group 1			Group 2	
Therapist					
1	*				
2				*	
Sex of patient					
male	5			6	
female	1			3	
Number of patients					
	6			9	
Age of patients (years)	**mean**	**range**		**mean**	**range**
male	29	26-36		35.3	26-42
female	52*	-		28.6	25-32
male and female	33	26-52		33	25-42

*none - only one female.

Figure 3.1:.Interview sections of patient interview before commencing

group therapy and Guttman scales derived.

The pre-therapy interview for patients covered the following areas:

       Knowledge of group psychotherapy

       Expectations of group psychotherapy

       Subjective adjustment

       Future

       Locus of control

       Freedom

       Decision making

       Responsibility

       Independence and dependence

       Problem handling

       Expectations for after therapy

Guttman scales derived and their consistencies:

100% consistency:	information seeking, effect of the group on one's life and alternative treatment, expectation of self in the group.
93% consistency:	expected emotional involvement in the group, normality (self and others' perception of self), need to alter lifestyle (self and others' perception of self), difficulties in decision making and preference for another to decide, independence (self and others' perception of self), group dependency and company preference, use and abuse of group therapy and previous experience in groups, expectations of the group situation, expectations of the therapist in the group, desire to be different and concept of "illness", locus of control, freedom, amount of responsibility (self and others' perception of self), dependency on others and compared to others, coping abilities and compared to previously, desire to change (self and others' perception of self), possibility of realistic change.
86% consistency:	friendship pattern, future and planning, amount of decisions (self and others' perception of self), type and amount of responsibility compared to others, frequency of problems compared to others, attitude towards problems, important factors in therapy and attribution at termination of therapy.
79% consistency:	adequacy of information regarding therapy.

Table: Changes in response to interview questions from pre- to post-therapy for group psychotherapy patients (N = 15)
IIIb.

Q		PRE-THERAPY		POST-THERAPY	
		Positive Response	Negative Response	Positive Response	Negative Response
5	Do you feel you know all you need to know about group therapy?	21%	79%		
3	Do you feel you knew all you needed to know about group therapy?			33%	67%
8	Have you discussed group therapy with anyone other than the doctor?	47%	53%		
4	Have you discussed group therapy with anyone other than the doctor?			60%	40%
9	Do you think there are going to be people similar to yourself in the group meetings?	35%	65%		
5	Do you think there were people similar to yourself in the group meetings?			80%	20%
10	Do you think you will learn anything about yourself from the group meetings?	67%	33%		
6	Do you think you learned anything about yourself from the group meetings?			86%	14%
11	Do you see yourself as having to work hard when in the group?	53%	47%		
7	Do you see yourself as having had to work hard when in the group?			72%	28%

93.

		PRE-THERAPY		POST-THERAPY	
Q		Positive Response	Negative Response	Positive Response	Negative Response
12	Do you think the group will be able to solve your problems?	27%	73%		
8	Do you think the group was able to solve your problems?			40%	60%
13	Do you feel that group therapy will change your life?	100%	0%		
9	Do you feel that group therapy has changed your life?			73%	27%

		Advisor	Doctor	Coordinator	Onlooker	Advisor	Doctor	Coordinator	Onlooker
14	How do you think the therapist will be in the group?	37%	28%	21%	14%				
10	How do you think the therapist was in the group?					47%	53%	–	–

		Positive Response	Negative Response	Positive Response	Negative Response
16	Do you think it is an important part of therapy for the patients to believe that the therapist has control over what happens in the group?	79%	21%		
12	Do you think it was an important part of therapy for the patients to believe that the therapist had control over what happened in the group?			87%	13%

		Adversely	Upset	Surprised	Wealth of Emotions	Adversely	Upset	Surprised	Wealth of Emotions
17	How do you think you might be affected by some of the things that happen to you in the group meetings?	14%	37%	21%	28%				
13	How do you think you were affected by some of the things that happened to you in the group meetings?					26%	28%	26%	20%

Q		PRE-THERAPY		POST-THERAPY	
		Positive Response	Negative Response	Positive Response	Negative Response
18	Do you think you will reveal your real self in the group?	42%	58%		
14	Do you think you revealed your real self in the group?			60%	40%
19	Do you think you will keep some things to yourself in the group?	79%	21%		
15	Do you think you kept some things to yourself in the group?			74%	26%
20	Do you think you would prefer another type of treatment?	60%	40%		
16	In retrospect, do you think you would have preferred another type of treatment?			33%	67%
22	Do you think you lead a normal life?	37%	63%		
19	Do you think you lead a normal life?			53%	47%
23	Do you think others see you as leading a normal life?	51%	49%		
20	Do you think others see you as leading a normal life?			67%	33%
24	Do you feel you get on well with other people?	79%	21%		
21	Do you feel you get on well with other people?			67%	33%

Q		More	Less	As it is	More	Less	As it is
25	Do you feel you have the number of friends you would like to have, would you like more or less?	65%	7%	28%			
22	Do you feel you have the number of friends you would like to have, would you like more or less?				60%	–	40%

95

Q		PRE-THERAPY Positive Response	PRE-THERAPY Negative Response	POST-THERAPY Positive Response	POST-THERAPY Negative Response
26	Do you feel you need to alter your lifestyle from what it is at present?	93%	7%		
23	Do you feel you have altered your lifestyle at all from what it was before joining the group?			80%	20%
27	Do you feel that others think you should alter your lifestyle from what it is at present	86%	14%		
24	Do you feel that others thought you should alter your lifestyle from what it was?			80%	20%
28	Do you see yourself as being an "ill" person?	65%	35%		
26	Do you see yourself now as being an "ill" person?			40%	60%
30	Do you think about your future?	65%	35%		
37	Do you think about your future?			67%	33%
31	Do you plan ahead in your every-day life?	38%	62%		
38	Do you plan ahead in your every-day life?			47%	53%
32	Do you think others see you as someone who plans ahead?	38%	62%		
39	Do you think others see you as someone who plans ahead?			53%	47%
33	Do you think you control what happens to you in life or that it is controlled by some other source?	41%	59%		
40	Do you think you control what happens to you in life or that it is controlled by some other source?			80%	20%

Q		Positive Response	Negative Response	Positive Response	Negative Response
34	Do you feel that sometimes you do not have enough control over the direction your life is taking?	27%	73%		
41	Do you feel that sometimes you do not have enough control over the direction your life is taking?			40%	60%
35	Do you value your freedom?	93%	7%		
42	Do you value your freedom?			93%	7%
36	Do you feel you have much freedom?	32%	68%		
43	Do you feel you have much freedom?			73%	27%
37	Do you feel you have many restrictions on your freedom?	86%	14%		
44	Do you feel you have many restrictions on your freedom?			80%	20%
38	Do you have to make many decisions every day?	73%	27%		
45	Do you have to make many decisions every day?			80%	20%
39	Do you find it difficult to make decisions?	76%	30%		
46	Do you find it difficult to make decisions?			47%	53%
40	Would you prefer if someone else made the decisions for you?	49%	51%		
47	Would you prefer if someone else made the decisions for you?			20%	80%

Q		Positive Response		Negative Response	Positive Response		Negative Response
		More	Less	Same	More	Less	Same
41	Do you feel you have more decisions to make than other people, less, or about the same?	34%	52%	14%			
48	Do you feel you have more decisions to make than other people, less, or about the same?				27%	13%	60%
		Many	Few		Many	Few	
42	Do you think others see you as someone who has to make many/few decisions?	27%	73%				
49	Do you think others see you as someone who has to make many/few decisions?				40%	60%	

Q		Home	Work	Both	Neither	Home	Work	Both	Neither
43	In general, do you think you have much responsibility at home, work, etc.?	50%	14%	7%	27%				
50	In general, do you think you have much responsibility at home, work, etc.?					40%	–	28%	32%

Q		Family	Home + Work	Nothing	Family	Home + Work	Nothing
44	What kind of things do you consider yourself responsible for?	37%	42%	21%			
51	What kind of things do you consider yourself responsible for?				27%	53%	20%
		More	Less	Same	More	Less	Same
45	How do you think this compares with other people?	35%	44%	21%			
52	How do you think this compares with other people?				26%	47%	27%

Q		PRE-THERAPY		POST-THERAPY	
		Positive Response	Negative Response	Positive Response	Negative Response
46	Do you think others see you as a person with responsibilities at home, work, etc.?	50%	50%		
53	Do you think others see you as a person with responsibilities at home, work, etc.?			54%	46%
47	Do you think you are an independent person?	50%	50%		
54	Do you think you are an independent person?			60%	40%
48	Do you think others see you as an independent person?	64%	36%		
55	Do you think others see you as an independent person?			80%	20%
49	Do you like doing things on your own?	74%	26%		
56	Do you like doing things on your own?			87%	13%
50	Do you like having people around you most of the time?	51%	49%		
57	Do you like having people around you most of the time?			60%	40%
		On Own	With others	On own	With others
51	Which do you prefer - being on your own or with others?	63%	37%		
58	Which do you prefer - being on your own or with others?			67%	33%
52	Is this from choice?	93%	7%		
59	Is this from choice?			100%	0%

Q		PRE-THERAPY				POST-THERAPY			

Q		Positive Response			Negative Response	Positive Response			Negative Response
53	Do you think you are sometimes too dependent on others?	73%			27%				
60	Do you think you are sometimes too dependent on others?					47%			53%

Q		Home	Work	Both	Neither	Home	Work	Both	Neither
55	Do you find that problems often arise in your everyday life, at home, work, etc.?	32%	7%	34%	27%				
61	Do you find that problems often arise in your everyday life, at home, work, etc.?					14%	–	53%	33%

Q		Well			Badly	Well			Badly
56	How do you feel you cope when problems do arise?	49%			51%				
62	How do you feel you cope when problems do arise?					80%			20%

Q		Positive Response			Negative Response	Positive Response			Negative Response
57	Do you find you sometimes need help in dealing with your problems?	93%			7%				
63	Do you find you sometimes need help in dealing with your problems?					67%			33%

Q		Wait			Prevent	Wait			Prevent
58	If you see a problem arising, do you wait till it happens, or take steps to prevent it?	54%			46%				
64	If you see a problem arising, do you wait till it happens, or take steps to prevent it?					40%			60%

Q		Positive Response			Negative Response	Positive Response			Negative Response
59	Would you describe yourself as someone who goes "looking" for problems?	73%			27%				
65	Would you describe yourself as someone who goes "looking" for problems?					33%			67%

Q		PRE-THERAPY		POST-THERAPY	
		Positive Response	Negative Response	Positive Response	Negative Response
60	Do you sometimes feel that your problems are the result of fate?	73%	27%		
66	Do you sometimes feel that your problems are the result of fate?			33%	67%
61	Do you think the majority of other people have similar problems to you?	66%	34%		
67	Do you think the majority of other people have similar problems to you?			93%	7%

Q		More	Less	Same	More	Less	Same
62	Do you feel you have more, less, the same problems now than you used to?	49%	44%	7%			
68	Do you feel you have more, less, the same problems now than you used to?				40%	60%	-

Q		PRE-THERAPY		POST-THERAPY	
		Positive Response	Negative Response	Positive Response	Negative Response
63	Do you think you will change as a result of group therapy?	79%	21%		
29	Do you think you have changed as a result of group therapy?			67%	33%
64	Would you like to change?	91%	9%		
30	Did you want to change?			87%	13%
65	Do you think others would like to see you change?	84%	16%		
31	Do you think others wanted you to change?			87%	13%
66	Is it important for you to get something out of group therapy?	93%	7%		
32	Was it important for you to get something out of group therapy?			87%	13%

		PRE-THERAPY		POST-THERAPY	
Q		Positive Response	Negative Response	Positive Response	Negative Response
67	Do you think you have an important part to play as to whether group therapy helps you or not?	86%	14%		
33	Do you think you had an important part to play as to whether group therapy helped you or not?			93%	7%
68	Do you think the therapist has an important part to play as to whether group therapy helps you or not?	93%	7%		
34	Do you think the therapist had an important part to play as to whether group therapy helped you or not?			73%	27%
69	Do you think the other group members have an important part to play as to whether group therapy helps you or not?	86%	14%		
35	Do you think the other group members had an important part to play as to whether group therapy helped you or not?			86%	14%
		Self	Other	Self	Other
70	To who or what do you think you will attribute how you are after having completed therapy?	70%	30%		
36	To who or what do you think you attribute how you are after having completed therapy?			60%	40%

analysis of this interview).

In addition, Table IIIb shows the response classifications from which the Guttman scales were derived, indicating responses both at pre-therapy and post-therapy.

Results and Discussion:

For the sake of brevity, a sample of the Guttman scales derived from the pre-therapy interview for patients will be presented and discussed.

Information seeking:

Whenever patients attempted to find out about group psychotherapy and discussed their impending treatment with people other than the therapist, it would appear that, while 93% of the sample did not try to find out about group psychotherapy, 47% did discuss their impending therapy with someone other than the therapist. Inspection of the raw data suggests that they usually discussed it with their spouse or parents, but did not feel they gained any benefit or reassurance from these discussions. Only 7% of the sample (i.e. one patient) actively tried to find out about group therapy by reading about it in the Public Library as well as discussed his impending treatment with his spouse. It is of interest that this patient felt he benefitted from such discussions.

Effect of the group on one's life and alternative treatment:

The patients appeared to have mixed feelings as to whether group therapy would alter their lives or not: 54% feeling that it would alter their lives, and 46% feeling it would not. When asked if they would prefer another type of treatment, 60% responded that they would prefer either individual therapy or drug therapy, although they were not sure if such treatments would be any more efficacious.

However, related to this finding was their perception of the possibility of realistic change.

Possibility of realistic change:

It appeared that most of the sample (79%) felt they would change to an appreciable degree as a result of group therapy and felt it was important for them to get something out of the group experience. Only three patients felt entirely negative about their impending therapy, whereas those who felt they would not change to a significant degree, at the same time felt that they would get some assistance from the group - this being in the form of reassurance.

Desire to change (self and others' perception of self):

Related to the possibility of change was the patients' desire to change. Of the sample, 86% felt they would like to change, although 19% felt that other people would not like to see them alter. Such a finding suggests that the patients may have realised that they were more likely to achieve limited personal benefit rather than extensive behavioural change from the group experience.

Desire to be different and concept of "illness":

A large proportion of the sample perceived themselves as being "ill" and wanted to be different from what they were (65% of the sample), whereas 35% did not perceive themselves as being "ill". However, 14% of this latter group did want to be different from what they were.

This initially confusing result may be understood in terms of how the patients utilized the term "ill". Those who saw themselves as "ill" used either the systemic or infectious disease model to explain why they had their current difficulties, while those patients who did not see themselves as "ill", employed the traumatic disease model, comparing themselves to people with broken limbs. Nevertheless, most patients wanted to be different from what they were suggesting, ill or not, they perceived themselves as being in some way "abnormal" or different from others.

Normality (self and others' perception of self):

It is of interest that the same proportion of patients not only

saw themselves as "ill" but also felt they did not lead a normal life,

although 51% did think that others perceived them as leading a normal life.

Hence, it would seem that, for most patients, there was some inconsistency

between how satisfied they felt with their lives and how others perceived

their behaviour. Consistent with this finding was the need patients felt

to alter their lifestyle.

Need to alter lifestyle (self and others'perception of self):

It was found that 93% of the sample felt they needed to alter their

lifestyle in some way, only one patient feeling he did not need to do so. It

is also of note that the same proportion felt others thought they should alter

their lifestyle, although the patients felt they lacked positive direction

as to how best to proceed in this matter. As such, it was pertinent to look

at the patients' expectations of the role of the therapist in the group.

Role of the therapist in the group:

Regarding the patients' expectations of the role of the therapist

in their forthcoming treatment, it appeared that there was a difference

between what the patients wanted the therapist to be like in the group and

what they thought he would be like in the group. Of the sample, 72% wanted

the therapist to take an advisory role in the group but in addition, the amount

of control the therapist had in the group meetings appeared to be important as

79% thought it necessary, whatever the role of the therapist, that he have

control of the group situation.

The present results tend to suggest that, in the small sample studied,

there were possible "kinds" of patient about to commence group psychotherapy,

bearing in mind the comparable selection procedures employed by the therapists.

In general, patients did not attempt to find out about group psychotherapy and,

if they did discuss their impending therapy with their relatives, they received

little reassurance. Most of the sample did, however, feel they would get

something out of the group experience although the quantity and quality of

anticipated assistance from the group, including the therapist, varied

considerably from patient to patient.

Most of the patients perceived themselves as being "ill", but there was an interesting difference within these patients in terms of the source of this self-attribution. Although they conformed to the systemic or infectious disease model, some patients felt they were made to feel "ill" either because they were attending a Psychiatrist or because of their family treating them as "in-valids". As such, the patients had mixed feelings as to how group psychotherapy might alter their lives. Most felt they would at least gain a better understanding of themselves although they doubted whether it would affect how others perceived them. Most patients felt they would not be perceived any differently by others as a result of therapy and, indeed, some felt others did not want to see them alter at all.

The foregoing results tend to suggest that the sample had relatively "moderate" expectations regarding their participation in treatment and the outcome of therapy, although there were individual differences. They did, however, have "high" expectations of the therapist's role in their treatment placing a high premium on the amount of control the therapist had in the group meetings yet, at the same time, anticipating varying amounts of activity by the therapist.

Such a finding supports previous research (e.g. Heine and Trosman (1960), Begley and Lieberman (1970), Garfield and Wolpin (1963) among others) in terms of how prepared patients are to contribute in treatment and may be found, subsequently, to suggest that there are differing prognoses for therapy based on whether patients place emphasis on passive co-operation or active collaboration with the therapist.

In attempting to summarize, most of the patients felt they would alter as a result of group therapy but had differing expectations as to how this would come about. A number of patients emphasized the role they themselves

would play, while others placed more emphasis on the role of the therapist in their treatment rather than themselves or the other group members. They did not, however, anticipate any dramatic changes in their lives as a result of treatment.

3.2.2. Therapists' expectations of group psychotherapy:

Subjects:
There were two therapists who each conducted an outpatient psycho-therapy group. Prior discussions with the therapists indicated that they shared similar aims in their group work and adopted the same theoretical model; namely, the Foulkes model, in their group.

Procedure and treatment of the data:

Each therapist participated in an interview prior to the first group meeting. The semi-structured interview had, in total, 19 questions (see Appendix B.5), designed to cover not only his assessment and expect-ations of his group patients, but also a self-assessment. The areas covered in this interview are indicated in Figure 3.2 . Each interview was tape-recorded, to be transcribed and analysed at a later date. The data collected from these interviews was found to be suitable for Guttman scale analysis and, from the 10 initial sections of the interview, eight possible scales were determined and subjected to Guttman scale analysis. It was subsequently found that all these scales had greater than 90% consistency, as shown in Figure 3.2 . (Appendix C.5 contains detailed Guttman scale analysis of this interview).

Results and discussion:

Both therapists saw the group as a place where poeple could interact with one another, somewhere patients felt safe enough to reveal things which are relatively intimate but very important and where they could accept both criticism and support from the other group members. In addition, the therapists felt this approach was based on their training and felt successful as therapists.

Regarding the role they anticipated adopting in the group, both therapists felt they would like to adopt the role of conductor in the group

Figure 3.2:   Interview sections of the therapist interview prior to

commencing group therapy and the Guttman scales derived.

<u>The interview covered the following areas:</u>

       Expectations of the patient

       Perception of the patient's presenting problems

       Suitability of treatment and alternatives for the patient

       Possibility of premature termination by the patient

       Hopes for the patient as a result of treatment

       Realistic expectations for the patient as a result

        of treatment

       Training of the therapist

       Approach to therapy

       Role to be adopted in the group and with the patients

        comprising the group

       Personal expectations of therapy

<u>Guttman scales derived and their consistencies:</u>

<u>100% consistency:</u>   therapist's attitude towards group therapy, therapist's expectations of his role in the group, therapist's expectations of personal change as a result of group therapy, therapist's locus of control, expedience of group therapy for the patient and possible alternative treatment.

<u>93% consistency:</u>   therapist's optimistic and realistic expectancies of change in the patients, attendance and participation of the patient in the group, problems of the patient and therapist's anticipated clinical involvement with the patient.

but, while one felt he would adopt this role successfully, the other felt

he would, at some time, adopt the role of leader when in the group. Neverthe-

less, both therapists felt they would personally alter as a result of the group

experience, feeling that they would learn about themselves.

Assessment of the prospective group members indicated that for

93% of the patients, the therapists felt that group psychotherapy was the

most suitable treatment, irrespective of what was available in the hospital

and, in addition, felt that 80% of the patients would attend the group meetings

regularly. The therapists did not, however, feel that the patients would

receive equal benefit from the group experience.

Such a view was derived from what the therapists saw as the main

problems of the patients and how prepared were the patients to use the group

as a tool to help themselves. It appeared that patients who had difficulties

in relation to their identity or had low self-esteem were anticipated to be

serious "therapeutic workers" if they were prepared to listen rather than

verbalize in the group or if they sought emotional support and reassurance

from the other group members without becoming overly dependent on the group.

In addition, there was a lack of congruence between the therapists'

realistic and optimistic expectations of change in the patients. While the

therapists' hopes ranged from the patient gaining insight into his problems

to emotional separation from his parents or, as in one instance, emigration,

the therapists' realistic expectations were more modest, anticipating only

partial change, no change, or termination by the patient when the group

became too threatening.

3.3. Summary: comparison of patients' and therapists' expectations of group psychotherapy

It would appear that the patients and therapists involved in the

present study had differing expectations of what their approaching therapeutic contact would consist of, what would be expected of them, and what the outcome of therapy would be - the differences being more prominent than the similarities.

For instance, the patients anticipated that their forthcoming treatment would be comparable to individual psychotherapy but in a group, primarily expecting direction from the therapist with little to be given to, or obtained from, the other group members apart from support. On the other hand, the therapists perceived the group milieu and the members who constituted the group as the major source of assistance, emphasizing the commonalities among the prospective members rather than their differences.

Related to this, the patients expected the therapist to have control over what happened in the group meetings, although the amount of activity they felt he would have to exhibit to maintain this control, varied. The therapists felt they would like to minimize their participation in the group. Nevertheless, one therapist anticipated that he might be compelled to be more active at times in the group than he would really like to be.

Regarding the expedience of group therapy, there was a striking difference between the views of the patients and their therapists. The therapists felt group therapy was the most suitable intervention for the patients, taking into consideration the other forms of intervention available in the hospital. In contrast, a large proportion of patients felt that group therapy was perhaps not the best treatment for their difficulties, indicating a preference for drug therapy or individual consultations, although these forms of intervention were not seen as being of potentially greater effectiveness. It may be that the general public knows comparatively little about group therapy compared to the more common treatments associated with the psychiatrist.

However, despite this, the present sample of patients were reluctant to rectify this situation by finding out what the treatment regime would be like.

Consistent with this difference, was how patients and therapists conceptualized the problems of the patient and their expectations of the patient's role in treatment. The therapists saw the role of the patients in the group as one of using the group, both the therapeutic milieu and the other group members, to assist themselves, while the patients, on the other hand, saw the group as somewhere they would get "treatment", not anticipating the importance of their own participation.

In addition, the patients perceived their difficulties as being recent in onset and described their main symptom of anxiety as being a reaction to their inability to cope with the demands of their lives. Put another way, the patients wanted to be treated for their symptoms while the therapists wanted the patients to question why they had developed such symptoms as well as learn how to cope more effectively.

In terms of the possible outcomes of therapy, the patients' hopes varied from being more at ease with one's problems to extensive behaviour modification, although the majority acknowledged their own limit- ations of achievement. The therapists' expectations of outcome were likewise modest, anticipating at best only partial change, at worst premature termination, or no change.

In summary, there were some striking differences between the expectations of patients and their therapists, such that it would appear that patients were anticipating a psychiatric-medical treatment regime while the therapists anticipated adopting a psycho-social model. This is of particular interest considering each prospective group member had been encouraged to

discuss their impending therapy with the therapist. It would, however, appear that there was a reluctance to do so and the patients were, on the whole, maintaining the "doctor-patient" relationship often found in other psychiatric and medical forms of intervention. For some patients, it may not be an exaggeration to say that they were sceptical of their impending treatment while others relied on the therapist to offer them the most appropriate treatment for their problems.

The only issue patients and therapists were agreed upon was that group therapy is not a "magic cure" and any gain from this type of intervention only results from at least being prepared to work on the problems in hand - the therapists feeling that the patients were in sufficient distress to do so successfully.

CHAPTER 4

Patients' and Therapists' Experience of
Group Psychotherapy

4.1.   General Introduction

4.2.   The Present Study

        4.2.1. Patients' experience of group psychotherapy

        4.2.2. Therapists' experience of group psychotherapy

4.3.   Summary: comparison of patients' and therapists' experience
                of group psychotherapy.

4.1   General Introduction

To discuss the process of therapy without indicating the changes

to which it refers is regarded by Kiesler (1973) to be a pointless exercise.

Indeed, he further claims that the traditional process-outcome distinction

perpetuates the use of pre-post designs in outcome studies.

Notwithstanding, all major viewpoints emphasize the importance

of the therapeutic relationship for the process and outcome of therapy.

From the therapist's standpoint, Fiedler (1950 a,b, 1951) suggested that

experienced therapists of different orientations concur in their character-

ization of an "ideal therapeutic relationship" as warm, accepting, and

understanding.   In contrast, Truax((1961), Truax and Carkhuff (1967)),argue

that patients, because of their patienthood, are unable to perceive

accurately the subtleties of interpersonal relationships, as are found in

psychotherapy.   Consequently, Truax argues that, from the patient's point

of view, assessments of the therapeutic relationship or his phenomenological

experience are poor indicators of how facilitative the experience of therapy

is.

Despite this argument, it remains that the patient's perception

of the quality of the therapeutic relationship is a factor that mediates

therapeutic change (eg. Heine (1953), Feifel and Eells (1963), Hathaway

(1948), Strupp et al (1964)). In addition, this appears to be the case

whether the therapy concerned is psychoanalytic or behavioural in orientation.

Ryan and Gizynski (1971), studying behaviour therapy, and Sloane et al (1975),

investigating psychotherapy, both conclude that personal interaction with the

therapist is reported by patients as highly important in treatment and its

outcome.   Llewelyn and Hume (1979) subsequently found that patients report

non-specific activities to be more useful than either psychotherapeutic or

behavioural-type activities, irrespective of the type of therapy, and go on

to say that they connect directly with the triad of therapeutic qualities described by Rogers (1961) of warmth, empathy, and genuineness as "the necessary and sufficient conditions of therapeutic personality change".

However, that therapists and patients report the same experiences in therapy as being important, is open to question. Mintz and Luborsky (1971) report that agreement in evaluation of the quality of therapist relationship style may be particularly problematic to obtain. Cartwright et al (1963) and Luborsky (1971) have found low agreement on judgments of the outcome of an entire treatment by patients, therapists and external observers. On the other hand, Mintz et al (1973) report a reasonable consensus in descriptions of several aspects of a psychotherapy session, in particular noting good agreement across all views in descriptions of the patients' emotional states. Nevertheless, evaluation of the "goodness" of the session did not correlate significantly with patient emotions, for all views, and there was consistently poor agreement in judging the quality of the therapist's relationship within a session and the "goodness" of the session itself.

While the data of Mintz et al (1973) confirms the reports of Auerbach and Luborsky (1968) and Mintz and Luborsky (1971) of what kinds of events are experienced as good therapy, suggesting an involved, understanding therapist and an involved, active patient, this apparent agreement on the verbal level as to what effective treatment is like does not deny the fact that raters did not agree as to when effective treatment was taking place.

The experience of psychotherapy emphasizes the ongoing involvement in the therapeutic process as it is perceived by the participants. This may include not only their perception of self, but also their perceptions of others and of the social and physical milieu. The fact that psychotherapy is a social situation, however, must not detract from the fact that the therapist is an extremely influential focus of awareness for the patients and also that

the patient's own self-perceptions are more likely to be divulged than in most other social situations. It is therefore amazing to find that there are only a few studies involving the participants' self-perception and perception of others in the process and outcome of therapy.

Most therapies require that the patient and therapist participate in a specialized type of conversation (Labov and Fanshel (1977)). Patients who perceive themselves as expressing their thoughts and feelings with greater "openness" early in therapy were found by Saltzman et al (1976) to have significantly better outcomes than patients who perceived themselves as being less open in their interaction with the therapist. Also found was that patients who felt they had a better "understanding" of what the therapist was trying to communicate to them had significantly better outcomes than their fellow patients. Likewise, the patient's sense of progress in problem resolution, even as early as the third session, was significantly and positively related to patient improvement. That patients who behave in a "structuring" (i.e. actively initiating) manner with their therapists have more successful outcomes is reported by Tovian (1977) in support of Saltzman et al (1976) and Yalom et al (1975).

Of the few results available on patients' internal self-experience in therapy, Saltzman et al (1976) found, in terms of patients' sense of role-identity, a tendency towards better self-rated outcome among patients who felt a greater sense of "responsibility" for resolving their problems and altering their behaviour, in contrast to those who placed more reliance on their therapists. Consistent with this, Jeske (1973) reported that patients who, in group therapy, more often "identified" with the experiences reported by other group members had more favourable outcomes than those who felt little or no identification. The inference of such studies would appear to be that the patient's experience of active and passive involvement in treatment is indicative of treatment outcome.

Likewise, Bent et al (1976) found patients who perceive their therapists as "active" and "involved" also have significantly better outcomes, while Tovian (1977) found that patients who perceived their therapists as being "detached" early in treatment, tended to deteriorate rather than improve in therapy.

Turning to the therapist's perspective, therapists' observations of patient role engagement have been found to be correlated with treatment outcome. Gendlin et al (1960) found that therapist reports of patients' movement from talking about to experiencing feelings was positively correlated with improvements in individual client-centred therapy. However, Roether and Peters (1972) also found that patients' expression of hostility, as perceived by the therapist, was positively related to outcome. Although somewhat conflicting and limited, these results suggest that therapist awareness of patients' initiative in experiencing feelings is indicative of therapeutic outcome.

Likewise, therapist ratings of patient prognosis are relevant to both the personal and role attributes of the patient, as perceived by the therapist. To date, however, only three process-outcome studies have included this variable: Praeger (1971) found no correlation between improvement and good prognosis early in treatment; Saltzman et al (1976) report a significant positive correlation between outcome and prognosis rates in the third session; and Strupp et al (1963) found that therapists' retrospective assessments of patient prognosis were correlated positively with outcome.

While the therapist is not the focus of therapeutic concern, there is some suggestion that the therapist's self-perceptions are a particularly interesting aspect of therapeutic process. Only two studies have focused on therapists' awareness of their instrumental participation with patients, both reporting positive findings in relation to outcome. Reviewing therapists' reports of their interpretive interventions, Malan (1976) found

that transference interpretations, which indicated similarities between patient reactions towards the therapist and earlier familial relations, gave strong, positive correlations with outcome, while interpersonal interpretations were negatively related to patient improvement. Similarly, Ryan and Gyzynski (1971) found that, in behaviour therapy, therapists of more improved patients were more likely'to report at post-therapy having deliberately encouraged positive expectations of successful outcome.

Regarding the therapist's sense of his own role investment, Saltzman et al (1976) report no correlation between patient improvement and the therapist's sense of involvement or "emotional availability", defined in terms of concern and attentiveness. On the other hand, Rosenthal and Levine (1970) found that for brief individual therapy with children, poor therapist motivation for the procedure was associated with poorer therapeutic outcome. As these two studies are not very similar nor are there any others bearing on this point, the issue is left in doubt.

It would, however, appear that it is the participants' interpersonal perception of the therapy process which is vital for successful therapeutic outcome, but are also important with respect to the confirmation or disconfirmation of prior expectations. Given that it is the patient who is the focus of therapeutic concern, it is of note that it is _his_ perception of the personal attributes of the therapist as distinct from the therapist's skills ; which appears to constitute one of the principal factors in treatment outcome.

4.2. The Present Study

4.2.1. Patients' Experience of Group Psychotherapy

Subjects and procedure:

Following the interview of patients before commencing treatment, it was decided to follow the progress of the patients during group psychotherapy at intervals of eight weeks. Therefore, given that the treatment

term was 18 months and allowing for vacations, the patients would have no more than seven interviews during this time. One patient terminated before the first "During Therapy" interview (i.e. in the first two months of the group), and by the last interview at this stage of the investigation, seven patients remained. While there was an attrition rate of 50% in the first 12 months of therapy, in the following six months of therapy, no patients terminated.

The interview employed during treatment was semi-structured with, in total, nine questions (see Appendix $B.2$), designed to explore various aspects of patients' perception of himself and the other group members in the process of group psychotherapy. Figure 4.1 indicates the areas covered in this interview, the Guttman scales derived and their consistency over the course of therapy. Each interview was tape-recorded, to be transcribed and analysed at a later date.

Data collected from these interviews was found to be suitable for Guttman scale analysis and from the six initial sections of this interview, three possible scales were determined and subjected to Guttman scale analysis. As can be seen in Figure 4.1, the consistency of those scales varied over the course of treatment (Appendix $C.2$ contains detailed Guttman scale analyses of these interviews).

Results and Discussion:

The Guttman scales derived from the patient interviews during group psychotherapy will be presented and discussed in detail.

Patient's perception of himself in the group:

In the first two months of group psychotherapy, 70% of the sample ($N = 14$) felt they were changing for the better as a result of the group, attributing this primarily to the reassurance they were receiving from the other members. In addition, 63% did not perceive themselves as being leaders within the group at this stage of therapy. By four months, a

Figure 4.1:   Guttman Scales derived from "During Therapy" Interviews for

Patients and Consistency of Responses.

The "During Therapy" interview for patients covered the following areas:

Perception of what has elapsed in the group

Perception of what has happened to the patient, personally

Any gain from the group experience

Fulfilment of initial expectations

Leadership pattern in the group

Enjoyment of the group meetings

Guttman scales derived from these interviews and consistency of responses

during group psychotherapy (at   intervals of two months):

Patient's perception of himself

in the group		93%	92%	100%	100%	100%	100%	100%
	N =	14	12	9	9	7	7	7

Patient's perception of the

group process in relation to

his initial expectations		93%	92%	89%	100%	86%	100%	100%
	N =	14	12	9	9	7	7	7

Patient's perception of the

other group members in

relation to the group

process		93%	92%	78%	78%	72%	100%	100%
	N =	14	12	9	9	7	7	7

similar trend was to be found in the patients studied although by this

time 20% of the sample had dropped out of treatment.

At eight months of therapy,there was a 40% dropout from the

original sample and, of those who remained in therapy, 67% felt they were

changing as a result of the group. This was attributed by the patients to

comparison with others in the group and favourable identification with those

similar to themselves. Regarding whether the patients perceived themselves

as leaders in their group, two patients (one in each group) said they saw

themselves in such a role.

By ten months of group treatment, there had been a 53% dropout

from the original sample, but thereafter there were no terminations, all the

remaining patients completing the treatment term. It is of interest that

at ten months, only 58% felt they were changing as a result of the group

but by twelve months, this increased to 71% and was consistent with the

responses at 14 months. Likewise it is of note that once the group member-

ship stabilized at ten months, it was subsequently reported that 44% of the

patients perceived themselves as being leaders in the group.

It would therefore appear that the patients' perception of change

in themselves during group psychotherapy did not follow a simple pattern.

Although it appeared that the amount and type of change reported by the

patient was dependent on the stage the group was at, eg. there was little

change perceived when the group was confronting the individual about his

defence mechanisms, the occurrence of patients dropping out of treatment also

appeared to influence those who remained. Those who remained reported

questioning the progress they had made and their continuing treatment.

Whether patients perceived themselves as being leaders in the

group during therapy, their reports revealed that, after an initial "settling

down" by patients into the group, one person in each group perceived himself as leader. Inspection of the raw data indicated that it was the same patients throughout treatment and it is of note that these patients were described by the therapists as adopting the role of "therapist's assistant" early in treatment, and subsequently maintained this role throughout therapy. However, it is of interest that, towards the end of therapy, there was an increase in the number of patients perceiving themselves as leaders within the group, their explanation being that they felt it was a collective leadership with no one member having more influence than another within the group.

It transpired, therefore, that a large proportion of patients terminated within the first ten months of therapy with the resultant effect that those who remained (N = 7), doubted their own progress and future treatment. Thereafter, until the completion of therapy, no patients terminated, the majority regaining confidence in their therapy and becoming serious therapeutic workers. It is also of note that, in this latter stage, no patient was perceived by the others to have more influence than anyone else in the group, although two patients did perceive themselves as leaders. The results tend to suggest that it was only after the dropouts ended and the groups achieved sufficient cohesion that the remainers felt secure enough to use the group for a therapeutic purpose.

Patient's perception of the group process in relation to his initial expectations:

In the first two months of therapy, the patients were divided about what was happening in the group. Either they felt they were getting to know each other and developing trust (N = 7) or they were unsure of what was going on in the group (N = 8). By four months, three patients also felt that the others were not very forthcoming. At six months, the patients felt they had got to know each other, patients now reporting that the group was either stagnating or not forthcoming, or individually, they were unsure of the whole enterprise. After this and until the end of treatment,

the patients reported that the group began to define the members' problems, suggest possible solutions and encouraged the individual to apply what he learned in the group to his everyday life. In addition, by 14 months, the patients (N = 7) reported anticipating the end of treatment and were preparing for this event by evolving coping strategies for the future.

With regard to getting something out of the group meetings, the overall finding was that patients did report some benefit, although this varied both qualitatively and quantitatively from individual to individual. Throughout the treatment term, approximately two thirds of the patients reported getting something out of the group, this varying from reassurance and support to identification with other group members and, in the final stages of the group, actively anticipating the future. While several patients commented that one only got out of the group what one was prepared to put in, it was also noted that a member did not have to be active within the group to benefit from it. Again it appeared that once the group membership stabilized, a larger proportion of remaining members reported gain from the group experience suggesting the importance of a sense of security on the part of the patient for any therapeutic work to commence.

When asked if they enjoyed the group meetings, the patients initially said they did not. At the end of two months of therapy, only 28% responded positively to this question. However, as therapy continued, more and more patients reported they were enjoying the meetings.

Therefore, with respect to the patients' perception of the group process in relation to their initial expectations, they saw the initial stage as one of getting to know each other and developing trust, gradually becoming uncertain of what was "supposed" to happen in the group or feeling that treatment was not as they had anticipated, and only after attending the group for eight months, did the members feel they were ready, both individually

and as a group, for serious therapeutic work. It would appear that the
present sample took some time to develop group cohesiveness, although this
may be a facet of the long treatment term, and it is of note that it was
at this stage of therapy that the last of the dropouts left. It is further
of interest that, knowing when the group would terminate, the members antic-
ipated this event and prepared themselves for after this event.

Within this framework, patients varied in the type and amount of
benefit they felt they received from the group experience. It transpired
that those patients who reported little or no benefit dropped out. However,
it is interesting that no patient reported becoming worse as a result of the
experience. Those patients who remained reported different types of benefit
at different points in time during therapy: in the early stages of the
group, the main benefit was that of reassurance while latterly, constructive
criticism and validation of experiences was most appreciated by the patients.
In addition preparation for after the group halts was seen as beneficial.

With regard to enjoying the group meetings, initially all but
two of the patients did not enjoy them. This is perhaps understandable given
the anxiety evoked by any treatment situation and, indeed, the novelty
of the group psychotherapy setting for many. However, as therapy progressed,
most patients reported enjoying the meetings, not only as a social gathering
but also on a therapeutic level, in terms of what they could contribute to,
and gain from, the group experience.

Patient's perception of the other group members in relation to the group
process:

Throughout the duration of treatment, the patients always felt that
some of the other group members were getting something out of the group
experience. During the first eight months of the groups the patients felt that
approximately two thirds of the other members were gaining from the experience.
Although the perceived gain varied from individual to individual, it is

interesting that the patients tended to concur on the type of benefit being derived by the others. In the latter stages of therapy, all but one patient were perceived to benefit. Two possible explanations for these findings come to mind: first, that those who did not benefit, and were seen by others not to benefit, dropped out, by simply remaining in therapy was perceived by the patients as indicative of benefit; or second, as those who remained in therapy felt they were personally benefitting from the group experience they further assumed that this must also be the case for the other group members.

When asked if some patients were participating moreso than others in the group meetings, the patients initially reported this to be the case for 35% of the sample. By ten months of therapy, however, all patients reported equal participation in the group meetings. Further, as treatment progressed, the patients came to differentiate between "verbal" and "non-verbal" particip- ation, emphasizing that a member did not have to be verbally active in the group to be seen as participating. Also, the patients distinguished between "constructive" and "destructive" participation with regard to the treatment process.

The patients' perception of leadership within the group indicated that, throughout treatment, one patient in each group was perceived as leader, although latterly there was a sense of "power-sharing" within the members. That these "leaders" also perceived themselves as such is of interest and, as already alluded to, it is of note that they were perceived by the therapists as being "therapist's assistant". Such a finding tends to suggest that these patients, having adopted (and been seen to adopt) this role initially, subsequently saw themselves (and were seen by the others) as maintaining this role throughout treatment.

Therefore, as treatment progressed, the patients perceived more of the other group members as benefitting from the experience, although it must not be overlooked that patients were dropping out of therapy in the first ten months. Within this period, patients who were not perceived as benefitting from the experience and were perceived as not participating, or participating in a destructive manner, in the group, dropped out. This finding suggests that the problem of group deviancy may be more subtle than originally suggested by Yalom (1966).

It is also of interest that one patient in each group perceived himself, and was perceived by the other members, as being in the role of leader. While, from a theoretical standpoint, it could be argued that such a patient would not be in a position to achieve the maximum "emotional" benefit as his participation would be principally on an intellectual level, it could be argued that the adoption of such a role was, in fact, "therapeutic" for these patients. Yet another possibility might be that adoption of this role, voluntarily or otherwise, is an example of the patient attempting to distance himself from the therapy process. In the present instance, the therapists felt it <u>was</u> therapeutic for these patients and initially encouraged them to adopt this role.

Summary.

The initial benefit reported by patients was that of being reassured that other people had similar problems while, as therapy progressed, they reported that the constructive criticism, advice and support was valuable, especially when anticipating the termination of the group. Although the therapists had assumed they had achieved group balance, it would appear that this may not have been the case as patients who perceived themselves and were seen by others in the group, to gain little from therapy, terminated when the principal dynamics apparent in the group were task orientation and group cohesiveness - both of these dynamics theoretically "following on"

from group balance.

Apart from the fact such dropouts were perceived as "failures", the
effect this had on the remaining members was to lead them to doubt the
progress they made and generally question the efficacy of group psychotherapy.
However, although it is not possible to distinguish whether it was a result
of the dropouts that the others gained cohesion and perceived themselves as
a group or whether it would have happened for some other reason, once cohesion
was achieved within the groups, the patients reported this fact, indicating
further that more were benefitting from their treatment and more reporting
satisfaction with therapy. It may perhaps be, as Lothstein (1978)
suggests, that the dropout phenomenon is basic to the establishment of group
cohesiveness and that, instead of attempting to prevent or reduce the dropout
phenomenon, efforts should be directed towards reconceptualizing the more
positive aspects of it.

Regarding the patients' perception of leadership in the group,
only two patients (one in each group studied) perceived themselves as adopting
this role, although in the latter stages, patients in both groups reported
that leadership was, by now, collective. While those who perceived themselves
as leaders were also perceived by the others as such and were described by
the therapists as being "therapist's assistant" it is of particular interest
that at no time were the therapists perceived by the group members as leader
in his group. While the therapists reported that it was therapeutically
valuable that these particular patients adopt such a role, from the patients'
standpoint, it transpired that the "therapist's assistant" acted in the
group as an intermediary between the patients and the therapist.

The patients' perception of the progress of therapy appeared to
follow a sequential pattern in five stages. Initially, they saw the group

principally as a social gathering where they got to know each other and
developed trust. At the second stage, the majority maintained this belief
while some began to see the members as being reticent and not very forthcoming.
At the third stage, there was a general report of stagnation within the group
with uncertainty about the group and the aims of treatment. It is perhaps
no coincidence that it was at this time that those who had seen the group
as reticent at the second stage, dropped out. In the fourth stage, the
remaining members gained sufficient cohesiveness to develop beyond being a
social gathering and becoming a therapeutic group. This continued until
the end of treatment although in the last months, the final stage of
preparing for the end of the group became apparent.

Patients' reports of benefit from the group meetings, per se, varied
from individual to individual and was dependent on what they regarded as
applicable to themselves at any one time. Nevertheless, as therapy progressed,
most patients reported increasing benefit from the meetings. Likewise, the
patients did not report enjoying the early group meetings but, over time, this
altered as their perception of benefit increased. This finding suggests that
patients do find the group situation initially very stressful and as such,
the initial commitment to attend for a set period, as employed by many
therapists (including those in the present study) may be invaluable if the
patients are to overcome the initial anxiety evoked by such a gathering.

As the patients reported themselves benefitting more as treatment
progressed, they also perceived the other members as deriving greater benefit.
It is open to question whether this was based on observation or on inference.
It may have been that the patients felt that because they, personally,
benefitted from the meetings, then the other members must also do likewise,
i.e. a halo effect. Nevertheless, the fact that the members concurred on the
type of benefit being derived by each of the other members, tends to suggest
that this perception was based primarily on observation.

Whether some members were perceived as participating moreso than others in the group meetings, patients' responses revealed that they assessed this aspect of the group on two dimensions: verbal/non-verbal and constructive/destructive. Patients who were perceived by the group as both verbal and destructive in the group, dropped out. One exception to this was a patient who completed the treatment term "to spite the therapist" (patient's own words).

In conclusion, it was therefore possible, despite the small sample, to characterize the patient who was more likely to drop out of the group in the early stages of therapy. Having entered the group, he felt, or was made to feel, deviant in some way from the other members, despite the careful selection of patients to the group by the therapists. In addition, he perceived the progress of treatment as incompatible with his expectations, expressing the view that the group was "too slow", not forthcoming, or stagnating. By his own report, he derived little or no benefit from the group meetings and was perceived by the other members as contributing little or being destructive in the meetings. Finally, he felt threatened by the group situation and reported he was unable to control it.

In contrast, the patient more likely to continue group therapy was prepared to endure the initial stress of the therapy situation in order to subsequently overcome his anxiety and use the group as a therapeutic tool to help himself. Although accepting the initial progress of therapy as being "slow", when other members were dropping out, he became doubtful about the efficacy of this form of treatment. Nevertheless, he reported deriving benefit from comparing himself to others in the group, identifying himself with the experiences of others, and was perceived by the other members as contributing in a constructive manner to the group's function. It is of note, however, that such contribution did not have to be verbal.

4.2.2. Therapists' Experience of Group Psychotherapy

Subjects and Procedure:

As was the case for patients in this study, the therapists were interviewed during the treatment term at intervals of eight weeks. Therefore, like their patients, they had no more than seven interviews during the treatment term, allowing for vacations.

The interview employed was semi-structured with, in total, nine questions (see Appendix B.6), aimed at investigating the therapist's perception of his group patients and himself in the course of therapy. Figure 4.2 contains the areas covered in these interviews; each interview being tape-recorded, to be transcribed and analysed at a later date.

The data collected from these interviews was found to be suitable for Guttman scale analysis and from five initial interview sections, three possible scales were determined and subjected to Guttman scale analysis. Inspection of Figure 4.2 reveals that while the consistency of the therapists' perception of himself in the group remained at 100% throughout the treatment term, the consistency of the other scales varied over the course of therapy (Appendix C.6 contains detailed Guttman scale analyses of these interviews).

Results and Discussion :

Therapist's perception of himself in the group:

Both therapists felt that, throughout the treatment term, they enjoyed the group meetings and personally benefitted from the experience. Further probing into what it was they felt they benefitted from revealed that they gained insight into how they portray themselves in the group and how they are perceived by the patients, as well as identifying themselves with their patients.

Regarding whether they perceived themselves as being leader in

Figure 4.2:   Guttman Scales derived from "During Therapy" Interviews for

Therapists and Consistency of Responses.

The "During Therapy" interview for therapists covered the following areas:

Perception of what has elapsed in the group

Perception of what has happened to himself, personally

Fulfilment of expectations for each patient

Leadership pattern in the group

Enjoyment of the group meetings

Guttman scales derived from these interviews and consistency of responses

during group psychotherapy (at intervals of two months).

Therapist's perception of

himself in the group	100%	100%	100%	100%	100%	100%	100%
N =	2	2	2	2	2	2	2

Therapist's perception of

the group members in relation

to his initial expectations

	93%	92%	89%	78%	86%	100%	100%
N =	14	12	9	9	7	7	7

Therapist's perception of the

group members in relation to

the group process	100%	92%	89%	78%	86%	100%	100%
N =	14	12	9	9	7	7	7

the group, both felt that, during the first ten months of their group,

this was not the case. However, during the remainder of the treatment term,

one continued to feel he was not leader while the other subsequently

felt he was leader, describing himself, at one stage, as a "benevolent dictator"

(therapist's own words). It is of note that this is exactly as they had

anticipated prior to commencing the treatment term.

Therapist's perception of the group members in relation to his initial
expectations:

Although at the end of the first two months of the treatment

term, the therapists reported that the meetings were achieving what they

had anticipated for 72% of the patients, thereafter, this increased to 100%.

Probing revealed that what the therapists felt their patients were achieving

corresponded with what patients reported as benefitting from (i.e. reassurance,

comparison and identification with others, etc.) although there was

dyssymetry in ten cases throughout therapy between a patient's self-report

of benefit and the therapist's report of benefit for that patient.

In addition, regarding whether the patients were when in therapy,

as anticipated by the therapists prior to commencing treatment, it was

reported at the end of two months, that 93% of the patients were as expected.

However, by four months, this had dropped dramatically to 8% (i.e. one patient).

Nevertheless, over the remainder of treatment, this subsequently increased to

86%.

These two findings, when taken together, tend to suggest that,

while, on the whole, satisfied with what their patients were achieving as a

result of the group experience, this perception was constantly being modified

in the light of the accumulating information the therapist gained of each

patient on experiencing the patient in the therapeutic setting. That such a

large proportion of patients were as anticipated in the first two months of

133.

therapy may have been the result of the therapists, like the patients,

getting to know the other group members. Presumably, at this stage, the

therapists were still getting to know their patients and had limited

knowledge of their patients' difficulties, as distinguished by Cox (1978).

However, as therapy progressed, the additional information gained from the

therapy setting influenced greatly the ways in which the therapists perceived

their patients.

In addition, it must not be overlooked that from six months until

the end of treatment there was a continual increase in the number of patients

fulfilling the therapist's expectations. While it may be, as already

suggested, that the therapists were able to <u>anticipate</u> more accurately how

the patient might be in the group based on their constantly growing knowledge

of each patient, an alternative explanation might be that, as suggested by

the raw data, those patients who felt deviant from the others, felt they

gained little in treatment, etc., also did not fulfil the therapist's

expectations and dropped out of therapy.

Regarding the way in which the therapist perceived his own role

in the group with reference to the needs of his group, it transpired there were

four main roles which the therapists saw themselves adopting over the duration

of therapy: supportive; a father figure (both regarded as "caring" roles);

a realist; and "someone who would demonstrate that doctors are not magicians"

(which the therapists regarded as "purposeful" roles).

Initially, both therapists placed great emphasis on the purposeful

roles they adopted, given that the group was in the initial stages of development,

the emphasis being on task orientation and group cohesiveness. From four to

eight months of the treatment term, both emphasized the caring roles to be

adopted and thereafter, till the end of therapy, they reported adopting both

types of role according to the needs of their patients, both individually

and as a group, at any one time.

Therapist's perception of the group members in relation to the group process:

In the first two months of therapy, the therapists felt that 93%

of the patients were benefitting from the group experience, attributing

this to the reassurance patients gained from meeting others with problems

similar to their own. It is perhaps no coincidence that it was the same

patients the therapists perceived as fulfilling their (i.e. the therapists')

expectations at this stage of therapy. The data would suggest therefore, that

a patient who fulfils his therapist's expectations is also assumed to

benefit from the therapeutic experience. However, at four months, 58% of the

patients were perceived by the therapists as benefitting and, as already

stated, only one patient fulfilled the therapists' expectations.

Subsequently, the percentage of patients perceived by the

therapists as benefitting from therapy gradually increased until, in the

last four months of therapy, all the patients were seen as benefitting.

While there was variation in the percentage of patients perceived to be

benefitting from the therapy experience over the course of treatment, there

was also reported to be qualitative differences in benefit, dependent on the

stage of therapy.

As already stated, the patients were initially seen to benefit from

meeting others with similar difficulties and being reassured that they were

not "insane" or "abnormal". After four to ten months in therapy, the

patients were perceived as gaining from developing a focus within the group

and, indeed, becoming a group of serious therapeutic workers. In addition,

given that some patients were terminating during this time, the therapists

felt those who remained gained from assessing exactly what their problems

were and assessing their progress, in the light of such terminations.

After this, the patients were seen to settle down to the
therapeutic work that the groups were originally created for. While the
therapists continued to report this until the end of treatment, they also
felt, in the last two months of therapy, that the patients benefitted from
anticipating their future after the termination of the group and discussing
how they would cope with this.

Regarding whether the therapists felt some patients participated
moreso than others in the group meetings, the therapists reported approximat-
ely 40% of the patients participated in the meetings during the first eight
months. Noting, as did the patients, the dimension of "verbal" and "non-verbal"
participation, once the dropouts ceased, the therapists reported that all
but one patient participated in the meetings over the remaining treatment
term.

Also, as was reported by the patients, the therapists felt that
throughout the duration of therapy, two patients (one in each group) were
leader in his respective group. While it is of interest that the therapists
described these patients as being "therapist's assistant", it is also of
note that patients and therapists concurred in identifying who these "leaders"
were.

Summary.

Analysis of the therapists' interviews during the treatment term
revealed that both therapists reported enjoying the group meetings and felt
that they personally gained much from the experience. As they had anticipated
prior to commencing therapy, both did not perceive themselves as adopting
the role of leader in the initial stages of the group. However, one therapist
did feel, after ten months, that he had been unable to avoid adopting this
role and subsequently perceived himself as such until the completion of
therapy.

Over the treatment term, both therapists reported being satisfied with the achievements of their patients but it must not be overlooked that this was the case only for those patients who remained in therapy, rather than all the patients who commenced treatment. Even so, the therapists' satisfaction appeared to be influenced by how they experienced the patients in the therapeutic setting itself. As the therapists learned more about their patients, so their aims and objectives were modified.

Initially, the therapists reported they were extremely pleased with their patients; their appraisal being based on their pre-therapy assessment and limited experience of the patients in the group situation. Subsequently, as the treatment term progressed, the therapists gained more information about their group members. At four months, however, only one patient was seen as achieving as anticipated and it is perhaps no surprise that it was at this point more patients dropped out than at any other time in treatment. Thereafter, therapists reported being, on the whole, satisfied with the accomplishments of their group patients.

The present results would suggest that therapists' perception of their group members during the treatment term was influenced more by actual interaction with the members than by the therapists' expectancies of that interaction. Such a finding supports the results of Lennard and Bernstein (1960) and Kumar and Pepinsky (1965). However, if there was great discrepancy between the therapists' expectancies and actual interaction with a patient, he reported being dissatisfied with the progress of treatment for that patient.

Therefore, while Sattler and Winget (1970) and Saunders and Vitro (1971) suggest that recent information has a more potent effect than prior information in the applied setting, the present results suggest this is the case if the more recent information confirms the prior information.

Patients whose therapist expected greater personality change were seen as achieving more in the meetings (and attended more meetings) than patients whose therapist expected less change. Nevertheless, there were some exceptions. Of the eight patients who dropped out, three had been regarded by the therapist as very suitable for group therapy and as patients who would complete therapy successfully. However, this was not subsequently the case, the therapists reporting the need for a reappraisal of these patients' suitability for this type of intervention. It may be, as suggested by Affleck and Garfield (1961), that therapists tend to be over-optimistic about patient length of stay in therapy, but in addition, over-optimistic about patient gain from treatment with the result they have difficulty in the correct identification of the early terminator. This would suggest there is a need for further research on the selection of patients for this treatment, especially on what bases therapists decide which treatment regime is most appropriate for a particular patient.

Regarding the therapist's perception of his role in the group, both therapists reported emphasizing the reality basis of their role in the initial stages of therapy. During the period of patients dropping out and development of group cohesion amongst those who remained, the emphasis was on emotional support and thereafter both types of role were adopted dependent on the needs of the group at any one time.

This would seem to be consistent with their perception of the dynamics in the groups throughout treatment. For instance, in the formative stages of the group, the principal dynamics of group balance and group task orientation require the therapist to emphasize the principles of group therapy as applied to his group members. When universalization and extensive emotional support are the main dynamics apparent in the group, clearly a supportive role from the therapist is valuable. While in the latter stages, where extensive defense confrontation and experiential validation are most

apparent, both types of role would be called for. However, it must not be

forgotten that, given the theoretical framework adopted by the therapists

in the present study, both therapists reported that they had a minimal

part to play in comparison to the other group members.

The benefit therapists reported their group members as receiving

from therapy varied over the treatment term, both quantitatively and

qualitatively. In the early stages of therapy, most were perceived as

benefitting. When patients were dropping out, however, fewer patients were

perceived by the therapists as benefitting from the therapy experience but

once the group membership stabilized, the number of patients perceived to

be benefitting from therapy increased again. That a similar pattern was

reported on patients' achievements in therapy tends to suggest that patients

who were perceived as gaining from the meetings were presumed to be benefitting

from therapy. However, the data revealed two patients who were exceptions

to this. Although completing the treatment term, both perceived themselves

as having gained very little from therapy. In contrast, the therapists felt

these patients had derived considerable benefit from treatment. Therefore,

the measurement of change, as perceived by the participants in therapy, is

indeed a thorny issue.

Related to this was the finding that therapists reported an

increase in participation by the patients as the treatment term progressed.

This suggests that, from the therapists' reports, patients became more

aware of the need to contribute to the group process as well as benefit

from it. Further, this increase occurred when the dropouts were tailing

off and patients were reporting the development of group cohesiveness.

Nevertheless, the therapists judged this aspect of their group on a verbal/

non-verbal dimension in contrast to their patients who further reported a

constructive/destructive dimension.

4.3.   Conclusion: Comparison of patients' and therapists' experience of group psychotherapy.

Although the patients and therapists were interviewed at the same points in time during the treatment term, the reports of therapists and patients were not found to be particularly in accord.   Nevertheless, there were some aspects of their experience on which they were agreed.

For example, therapists and patients identified the same patients as adopting the role of leader throughout therapy.   In contrast, neither therapist was ever perceived by his group to be leader, despite one therapist reporting he had adopted this role in the latter part of therapy.   Therefore,while this therapist perceived himself as a "benevolent dictator" latterly (his own words), his patients did not agree. Such a finding raises the issue apparent when an individual monitors his own behaviour at the same time that his behaviour is monitored by others. However, both therapists and patients perceived the leadership pattern within the group develop from one individual being leader to leadership of a collective nature within the group membership.

Both therapists and patients similarly agreed on the type of benefit each of the members derived from the group at any one time, although this is not to say that an individual patient reporting what he felt as beneficial concurred with what the others (patients and therapist) ascribed to him.   Therefore, while both parties agreed on a general level, differences became apparent for individual cases.

Likewise, the patients' reports of the progress of therapy corresponded closely with what the therapists thought they were achieving, but this did not necessarily agree with the personal gain reported by individual patients.   In addition, it transpired that no dropout perceived himself, or was perceived by the others, to be any "worse" as a result

of his therapy experience.

In trying to conclude this chapter, it is possible to list the main findings from the interviews completed during therapy, as follows:

1. patients and therapists were able to agree on general aspects of the group situation, although when specific comparisons were sought, they became divergent in their reports.

2. responses to the interviews were particularly inconsistent when the members were attempting to achieve a therapeutic alliance with the other group members.

3. therapists were no better or worse than were their patients at perceiving what was happening in therapy.

4. the interviews highlighted the difference between an individual monitoring his own behaviour and his behaviour being monitored by others.

Finally, a word is required on the fact that the interviews demanded that the participants focus on certain aspects of their therapeutic experience. It could be argued that such focusing enhanced the possibility of self-monitoring by the participants or indeed, perhaps even altered the process of therapy. Such arguments make the present investigation hard to defend from a theoretical viewpoint. However, the design of all psycho-therapy research requires the subject to focus on those aspects of the experience the investigator regards as most pertinent, not only for his investigation but also to other clinicians. The defence for the present investigation is that as the concept of causality has no absolute meaning in group psychotherapy, it was necessary to focus on various aspects as it can only hope to be defined in a multidimensional context.

CHAPTER 5

Patients' and Therapists' Assessment
of the Outcome of Group Psychotherapy.

5.1.   General Introduction

5.2.   The Present Study

      5.2.1   Patients' assessment of the outcome of group
           psychotherapy.

      5.2.2   Therapists' assessment of the outcome of group
           psychotherapy

5.3.   Summary:comparison of patients' and therapists' assessment of
      the outcome of group psychotherapy.

5.4.   Six months follow-up interview of patients.

5.1.   General Introduction

An assumption underlying most forms of psychotherapy is that

the relationship between the therapist and his patient is the vehicle

for therapeutic change. Further, it is frequently assumed that the fact

of a patient's remaining in treatment may be interpreted as evidence of

the "goodness" of the relationship and therefore of a probability of an

ultimately successful outcome.

Consequently, outcome is 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 (Malan (1973)). However, reviews of the effects of psycho-

therapy have been both controversial and extremely influential; the ambig-

uity of the data in question being the main contributor to the controversy.

The first comprehensive review of the outcome problem came from

Eysenck (1952), his subsequent contributions ((1960), (1965), (1966), (1967)),

and Rachman ((1971), (1973)). Eysenck has attempted to show that roughly

two-thirds of neurotic patients, no matter how they are treated and whether

they are treated or not. As there are apparent weaknesses in his claim,

there have been numerous critical comments and reexamination of the original

data (see Bergin (1971)).

Bergin (1971) concludes that most forms of psychotherapy make

patients worse as well as better, and this accounts for the lack of

difference in the average improvement found in many studies between treated

patients and controls, that untreated patients improve, at least symptom-

atically, with the passage of time, and that, as far as certain types of

symptoms are concerned, behaviour therapy has been shown to be effective.

Nevertheless, any method of assessment must do justice to very great quantitative differences and important qualitative ones between one therapeutic result and another (Malan (1959)). As no two patients are exactly alike, no method of assessment based on general criteria is specific enough to give accurate results. Likewise, a symptom may disappear for a number of different reasons without any solution of the "basic" problem. For example, it may disappear as a response to relief from external stress, to the relation with the therapist ("transference cure"), or as a "flight into health". The problem arises of deciding which factor is operative.

The answer can, to some extent, be given by long follow-up: obviously, the longer a "cure" lasts, the more likely it is to be due to a fundamental change. However, even with a long follow-up, the disappearance of a particular symptom may be balanced by some other impoverishment of life which is not so obvious but equally crippling.

Unfortunately, there are also two factors which may make the observed effect of therapy even more limited, namely, deterioration effect and spontaneous remission.

Proposed by Bergin (1966), the term "deterioration effect" is used to describe the general finding that some patients are worse after psychotherapy. While deterioration implies some impairment of vigour, it has generally been seen as a worsening of the patient's symptomatic picture, the development of new symptoms, or the exaggeration of existing symptoms, as assessed before and after therapy. Hadley and Strupp (1976) further contend that the negative effects of therapy may include a sustained dependency on the therapist or therapy and the development of unrealistic expectations that result in the patient trying to go beyond his capabilities.

Such negative effects are, however, more subtle and perhaps more difficult for the therapist to be aware of.

Inspection of the empirical literature leads to the conclusion that deterioration can, and does, occur in a wide variety of patient groups (e.g. Fairweather et al(1960), Powers and Wilmer (1951), Barron and Leary (1955). Further, it is reported in studies that utilize therapists of different training and experience (e.g. Uhlenhuth and Duncan, (1968), Carkhuff and Truax (1965), Gotteschalk et al (1971)), and similarly, treatment techniques for which some deterioration can be identified are very diverse and not exclusive to psychotherapy (e.g. Elmore and Sugarman (1975), Shader and DiMascio (1970)).

Regarding group treatment in particular, it is difficult to identify deteriorative effects that relate exclusively to group treatment. For instance, Lieberman et al (1973) indicate that generic names identifying the groups they investigated did not have differential process or outcome correlates. More recently, Hartley et al (1976) specifically examined the empirical evidence on encounter groups with the question of deterioration the principle focus of the study. Summarizing nine studies which had appeared in the previous decade, they reported a large variation in estimated casualty rates across studies from less than 1% to approximately 50%, the median rate being about 6%. The conclusion reached by Hartley et al (1976) is that these varying rates are a function of the casualty criteria employed, varying member characteristics, and perhaps the diverse nature of the treatments studied.

In contrast to deterioration, spontaneous remission is also of interest as it is presumed to confound the success rates that can be attributed to participation in psychotherapy. In attempting to decide which, if any, baselines are appropriate, there has been an inability to

distinguish those studies that include subjects who had minimal treatment but not extensive psychotherapy from those studies that include subjects who were, for the most part, untreated.

Nevertheless, Bergin and Lambert (1978) comment that the two-thirds estimate of Eysenck (1952) and supported by Rachman (1973) is not only unrepresentative but, based on their own analysis, a most unrealistic figure for describing either the spontaneous remission rate or rates for minimal treatment outcomes. Nevertheless, no study has, to date, attempted to describe recovery rates by diagnostic classification whilst, at the same time, holding constant other variables such as past history of disturbance, degree of disturbance, and type of onset.

If the outcome of psychotherapy is measured by change, there is an ever increasing wealth of knowledge that confirms the value of psychotherapy, but differences in outcome between various forms of intervention remain scarce. Behaviour therapies, and their cognitive variations do, in some instances, show superior outcomes, but this is by no means the general case.

Sloane et al (1975) in comparing psychotherapy and behaviour therapy, found that both treatments were, by definition and practice, different. Patients were matched on several variables and randomly assigned to behaviour therapy, to short-term psychoanalytic therapy, or to a waiting list control group. The major outcome measures were pre- to post-test changes on a measure of target symptoms and measures of social and work adjustment. Results at the four month follow-up showed that the behaviour therapy and the psychoanalytically oriented therapy groups had improved significantly more than the waiting list group on the measure of target symptoms change; however, there were no significant between-group differences on the measures of work and social adjustment. In

general, across all measures used in the study, the follow-up results

showed that behaviour therapy was about as effective as psychoanalytically

oriented psychotherapy.

While two groups of therapists did different things in

treatment, they seemed to achieve basically similar results, this being

supported by the finding that the mean improvement scores of patients were

similar for the two types of intervention, but the variance for psycho-

therapy was significantly greater.

Indeed, comparing the two types of treatment, Sloane et al (1975)

conclude:

> "Behaviour therapy, instead of being limited to patients
> with circumscribed patterns such as phobias, may in fact
> be suitable for a wider range of patients than traditional
> psychotherapy. Analytically oriented therapy as practiced
> in this study seemed to work best with a certain type of
> patient. In contrast, a broader range of problems was
> susceptible to the behavioural techniques used. Given the
> right combination of patient and therapist, psychotherapy
> was as effective, more effective than behaviour therapy.
> With the wrong combination, it was less effective".

(Sloane et al (1975), p.213-214).

The results of Sloane et al (1975) may indicate that behavioural

techniques simply work more quickly to accentuate this improvement in

a greater variety of patients. Alternatively, focused behavioural

techniques may be more effective in producing modest yet consistent gains

than the more diffuse techniques of insight therapy. Even so, the fact

remains that changes in both behavioural and internal states are important.

Therefore, employing the distinction between dynamic and symptomatic

criteria, Truax and Carkhuff (1967), reviewing a number of studies of

patient characteristics and patient change, suggested that certain contra-

dictions in outcome research could be resolved by distinguishing between

these two types of criteria. For instance, initial level of inner

disturbance is positively correlated with outcome, while initial level of

behavioural disturbance, is negatively related to outcome. Malan (1976),

developing this concept further, devised what he calls an assessment of

internal or dynamic changes as opposed to symptomatic or behavioural

change. There have, therefore, developed several multiple criterion

measures of outcome as patient improvement need not be integrated or

consistent.

Using multiple criterion measures, Wilson and Thomas (1973)

and Ross and Proctor (1973),found that a specific treatment to reduce

apparently simple fears resulted in a decrease in behavioural avoidance

of the feared object but did not alter the self-reported level of discomfort

associated with the feared object. Further, a physiological measure of

fear indicated no change in response to a feared object as a result of

treatment yet improvement in subjective self-report was significant. Such

results suggest that, since divergent processes are occurring in therapeutic

change, divergent methods of criterion measurement must be used to match

the divergency in individuals and in the change processes that occur

within them.

Complex psychotherapy outcome studies using factor analyses of

multiple change criteria, have yielded similar results (e.g. Cartwright

et al (1963), Nichols and Beck (1960), Gibson et al (1955), Forsyth and

Fairweather (1961)). Rather than some conceptual variable being identified

which cuts across techniques of measurement, the main factors of these

studies tend to be closely associated with the method of measurement

or sources of observation used in gathering the data.

More recently, the study of Berzins et al (1975) was addressed

directly to the issue of consensus among criterion measures. Using several

instruments and sources of observation, analysis of the outcome measures showed generally positive outcomes for the treated group as a whole at termination. However, their primary hypothesis was that problems of intersource consensus could be resolved through the application of alternatives to conventional methods of analysis. Subjecting their data to principle components analysis, four components were derived, namely: changes in patients' experienced distress as reported by patients on a variety of measures; changes in observable maladjustments as noted by patient, therapist, and psychometrist; changes in impulse expression; and finally, changes in self-acceptance. Underscoring the obvious complexity and wealth of knowledge that may be obscured by a limited analysis of data, Mintz et al (1979), support the findings of Berzins et al (1975).

In a discussion of therapeutic outcomes, Strupp and Hadley (1977) emphasized the multiple effects of psychotherapy and the need for a conceptual model in evaluating the diverse changes that result from psychotherapy. They therefore present a tripartite model which suggests that outcome be viewed from the vantage point of society (behaviour), the individual himself (sense of well-being), and the mental health professional (theories of healthy mental functioning), suggesting also that these three views be assessed simultaneously. Such a model indicates that interpersonal and non-specific or non-technical factors are still predominantly seen as stimulants of patient improvement.

In conclusion, outcome studies of psychotherapy have provided much disaccord, not only in terms of the criteria of change but also the multidimensional outcome of psychotherapy for any individual. Nevertheless, it has been generally conceded that interpersonal and non-specific factors are crucial ingredients, even in the more technical therapies. This is not to say, however, that techniques are irrelevant, but that their potency diminishes somewhat when compared with that of personal influence.

The rationale for the present study is based on the research discussed here and was therefore to evaluate the role of interpersonal perception in the outcome for patients in group psychotherapy, given the importance of personal influence in stimulating patient improvement and the fact that the outcome of therapy for any patient must be assessed on several dimensions.

5.2. The Present Study

5.2.1. Patients' assessment of the outcome of group psychotherapy

Subjects and Procedure:

Having followed the progress of patients from before they commenced group psychotherapy, they were assessed when therapy was terminated or if they terminated prematurely. Therefore, of the 15 patients in the study, eight patients were interviewed on terminating during the treatment term and seven patients were interviewed when the treatment term came to an end.

The interview employed at termination was semi-structured with, in total, 68 questions (see Appendix B.3), designed to assess any change in patients' self-appraisal as a result of group psychotherapy and their view, in retrospect, of therapy. Figure 5.1 indicates the areas covered in this interview and it can be seen that they correspond closely with the areas investigated prior to commencing therapy (see Chapter 3, Table IIIb). Each interview was tape-recorded, to be transcribed and analysed at a later date.

The data collected from these interviews was found to be suitable for Guttman scale analysis. From the 10 initial sections of the post-therapy interview for patients shown in Figure 5.1, 25 possible scales were determined and subjected to Guttman scale analysis. As can also be seen in Figure 5.1, 21 of these scales were found to have 90% or greater

consistency. (Appendix C.3 contains detailed Guttman scale analysis of this interview).

Figure 5.1:   Interview sections of patient interview at termination of

group therapy and Guttman scales derived.

The post-therapy interview for patients covered the following areas:

Satisfaction with knowledge of therapy prior to treatment

Fulfilment of initial expectations

Subjective adjustment

Perception of change in self

Future

Locus of control

Responsibility

Independence and dependence

Problem handling

Decision making

Guttman scales derived and their consistencies:

100% consistency: effect of the group on one's life and alternative
                    treatment, fulfilment of initial expectations of self
                    in the group, normality (self and others' perception of
                    self), need to alter lifestyle (self and others'
                    perception of self), difficulties in decision making
                    and preference for another person to decide, independence
                    (self and others' perception of self), group dependency
                    and company preference, locus of control, freedom,
                    fulfilment of the possibility of realistic change,
                    frequency of problems and compared to others.

93% consistency: fulfilment of expected emotional involvement in the group,
                    amount of responsibility (self and others' perception
                    of self), coping abilities and compared to previously,
                    desire to change (self and others' perception of self),
                    friendship pattern, future and planning, type and amount
                    of responsibility compared to others, concept of "illness"
                    in retrospect and at post-therapy (self and others'
                    perception of self), perception of the therapist's role
                    in the group, patient's perception of the expedience of
                    group therapy for others similar to themselves.

87% consistency: attitude to problems, important factors in therapy and
                    attribution at termination of therapy, amount of decisions
                    (self and others' perception of self), satisfaction with
                    the information given about the group before starting.

Results and Discussion:

Rather than discuss all the Guttman scales derived from the post-therapy interview for patients, a sample of scales will be presented. It should also be noted that the following discussion is based on the responses of all the patients who participated in the post-therapy interview, i.e. N = 15.

Satisfaction with the information given about the group before starting:

Whether patients had been satisfied with the information they were given by the therapist about the group prior to commencing, it was apparent that 67% of the sample felt, at post-therapy, that they had not been told enough about their treatment and felt that the doctor should have told them more about what happens in group therapy, before attending their first group meeting. In addition, 60% of the sample (N = 15) had discussed their treatment with others outside of the group - usually their spouse or parents, and reported being reassured by such discussions.

Effect of the group on one's life and alternative treatment:

Of the present sample, 73% felt that attending group therapy had altered their lives, while 29% felt that it had not. Further, asked if they would have preferred another type of treatment, 67% said they would not and 33% felt they would have preferred drug therapy.

Related to this finding was the patients' perception of realistic change.

Fulfilment of the possibility of realistic change:

It appeared that, while 67% of the sample felt they had changed to an appreciable degree as a result of group therapy, 87% reported having gained from the group experience in some way. There were, therefore, three

patients who reported having gained from the group experience but felt they had not changed to an appreciable degree. Only two patients felt entirely negative about their therapy experience, saying they had not changed at all and had gained nothing from the group experience.

Concept of "illness" in retrospect and at post-therapy (self and others' perception of self):

In retrospect, 80% of the sample felt they had been "ill" before commencing group psychotherapy, 73% also feeling that others had also perceived them as such. However, at post-therapy, 40% of the sample felt they were "ill" and that they were perceived as such by others. It is of interest that those patients who perceived themsevles as "ill" at post-therapy did not complete the treatment term and also employed the infectious disease or systemic model to describe their difficulties. In contrast, patients who did not perceive themselves as "ill", tended to complete the treatment term and utilized the traumatic disease model when describing their difficulties.

The finding that there was a decrease in the proportion of patients perceiving themselves as "ill", tends to suggest that patients, irrespective of whether they completed the treatment term or not, made some re-appraisal of themselves as a result of their therapy experience.

Normality (self and others' perception of self):

At post-therapy, 53% of the sample felt they were leading a normal life and 47% felt they were not, although 67% felt others perceived them to be leading a normal life. A similar finding was reported prior to therapy and the present result suggests that at post-therapy, there remained some inconsistency between how the patients perceived their lives and how they thought others perceived their lives. However, this was in marked contrast to whether the patients felt they had altered their lifestyle.

Need to alter lifestyle (self and others' perception of self):

It was found that 80% of the sample felt they had altered their lifestyle in some way as a result of group psychotherapy and felt that others had also wanted them to alter their lifestyle. However, the manner in which patients felt their lifestyle had altered did not necessarily correspond with how they thought others had wanted to see their lifestyle alter. For example, the patient who felt more independent subsequent to therapy was not necessarily appreciated by the other members of his family - especially if it had been convenient for that patient to be an "in-valid" member of the family.

The role of the therapist in the group:

Regarding the therapist's role in the group, at post-therapy, it appeared that 53% of the sample had perceived the therapist to be "doctor" in the group and 47% had perceived him to be in an advisory role. Nevertheless, the amount of control the therapist had in the group meetings was regarded as important by the patients as 87% felt it was necessary, whatever the role of the therapist that he had control over what happened; this result showing no change from pre-therapy.

The present results tend to suggest that in the present sample of patients, there was general dissatisfaction with the information they were given by the therapist about their therapy prior to commencing treatment. Not only did they feel they were not told enough about group psychotherapy in genral but more particularly, they felt they were not told what might possibly happen in the group situation itself. It is perhaps because of this they discussed their therapy with spouses or parents and it is of note that such discussions were felt to be beneficial because of their reassurance although providing no information about group psychotherapy.

However, most of the sample felt their lifestyle had altered

as a result of group psychotherapy; this varying both quantitatively and qualitatively between individual members. Furthermore, most patients reported that, in retrospect, they would not have preferred an alternative treatment. The three patients who felt they would have preferred another form of treatment all felt they should have been given medication. Indeed, not only did they fail to complete the treatment term but also did not subsequently seek the treatment of their choice.

Similarly, the majority of the sample felt they had changed their attitude towards self to an appreciable degree as a result of group therapy, having gained numerous benefits from the experience. In most cases, the patients felt the principle benefit derived was that of, through comparison with others, learning they were not "abnormal", that other people had difficulties similar to their own, and that in resolving their own difficulties, the other group members could learn from their experiences and apply this to their own problem resolution. It is of particular note, however, that in contrast to Truax and Carkhuff (1967), no patient in the present study reported that he was "worse" as a result of his therapy experience.

If the concept of "illness" is equated with the concept of "abnormality", the finding that comparison and favourable identification by the patients were two of the main benefits of therapy reported by the patients is consistent with the result that there was a decrease in the proportion of patients who perceived themselves to be ill at post-therapy, although 40% of the sample still felt they were "ill" after termination. It is of note, however, that there was no apparent change in whether they felt they lead a normal life or indeed, if others perceived them as leading a normal life.

Regarding the therapist's role, the patients perceived their therapist as being in a position of authority within the group, perceiving him

either as an advisor or doctor in the group situation. Therefore, despite the aim of encouraging the group members to take responsibility for the group, the group members still attributed a certain amount of responsibility for the group to the therapist.

In attempting to summarize, most patients, whether they completed the treatment term or not, felt they had altered both in their attitude towards self and in their lifestyle, although patients who completed therapy reported greater change. Furthermore, patients attributed change primarily to themselves, emphasizing the effort they had to put into their therapy but at the same time, highlighting the value of comparison and favourable identification with other group members similar to themselves.

Nevertheless, this is not to say that they minimized the role of the therapist in their treatment. Despite aiming for the contrary, the therapist was perceived to be an authority figure within the group, patients feeling that it had been an important part of therapy to feel that the therapist had control over what was happening in the group meetings. There was also a decrease in patients reported that they perceived themselves to be "ill" at post-therapy, these patients describing their difficulties within the systemic model of disease. However, most patients felt they had altered their lifestyle to an appreciable degree as a result of group psychotherapy although they had mixed feelings about whether they were subsequently leading a normal life or, indeed, whether they were perceived by others to do so. Finally, it must be noted that no patient reported being worse as a result of his therapy experience and there were no reports of "flight into health" by any patient.

5.2.2. Therapists' assessment of the outcome of group psychotherapy.
Subjects and Procedure :

As was the case for patients, the two therapists were interviewed

when the treatment term was completed or if a patient terminated within
the treatment term.

The interview employed was semi-structured with, in total, 16
questions designed to investigate not only his assessment of the group
members, but also his self-appraisal at post-therapy. The areas covered in
this interview are contained in Figure 5.2; each interview being tape-
recorded, to be transcribed and analysed at a later date.

Data collected from these interviews was suitable for Guttman
scale analysis. Seven possible scales were determined and subjected to
Guttman scale analysis, all but one subsequently being found to have greater
than 90% consistency. (Appendix C.7 contains detailed Guttman scale
analysis of this interview).

Figure 5.2: Interview sections of the therapist interview at termination
of group therapy and Guttman scales derived.

The post-therapy interview covered the following areas:

Perception of change in the patient
Satisfaction with the outcome
Perception of his role in the group
Locus of control
Suitability of group therapy for the patient and future prognosis
Fulfilment of the therapist's optimistic and realistic expectations of change
Therapist's perception of patient participation in the group process and
 attribution of change at termination.

Guttman scales derived and their consistencies:

100% consistency:	therapist's perception of his role in the group, therapist's perception of personal change as a result of the group, locus of control, fulfilment of the therapist's optimistic and realistic expectations of change in the patient.
93% consistency:	suitability of therapy for the patient and future prognosis, participation by the patient in the group and attribution of change at termination as perceived by the therapist.
87% consistency:	therapist's perception of change in the patient and satisfaction with the outcome.

Results and Discussion:

Regarding the role therapists had adopted in their group, they had both wanted to adopt the role of "facilitator". One therapist felt he had adopted this role successfully throughout treatment, while the other felt that, towards the end of therapy, he had adopted the role of "leader" in his group. It is interesting that this latter therapist also reported that he had not personally changed in any way nor had he learned anything about himself as a result of the group experience. In contrast, the other therapist felt he had, personally, altered and had learned about himself as a result of the therapy experience. It is suggested that the role a therapist perceives himself as adopting within his group may also influence perception of his own gain from the therapy experience.

Asked if they felt group therapy had been the most suitable treatment for these patients, the therapists felt that for 80% of the sample, group psychotherapy had been the best choice. However, they also felt that 40% of the sample would require psychiatric assistance in the future. Interestingly, it was those patients who at post-therapy, perceived themselves to be "ill" and tended not to complete therapy. Nevertheless, in retrospect, the therapists would not have offered the patients any other alternative form of therapy.

This also appeared to be related to how the patients had been perceived by the therapist in the group situation. Patients who had been perceived by the therapist to act out in the group or verbalize rather than listen were thought to possibly require further professional help at some time in the future; the therapists feeling that they had not, on this occasion, been able to help such patients. Patients who had sought emotional support from the group and who had been perceived by the therapist to listen rather than verbalize when in the meetings, were seen by the therapists to have derived greater benefit from the group experience and were perceived

to be less likely to seek professional help at a later date. It is also
of interest that therapists felt that patients who had derived much from the
therapy had done so because of the therapy experience rather than what the
patient had committed to his treatment, while patients who, in the therapist's
eyes were "failures", were seen to be such because the therapists had
not been able to help them.

Assessment of the type and amount of change in each patient by
the therapist revealed that changes in social relationships, change in
employment, increase in insight and emotional separation from parents were
perceived by the therapists to have occurred for 67% of the sample. Never-
theless, in 33% of the sample, no change was perceived by the therapists,
although no patient was seen to be worse as a result of therapy nor were
there any instances of spontaneous remission. It is however, particularly
striking that in only 20% of the sample, i.e. three patients, were the
therapists satisfied with the outcome of therapy.

5.3. Summary: comparison of patients' and therapists' assessments of
the outcome of group psychotherapy.

It is apparent that group psychotherapy patients assessed the
outcome of their therapy on several criteria which ranged from a reduction in
their symptoms or presenting problems and the ability to cope better with
their difficulties through to modification of their self-attitude achieved
through comparing themselves to other group members, gaining insight into
how they were perceived by others, and gaining insight into themselves.
Patients who terminated during therapy tended to report the former outcomes
while patients who completed therapy reported the latter. Indeed, one
benefit reported by all patients was the realization that they were not
"unique" , "abnormal" or "in-valid" individuals, and that their problems were
not "unique", "abnormal", or "in-valid".

Although patients who terminated during therapy did report some gains from their therapeutic experience, patients who remained in therapy till the end recognized greater change in themselves and of a qualitatively different kind from the terminators. However, the therapists' perception of change in the group patients tended to emphasize quantitative changes as well as qualitative and indeed, what might be described as "concrete" and "abstract" changes; for instance, the difference between coping better with a job ("abstract") or getting another job ("concrete").

It is also of note that the patients recognised at post-therapy that group psychotherapy is no "magic cure" although they recognised the therapist as being important and influential in the group meetings as well as in the process of therapy for them all. That it was no "magic cure" was a view shared with the therapists who were, on the whole, satisfied with their choice of therapy for these particular patients but they were also genrally dissatisfied with the therapy outcomes, feeling not only that more might have been achieved, but also that some patients would return for psychiatric assistance in the future.

It was interesting also that those patients who were perceived by the therapists to have changed as a result of their therapy were perceived to have altered because of their group experience. In contrast, patients who were perceived by the therapist to have shown no change were judged by the therapists to be "failures" because the therapist alone had been unable to help them. No patient was perceived by the therapists to have altered principally because of his own effort and this is in marked contrast to the patients' self-reports.

It is finally noted that, in the present study, neither therapists nor patients reported deterioration as a result of group psycho-therapy or spontaneous remission.

5.4.   Six month follow-up interview of patients

Six months after termination, all patients were interviewed to assess whether they had relapsed, improved subsequently, or had not altered since treatment. (This interview and Guttman scale analysis of this interview are in Appendix B.4 and C.4).

It was found that 54% of the sample reported some recurrence of initial difficulties which had originally brought them to the therapist and, of these patients, 27% had sought professional help from the therapist after termination of therapy. Nevertheless, 67% of the sample felt that their treatment had been successful, 73% feeling that they had coped well in the last six months.

Hence, although there was some recurrence of initial difficulties reported, most patients felt they had coped well since therapy ended or if they chose to terminate, felt therapy had been successful, and had not sought professional assistance. Four patients who had felt they coped badly did, however, seek assistance from the therapist. It is of interest that, of these four "returners", two had been perceived by the therapist to have verbalized extensively in the group while the other two patients had sought extensive emotional support.

It may perhaps be the case that, although few patients sought further help from the therapist, the four patients who did so had used the therapy experience inappropriately, either by distancing themselves from the other group members (i.e. by extensive verbalization) or by becoming overly dependent on the therapy or therapist. Such outcomes would, according to Bergin (1966), be regarded as negative effects of psychotherapy.

CHAPTER 6

Locus of Control

6.1.   Introduction

    6.1.1   Social learning theory and locus of control.

    6.1.2   Expectancy modification through psychotherapy.

6.2   The Present Study

6.3   Results and Discussion

6.1. Introduction

    6.1.1.   Social learning theory and locus of control:

            The Internal-External Locus of Control Scale (I-E Control Scale) is based on Rotter's (1954) social learning theory and postulates two characteristic world views or generalized expectancies concerning reinforcement upon the individual's own behaviour. External control refers to individuals who believe that reinforcements are not under their personal control but rather under the control of powerful others, chance, luck, fate, etc., while internal control refers to individuals who believe that reinforcements are contingent upon their own behaviour, capacities, or attributes. Thus, depending on his past reinforcement experiences, a person will have developed a consistent attitude tending towards either an Internal or External Locus as the source of reinforcement.

            Reliability measures reported from the I-E Control Scale have been consistent. The test-retest reliability measures reported by Rotter (1966) for varying samples and for intervening time periods varying from one to two months, ranged between 0.49 and 0.83. Likewise, Hershe and Scheibe (1967) found test-retest reliability coefficients that ranged between 0.48 and 0.84 for a two month period. Harrow and Ferrante (1969) found for a sample of 86 psychiatric subjects, over a six week period, a test-retest reliability of 0.75 which compares favourably with data obtained from normal samples.

            In addition, researchers have remarked on inherent limitations in the I-E Control Scale. Coan (1968, 1974) has argued that the I-E Control Scale favours items dealing with social and political events as opposed to items regarding personal habits, traits, goals, or other interpersonal and intrapersonal concerns. Coan suggested that the items on the I-E Control Scale may not tap all major aspects of personal control. A

similar conclusion is reached by several others (e.g. Clark (1976) Collins et al (1973), Levenson (1973), Davidson and Bailey (1978)).

Another study which attempted to clarify the factor structure of the I-E Control Scale was performed by Mirels (1970). When administered to 316 college students, he found that the varimax rotation identified two factors. Factor I concerned the amount of control one believes he personally possesses, while Factor II concerned the extent to which one believes a citizen can exert control over political and World affairs. As such, Mirels (1970) suggested that the I-E Control Scale be modified to distinguish those aspects of a person's world view which indicate a personality trait and those which reflect societal norms.

Nevertheless, Rotter (1966) has demonstrated both the consistency of individual differences in this dimension and its relationship to other personality constructs, such as competence (White (1959)); Adler's concept of striving for superiority (Ansbacher and Ansbacher (1956)); autonomy (Angyal (1941)); need for achievement (Crandall (1963)); and field dependence (Witkins et al (1954)).

Based on the assumption that expectancy is both a function of probability, based on past history of reinforcement, and a generalization of expectancies from related behaviour-reinforcement patterns, research has centred on the socialization process as the primary factor in the shaping of an individual's expectancy. There is considerable empirical support for this assumption in that individuals from varying social environments, and presumably having different social learning experiences, show differences in this social dimension. For example, Locus of Control differences have been reported for individuals varying in ethnic background (e.g. Battle and Rotter (1963), Lefcourt and Ladwig (1965)); socioeconomic status

(e.g. Battle and Rotter (1963)); birth order (e.g. MacDonald (1971));

and sex (e.g. Brannigan and Tolor (1971a,b)).

Still other investigators (Brannigan and Tolor (1971a,b)

Chance (1972), Davis and Phares (1969), Cromwell (1963), Katkovsky et al

(1967), Tolor and Jalowiec (1968))have concentrated on the key figures in

the individual's life, principally the parents, in trying to determine the

etiology for the development of an Internal versus an External expectancy.

On the whole, these studies reported positive parent-child relationships,

characterised by warmth and supportiveness, to be related to Externality.

6.1.2. Expectancy modificatton through psychotherapy:

Singer (1970) has pointed out that a belief in External control

is one of the prime expressions of psychopathology. He states:

> "Man is all too prone to search for external guidelines and
> conditioners because freedom of choice and action, and the
> awareness of such freedom and the responsibility associated
> with this awareness, are frequently unbearable. But this
> very search for external motivations and this very abandoning
> of freedom are the essential expressions of psychopathology
> itself. Escape from freedom, as Fromm and others has shown
> so well, is giving up one's humanness, represents self-oblivion,
> leads to willing submission to totalitarian domination, and
> is therefore pathological..."

(Singer (1970),Preface,pxviii-xix).

Recent research has focused on the effects of psychotherapy on

the indivudual's expectancy for Internal or External control of reinforcement.

Smith (1970), for example, compared the initial locus of control scores of

individuals facing a "crisis" situation (e.g. death of a significant other,

breakup of an important interpersonal relationship, a threat to physical or

family integrity and other emotional hazards), and with those taken after

six weeks of intervention therapy. The basic results indicated that crisis

patients were initially more External than non-crisis, psychologically

disturbed patients undergoing therapy (who were more External than the

norms for normals), and also after six weeks of therapy, crisis patients showed a highly significant change in the direction of Internality whereas noncrisis patients showed only a small change but also in the Internal direction. The findings supported Smith's (1970) hypothesis that the individual in a crisis situation, being overwhelmed by influences which he feels powerless to control, develops a very External attitude, but as the crisis is gradually resolved, he should come to perceive greater personal control over his life situation.

In regard to psychological disturbance or pathology, three attempts have been made to evaluate the effects of therapy on expectancy. The first, a study by Harrow and Ferrante (1969), compared pre- and post-therapy locus of control scores for several diagnostically different groups of acute psychiatric inpatients - schizophrenics, manics, depressives, and character disorders. All patients were given the I-E Control Scale during their first and seventh weeks of hospitalization. It was expected that after seven weeks of therapy patients would have changed in the direction of increased Internality. This formulation was based on the prediction that as sympotamtic improvement progressed, patients would become capable of greater mastery and perceive greater personal control.

In analysing the change scores, they found that the group, as a whole, became more Internal, but not significantly so. However, they noted that the schizophrenics may have represented a confounding factor, since they became slightly more External over the short therapy interval. When non-schizophrenics were compared against schizophrenics, they found a significant Internal change for non-schizophrenics.

In interpreting their findings, Harrow and Ferrante (1969) suggested that the absence of a change towards Internality, in the schizophrenics, was not surprising when taken in conjunction with their

clinical status at the end of the seventh week. In terms of degree of

pathology, these individuals would still be termed as very "sick", with

six weeks being too short a time for a significant change to occur.

Levenson (1973) also reported a lack of change in locus of control in a

psychiatric population with a comparable period of hospitalization.

In general, however, Harrow and Ferrante (1969) found that

the non-schizophrenic patients, other than the manic patients, tended to

become more Internal as they improved over the six week period. These

results supported the hypothesized relationship between increased personal

control and symptomatic improvement. An interesting note concerns the

manic patients becoming more External over the therapy interval. Those

patients were initially extremely Internally oriented (being far more

Internal than the norms for normals) but, during hospitalization, as they

recovered from their original grandiose feelings and became more aware

of "reality", an appropriate shift was observed in the External direction.

A third study by Gillis and Jessor (1970), offered additional

support for the above findings. They compared pre- and post-Internal-

External scores for psychiatric patients, but added a control group

consisting of patients who received the I-E Control Scale upon admission

to the hospital and again after a ten week nontherapy interval. The basic

findings were that the nontherapy patients showed no significant change

in locus of control and, in fact, became slightly more External over the

ten week interval, while the therapy group, as a whole, showed a slight,

nonsignificant change in the Internal direction. However, when a more

precise clinical analysis was performed on the therapy group, eliminating

those patients showing no improvement, the "improved" therapy group

showed a significant change in the direction of greater Internal control.

Taken together, these three studies offer support for the

predicted modification of expectancy through therapy, although they offer

very little direct evidence as to which therapeutic factors accomplish this

change in expectancy.

Rotter (1954) suggested that changing expectancy is a prime

function of psychotherapy:

> "with the emphasis being on a quite active role of
> interpretation on the part of the therapist.
> Interpretation serves the purpose of changing
> expectancies for specific behaviours or groups of
> behaviours and of changing the values of
> reinforcements or beeds by changing the
> expectancies for subsequent reinforcements.
> Such interpretations should be made in common-
> sense terms and based on maximum use of the
> patient's own experience."

> (Rotter (1954), p.397)

Therefore, from the social learning point of view, the purpose of therapy

is not to solve all the patient's problems, but rather to increase his

ability to solve his own problems. While no attempt has been made to

assess this social learning viewpoint directly, Dua (1970) compared the

relative effectiveness of action-oriented and re-educative therapy on

changing expectancy in female college students who expressed concern

over difficulties developing satisfying interpersonal relationships. The

emphasis of the action programme was on directing the client to define the

problem behaviourally, and to develop a sequence of actions to expand her

behavioural repertoire in order to improve her relationship with a

"significant other". On the other hand, the re-educative programme was

designed to influence attitudes that the client had towards the

individual with whom she desired to improve her relationship. The

treatment was primarily concerned with the cognitive processes and verbal

interaction involved in interpersonal relations and both treatment

programmes were conducted for an eight week period, with two sessions

per week. A comparison of pre- and post-therapy measures of expectancy

indicated that while both treatment groups became more Internal, the

change for the clients in the action oriented programmes was significantly greater than those of the re-education group.

Similarly, Parks et al (1975) conducted a study investigating the effectiveness of a short-term therapeutic technique focusing on "eliminating self-defeating behaviours" in changing expectancy in college students. The treatment consisted of a seven step process designed to provide the client with mastery over self-defeating behaviour Eight one hour sessions were conducted over a four week period. A comparison of pre- and post-therapy measures of expectancy revealed that the therapy group became significantly more Internal than a matched control group. Furthermore, this increased Internality remained stable at a four month follow-up.

In sum, the implication that may be drawn from the studies reviewed here, is that Externality is related to poor psychological adjustment and psychotherapy can be effectively utilized to modify expectancy. With the exception of the manic population, individuals improving with treatment tend to perceive themselves as having greater control over their lives. Nevertheless, further research is needed to determine, more precisely, which therapeutic factors and styles are most effective in changing expectancy.

6.2. <u>The Present Study</u>

It was decided to ask the patients to complete the I-E Control Scale for three main reasons:

1. The patients in the present sample were outpatients which is in contrast to the hospitalized samples of Harrow and Ferrante (1969), Levenson (1973), and Gillis and Jessor (1970).

2. The present sample were diagnosed as being anxiety neurotics compared

    to the patients studied by Harrow and Ferrante (1969) and Levenson (1973).

3. The therapy interval in the present study was 18 months compared to the

    previous time periods of up to eight weeks.

Hypotheses:

The following hypotheses were formulated:

1. As symptomatic improvement is achieved over the treatment term, the

    patient will perceive himself to have greater personal control and

    mastery over his environment.

2. Patients who successfully complete treatment will perceive themselves

    as having greater personal control and mastery over their environment

    than patients who terminate therapy prematurely.

Subjects:

All patients were asked to complete the I-E Control Scale

prior to commencing group therapy and also after terminating therapy.

Therefore, 21 patients completed the test before treatment and 15 patients

completed it after terminating.

Materials:

Rotter's I-E Control Scale is a 29-item forced-choice test

including six filler items intended to make somewhat more ambiguous the

purpose of the test, as shown in Appendix D . It can also be seen that the

test is presented to the subject as being the Social Reaction Inventory.

The items are not arranged in a difficulty hierarchy but

rather are samples of attitudes in a wide variety of different situations.

The test is an additive one and items are not comparable; the score for

the subject being the number of External choices he makes.

6.3   Results and Discussion.

Several comparisons were completed on patients' scores on the I-E Control Scale as indicated in Table VI, which shows the means and standard deviations for each comparison.   It can also be seen that all the comparisons showed a movement in the direction of Internality from pre- to post-therapy testing.   This reached a significant level for patients who successfully completed therapy and for the patients as a whole, although it did not reach a significant level for those patients who terminated therapy prematurely, as can be seen from application of the one-tailed t-test to these findings.

Therefore, with reference to the hypotheses stated previously, Hypothesis 1, which stated that as symptomatic improvement is achieved over the treatment term, the patient will perceive himself to have greater personal control and mastery over his environment, was supported by the overall result.   As a group, patients' scores on the I-E Control Scale reflected significantly greater personal control at post-therapy when compared to their responses prior to therapy.

Table VI: Application of the one-tailed t-test to pre- and post-therapy scores for group psychotherapy patients on Rotter's Internal-External Control Scale.

	mean	sd	N	t	significance
Pre-therapy	11.48	4.58			
Post-therapy	9.33	4.89	15	3.207	.005*
Terminators (pre-therapy)	12.62	5.24			
Terminators (post-therapy)	10.75	3.81	7	1.580	NS
Non-terminators (pre-therapy)	10.77	4.19			
Non-terminators (post-therapy)	7.71	5.77	8	3.334	.01

*application of the one-tailed t-test

Hypothesis 2: that patients who successfully complete treatment will perceive themselves as having greater personal control and mastery over their environment than patients who terminate therapy prematurely, was supported by the results. While patients who successfully completed treatment significantly modified their responses on the I-E Control Scale towards Internality, patients who terminated prematurely, although their responses did indicate some movement towards Internality, this did not reach a statistically significant level. However, these findings are tempered by the fact that, comparing terminators versus non-terminators at pre- and post-therapy, there were no significant differences (t = 0.669, N = 15, NS; t = 0.326, N = 15, NS). It is suggested, therefore, that while both terminators and non-terminators became more Internal in their responses to the I-E Control Scale, patients who successfully completed treatment showed significantly greater change than those patients who terminated prematurely.

In addition, considering the small sample, it is interesting that the test-retest coefficient of reliability in the present study was 0.85 which is higher than 0.75 reported by Harrow and Ferrante (1969) for their psychiatric sample over a six week period, and compares favourably with the reports of Rotter (1966) and Hershe and Scheibe (1967) of 0.83 and 0.84 respectively, for a normal sample over a two month time interval.

Taken together, the present results suggest, in agreement with previous research, that Externality may be related to poor psychological adjustment. The fact that the present results indicated a movement in the direction of Internality from pre- to post-therapy also suggests that the present sample, as a whole, effectively modified their expectancy as a result of therapy. However, those who modified their expectancy to a significant level were patients who successfully completed group psychotherapy.

CHAPTER 7

Treatment Expectancies Questionnaire

7.1   Introduction

7.2   The Present Study

7.3.   Results and Discussion

7.1.   Introduction

Examination of the empirical research on non-specific factors in treatment emphasize the influence of expectancies on treatment outcomes — not only in psychotherapy but also in behaviour therapy and drug therapy (including placebo research), and suggests that the most effective treatment for a patient is likely to be that which is consistent with his expectations and more general beliefs and assumptions about his environment (e.g. Bannister and Fransella (1971), Hinkle (1965), Wright (1970). Indeed, Wright (1970) suggests that a symptom may be regarded as part of a person's experience of himself which he has singled out and circumscribed as in some way inconsistent with the rest of his experience of himself. More specifically, Applebaum (1973), Abramowitz and Abramowitz (1974), and Caine and Wijesinghe (1976) suggest a positive correlation between "psychological-mindedness" and response to group psychotherapy.

Caine et al (1981), working within such a framework and recognising the inadequacies of the "medical model" for the understanding and psychological treatment of neuroses, have developed several measures of adjustment strategies such as "convergent-divergent thinking" (Hudson (1968), "conservatism" (C scale), "control", "openness to inner experience", and "direction of interest" (DIQ); the "personal style of an individual being defined by these strategies, and by the patient's expectations from treatment, measured by the Treatment Expectancies Questionnaire (TEQ).

Summarizing their results over several years, Caine et al (1981) suggest that patients with an "inner" orientation on such measures are more likely to respond to group psychotherapy and those with an "outer" orientation are more likely to respond to a more structured approach such as behaviour therapy.

Having found that patients are unable to verbalize very precisely how they feel about treatment and have an inadequate conception of either group or behaviour therapy (Caine (1965), Caine and Wijesinghe (1976), Caine et al (1973)), and that both patients and staff differ among themselves about the nature of "psychiatric illness" and about how the treatment should be approached (Caine (1970),(1975), Caine and Smail (1969)). a number of questions were found which might reflect a preference for an organic or psychological approach to treatment. On submitting this list of statements to both group and behaviour therapists to sort into favourable or unfavourable attitudes as far as their own treatment was concerned, 28 statements were found where there was complete agreement among the therapists, and were subsequently employed in constructing the TEQ.

Subsequently, Caine and Wijesinghe (1976) found that patients who remain in therapy for at least nine months show a more psychological treatment set at pre-therapy than the dropouts. However, in this study, they questioned the validity of regarding patients who dropped out as treatment failures, although Elkan et al (personal communication in Caine et al (1981)) successfully replicated these findings.

Relating the TEQ to other measures of adjustment, Caine and Wijesinghe (1976) report that patients who are rated as responding to treatment have a more psychological treatment set and a more inward direction of interest, yet there was no significant difference, in this study, between the groups on the C scale. Also, on a two year follow-up after discharge, of those patients who responded to the questionnaire, there was a significant difference between successful and unsuccessful patients on the C scale as well as the TEQ and DIQ. Responses to the Symptom Sign Inventory Personal Disturbance Scale also indicated that the successful patients had higher scores which were interpreted as a greater willingness to admit to symptoms.

Wijesinghe (1978) further examined treatment response as evaluated by patients and therapists for patients in psychotherapy and behaviour therapy, concluding that there were no significant interactions between response to a particular form of treatment and pre-treatment scores on the DIQ and C scale. However, Caine et al (1981) suggest that this may have been due to a failure to control for the fact of inclusion in both samples of patients, patients who had been treated individually together with those who had been treated in groups. Nevertheless, in a study of response to ECT by endogenous depressives, Anyaegbuna (1979) reported in Caine et al (1981))found that patients rated as successfully treated by psychiatrists showed more medical-physical expectancies on the TEQ than those not so judged.

Further examination of the differences in pre-treatment scores between "improvers" and "non-improvers" in samples of patients in group psychotherapy or behaviour therapy, has led Caine et al (1981) to suggest that the patient who improves in group psychotherapy shows a more psychological treatment set on the TEQ and more radical social attitudes on the C scale than the "non-improver". On his repertory grid, the self element loads highly on the first component, indicating a heightened self-awareness, and there is a low level of self-esteem, presumed to suggest greater motivation to change. In addition, his symptom constructs carry fewer implications in terms of other constructs than do those of the "non-improver".

Regarding behaviour therapy patients, Caine et al (1981) suggest only two significant differences between the "improvers" and "non-improvers": first,the patient who improves has conservative social attitudes and second, his symptoms have more implications in terms of other constructs than do those of the "non-improver".

Comparing the "improvers" in these two forms of intervention

indicated that group psychotherapy "improvers" are more inner directed,
have more "psychological" treatment expectencies, and more radical social
attitudes than behaviour therapy "improvers". Further, they admit to a
greater urge to act out hostility and more psychotic symptoms, as well as
being of higher verbal activity, Caine et al (1981) suggesting that they
may be more open to the experience of psychological distress. In addition,
the symptom constructs are of less importance to the group psychotherapy
"improvers", in terms of their relationships to other constructs, than to
the behaviour therapy "improvers".

7.2 The Present Study

Given these considerations, it was decided to use the TEQ in
the present study to investigate its predictive validity in the selction
of patients for group psychotherapy and also to distinguish between patients
who might terminate treatment prematurely or complete treatment successfully.
The following hypothesis was therefore proposed:

The patient who successfully completes group psychotherapy
shows a more psychological treatment set on the TEQ than the patient who
terminates prematurely, as measured prior to treatment.

Subjects:

All patients were asked to complete the TEQ prior to commencing
group therapy and also after terminating therapy. Twenty-one patients
completed the questionnaire before treatment and fifteen patients completed
it after termination.

Materials:

The Treatment Expectancies Questionnaire is a 28-item, multiple-
choice test, as shown in Appendix E . The items are not arranged in a
difficulty hierarchy but rather are samples of attitude favourable to a
behaviour therapy approach and those favourable to a group therapy approach.

In scoring the TEQ, the following system prevails: T = 4, PT = 3, PF = 2, F = 1 - the higher the score, the greater the tendency for the subject to prefer treatment of a structured approach. In addition, the test is additive and items are not comparable; the total score for a subject being the number of behaviour therapy oriented choices he makes.

7.3. Results and Discussion

Several comparisons were completed on patients' scores on the TEQ at pre- and post-therapy, as indicated in Table VII which shows the means and standard deviations for each comparison. It can be seen that all the comparisons showed a movement in the direction of a more behavioural treatment approach from pre- to post-therapy. Table VII further indicates that, while there was no significant difference between pre- and post-therapy responses of terminators, there was a significant difference in the responses of non-terminators between pre- and post-therapy, and for the patients as a whole.

Table VII: Application of one-tailed t-test to pre- and post-therapy TEQ scores for group psychotherapy patients.

	mean	sd	N	t	significance
Pre-therapy	31.33	8.24			
Post-therapy	34.53	8.53	15	2.767	.01*
Terminators(pre-therapy)	32.25	5.65			
Terminators(post-therapy)	33.62	5.99	7	0.079	NS
Non-terminators(pre-therapy)	30.77	8.65			
Non-terminators(post-therapy)	35.57	11.19	8	2.937	.025

*application of the one-tailed t-test.

In relation to the hypothesis stated previously, namely that the patient who successfully completes group psychotherapy shows a more psychological treatment set on the TEQ than the patient who terminates prematurely, as measured prior to treatment, the present results did not support

this. There was no significant difference in the responses of terminators versus non-terminators at pre-therapy (t = 0.196, N = 15, NS) or at post-therapy (t = 0.428, N = 15, NS). The present findings do indicate that there was a significant movement in the direction of a more behavioural treatment orientation as a result of group psychotherapy for the patients as a whole. Differentiating between terminators and non-terminators, it was found that, while there was no significant difference in the responses of terminators, patients who successfully completed therapy showed a significant movement towards a more behavioural treatment set.

Therefore, regarding the use of the TEQ in the selection of patients suitable for group psychotherapy, and further, to distinguish between potential terminators and non-terminators, the present results indicate that, for the present sample, the questionnaire was unable, on the pre-therapy scores alone, to differentiate between those patients liable to complete therapy successfully or not. Unfortunately, the sample studied was small and no other study has, to date, employed the TEQ as a repeated measure, with which to compare the present results. To date, responses to the TEQ have been analysed in the light of whether a patient subsequently had a successful therapy outcome or not and no attempt has been made to investigate a patient's response to the TEQ at termination of therapy.

However, the present results indicate that, at the end of group therapy, patients' responses to the TEQ were more favourable to a behavioural treatment orientation than they were prior to commencing therapy. Two tentative explanations for this result are advanced: first, the movement towards a behavioural treatment orientation is peculiar to the present sample or second, patients' understanding of the etiology of their difficulties (one of the aims of therapy) does not, ipso facto, enable them to cope any better with these problems and they subsequently assess the

efficacy of their therapy in the light of this.

Bearing in mind the small sample employed and the use of only one instrument in the "battery" employed by Caine et al (1981), the present results are particularly interesting when one considers that the test-re-test coefficient of reliability was 0.93 in the present study. However, to say more at this juncture would only be speculation and further research is obviously required to validate the present findings.

CHAPTER 8

The Semantic Differential in Psychotherapy.

8.1.   Introduction:

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            over time for group psychotherapists.

    8.3.5. Summary

8.4.   Conclusion

8.1.   Introduction

    8.1.1.   The semantic differential technique.

        The semantic differential is not a particular test but rather a highly generalizable operation of measurement which can be adapted to specific research problems. Osgood (1952) postulated a geometrical model in the form of a semantic space defined by logical opposites; factor analysis being used to identify the independent dimensions of this space, representing the ways people make affective meaning judgments. Three factors: Evaluative, Potency and Activity, were found to account for 50% of the total variance in how individuals make meaningful judgments, of which the evaluation dimension accounts for two-thirds. The generality of this factor structure was further tested by varying subject populations, concepts judged, type of judgmental situation, and the factoring method used in analysing data (Osgood et al (1957)).

        The measuring operation or semantic differential can be described as follows: adjectives are identified as representative of these three major dimensions along which affective meaningful processes vary; these have a high coverage of meaning on one factor and negligible amount on the others. These opposites are used to define the ends of seven-point scales. In practice, an individual judges a particular concept against a set of these scales. Judgments result in the successive allocation of a concept to a point in multidimensional space. In this manner, change in the meaning of a concept over time, the subtle differences between two or more concepts, and individual differences in the meaning of a single concept may be quantitatively represented.

        Osgood and other investigators have had a continuing interest in the attempt to identify what they have referred to as the basic dimensions of meaning in language behaviour. In the attempt to purify the factor structure and to isolate more sensitive scales to represent each factor, investigations have been completed in which adjectives, concepts, subject populations, and

methods of factor analysis have been varied.

For instance, Kubiniec and Farr (1971), taking the basic
assumption of the semantic differential technique that subjects rate each
of a number of concepts on each of several bipolar adjective scales, question
that subjects' responses on these scales represent the connotative meaning to
them of the respective concepts, in common with previous researchers (e.g.
Gullikson (1958), Ware (1959), Osgood et al (1957)).

There is extensive evidence to suggest that the loading of
given scales on given meaning dimensions is a function of the particular class
of concepts used. That is, a scale which loads on the evaluative dimension
for a given concept may not load on the evaluative dimension when used to
rate a different concept. However, when a specific class of concepts is
employed, and the purpose of the instrument is to measure individual differ-
ences in scale responses to particular concepts, summing over concepts or
analysing each concept separately may obscure important information. Such a
conclusion is drawn by Kubiniec and Farr (1971), Manis (1959), Anderson (1965),
and Russell (1979).

Heise (1969) reviewed the methodological research on the
semantic differential concerning metric, sources of rating variation, and the
structure of ratings. His major conclusions were that the metric assumption
involved in semantic differential scales are, in some ways, inaccurate but
adequate for many applications, but biased errors may arise in semantic
differential data because of scale-checking styles, that a substantial portion
of variation in semantic differential ratings is due to individual differences
and temporal variations in responses, and that the basic dimensions of average
response on semantic differential scales are evaluation, potency, and activity,
and no extensive proliferation of basic dimensions beyond these can be expected.

In addition, there are individual differences in the size and character '
of semantic space, the appearance of scale-concept interactions frequently are
a methodological artifact which would not occur in adequately designed studies,
and the existence of real scale-concept interactions demands tailoring the
semantic differential to different stimulus domains.

Based on the review of Heise (1969), Miron (1969, 1972)
questioned what it is that is being differentiated by the semantic differential,
given the distinction between denotative and connotative meaning which extends
the semantic differential structure to the area of personal judgments. Miron
(1969, 1972) argues that there is no distinction when based either upon
commonality of responding or lexical analysis of terms typically assigned to
the semantic differential dimensions, and suggests a semantic feature approach
invoking the notion of privilege of occurrence as an explanation of the
semantic differential adjective structure so reliably obtained in diverse
areas of application.

The findings of such studies suggest that, if the researcher
uses specific Osgood scales, these scales represent the factors of Evaluation,
Potency and Activity. They do not, however, indicate which of Osgood's sets
of scales and which factor-analytic results served as the basis for the
particular scale chosen. In addition, few studies report both that Osgood's
semantic differential was used and that specified scales had been chosen for
the investigation being reported.

Typically, the semantic differential has been used as a measure
of self-concept, but, in constructing a self-concept measure, one must
formulate as precisely as possible a "literary" definition of the construct
one is trying to measure, and then to choose items which appear, a priori,to
have possible construct validity for measuring the defined concept. The items,
that is, the bipolar adjective scales, should appear to represent important,

salient features of the concept; and their structure should be made as

clear as possible so as to minimize inter-subject variability in interpretation

of the items. However, Osgood scales fall short on both these points,

principally because the goal of Osgood et al (1957) was not primarily self-

concept measurement and, related to this, the scales were not chosen to be

primarily relevant to the self-concept.

The goal of Osgood's research was to see whether individuals'

"connotative" meanings for or attitude towards a very wide variety of concepts

might be construed as involving a limited number of dimensions. Consistent

with this, he argued that for an ideal semantic measuring instrument, one needs

to select a small set of scales with the following properties: high loading

on the factor they represent; high correlation with the other scales representing

the same factor; low correlation with scales representing other factors, and

hence low loading on other factors, and finally, a high degree of stability

across the various concepts judged.

In general, the use of bipolar adjective sets appears to be

commendable in that the explicit contrast presented within each scale can help

communicate to the subject the meaning of each adjective more clearly than is

the case in an adjective checklist or a unipolar adjective scale. In addition,

the use of multistep scales can decrease uninterpretable "remainder variance"

and increase dependable, potentially valid, inter-subject differences.

8.1.2. The use of semantic differentials in psychotherapy.

Researchers working with the semantic differential have been

increasingly interested in the personality and psychotherapy area. Although there

are numerous "personality tests" available, there does not seem to be any

standardized way of simply describing, and hence accurately communicating, the

individual personality. "Personality" can be regarded, for present purposes, as

essentially a meaningful construct developed out of interpersonal interactions,

and therefore, the general techniques of semantic measurement should be applicable. Also, it is usually the connotative meaning rather than the denotative meaning of the individual in which there is interest.

The earliest study of changes in meaning experienced by patients in psychotherapy was conducted by Mowrer (1953). His subjects, two patients suffering from agoraphobia, judged eight concepts (ME, MOTHER, FATHER, BABY, LADY, GOD, SIN and FRAUD) at the beginning, middle and termination of psycho-therapy. He interpreted his results as substantiating his theoretical position that the neurotic is typically an individual who represses his own self-critical faculty, that is, his conscience.

A second early application of the differential to investigate semantic changes in psychotherapy was that of Moss (1953). He obtained ratings of concepts from two patients at several points during the course of therapy. An innovation which Moss (1953) introduced was to obtain differential ratings under the hypnotic state which, as a presumed index of "unconscious" meanings, could be compared with ratings made in the waking state, as an index of "conscious" meanings. The data obtained indicated a wide discrepancy between waking and hypnotic ratings at the beginning of therapy and a significant reduction as treatment progressed. These results were interpreted to mean that areas of neurotic conflict within the personality are characterized by dissociation such that different levels of meaning, conscious and unconscious, coexist, and that as conflict is resolved, there is integration of these originally discrepant levels.

An approach to the problem of an accurate characterization of patient personality was next undertaken in the semantic analysis of "The Three Faces of Eve", originally reported by Thigpen and Cleckley (1954). On the basis of the differentials given to the three aspects of this personality, Osgood and Luria (1954) questioned whether the emergent personality, Jane was

a successful resolution of therapy. This doubt was later verified when it was found that Jane was simply Eve Black playing the role of a person acceptable to the therapist. The original clue was that the semantic structure derived from Jane's ratings was collapsed or oversimplified; that is, there was a reduction in discrimination so that it became almost entirely evaluative in nature. Such results would tend to suggest that when individuals role-play, there is a detectable simplification of the semantic structure.

Luria (1959) checked a number of hypotheses concerning the nature of meaning changes of patients in psychotherapy. She found, for example, that prospective therapy patients can be discriminated from normals on the basis of their relative devaluation of SELF and PARENTS concepts. Somewhat surprisingly, therapy resulted in an increase in positive attitude towards SELF but not towards the parents. However, this study highlighted the basic question of the intelligent selection of concepts more relevant or sensitive to changes expected within psychotherapy.

More recently, Bond and Lader (1976) found that psychiatric patients have a less favourable self-concept than normal controls, seeing themselves as worse than the man-in-the street and evaluating this unknown individual, their doctor and medicine as being more relaxed than the controls rated them. However, as these measurements were only made prior to therapy, it is not known what happened to these perceptions as a result of treatment.

Likewise, Dymond (1954) found that patients entering therapy produced less well-adjusted self-descriptions as measured against a standard set up by expert clinicians than patients who did not wish therapy. But measurements at post-therapy indicated that there was a significant improvement in the experimental group which did not occur in the control group. The fact that these therapy gains in adjustment were maintained over the follow-up period and the concurrence of these post-therapy scores with the therapists'

ratings of success of therapy lead Dymond (1954) to conclude that those who

appeared to be most successful in therapy also described themselves in ways

which agreed best with an eclectic criterion of adjustment. A similar

conclusion is reached by Brod et al (1964), Harder et al (1979), Butler

and Haigh (1954),and Snyder (1976).

In an investigation of the effects of marathon psychotherapy,

Dies and Hess (1970b) offer tentative verification that marathon psychotherapy

may produce a greater degree of intimacy and interpersonal openness than

more conventional group therapy. Results from the semantic differentials

used in this study indicated that marathon participants manifested a

comparatively greater propensity to express positive attitudes towards their

group experience on the potency and activity dimensions of the adjective

pairs and support an earlier finding of Dies and Hess (1970a).

The notion that individuals with stable self-concepts are

better adjusted than those with unstable self-concepts has been supported

by several investigators (e.g. Bogard (1976), Dingman et al (1969), Sappington

(1973) Brownfain (1952), and Endler (1961)). For instance, Brownfain (1952)

found that individuals with more stable self-concepts have a higher level

of self-esteem as manifested by a higher mean self-rating and also a

higher self-rating of their self-acceptance. In addition, they see themselves

more as they believe other people see them, they are better liked and

considered more popular in a group, and they show less evidence of compen-

satory behaviour of a defensive nature.

Endler (1961) found that the evaluative meaning of the self-

concept (ME) was significantly modified during psychotherapy in the direction

of greater self-valuation; such a finding corroberating the contention of

Rogers (1951) and Snygg and Combs (1949) that the phenomenal self is the key

personality concept, and psychological adjustment is greatly determined by

its significance or meaning. The greatest changes occurred on the Evaluative

factor of the concept, primarily because it accounts for most of the variance

of the meaning construct and is especially important in the context of

personality adjustment. However, it was possible to predict improvement

from a knowledge of changes of the three meaning factors of the self-

concept, and supports Snygg and Combs' (1949) notion that one of the criteria

of effective therapy is a change in the patient's meaning system, or a

perceptual reorganization of the phenomenal field. Endler (1961) concluded

that changes in the meaning of the self-concept is a promising criterion of

improvement during therapy, the Evaluative factor of meaning being the most

sensitive to change, and appearing to be an important determinant of psycho-

logical adjustment.

The general assumption being followed in these studies is that

"mental illness" is essentially a disordering of meanings or ways of perceiving

from those characteristics of people judged "normal" in society, and that the

process of psychotherapy, from the patient's point of view, is essentially

a reordering and changing of these meanings.

8.2.   The Present Study

8.2.1.   Subjects and Procedure:

All patients were asked to complete various semantic differentials

prior to commencing group psychotherapy, at several points during therapy, and at

termination. Therefore, 21 patients judged the concepts indicated in Table

VIIIa at various points in time. It can also be seen that each concept used

employed the same 18 bipolar scales, giving approximately equal weight to the

first three factors isolated by the factor analytic work of Osgood et al (1957).

These adjective scales and their factor loadings are also displayed in Table

VIIIa. The concepts used in this form of the differential were selected after

consultation of previous research on the use of semantic differentials in psycho-

therapy and pretesting for their differentiating power. Ideally, they should

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Table VIIIa: Concepts and scales used in this study with group therapy
                patients.

Concepts

How I perceive myself   The group

My ideal self   How I think the group perceives me

My parents   The therapist

        How I think I was before I joined the group

Scales and their factor loadings

(in brackets are the loadings reported by Osgood et al (1957)

	Evaluative	Potency	Activity
optimistic - pessimistic	.39 (.37)	-.05(-.05)	.09 (.07)
sociable - unsociable	.39 (.42)	-.19(1.19)	.28 (.18)
successful - unsuccessful	.49 (.51)	.18(.08)	.32 (.29)
elated - depressed	.42 (.45)	.07(.07)	.19 (.17)
important - unimportant	.36 (.38)	.14(.04)	.31 (.31)
healthy - sick	.35 (.33)	-.02(-.03)	.03 (.04)
strong - weak	.26 (.30)	.50(.40)	.12 (.10)
severe - lenient	-.29 (-.25)	.43(.43)	.14 (.04)
brave - cowardly	-.06 (-.06)	.29(.34)	.04 (.06)
prohibitive - permissive	-.13 (-.16)	.20(.21)	-.05 (-.04)
serious - humorous	.02 (.01)	.22(.23)	.07 (.09)
masculine - feminine	-.15 (-.14)	.44(.47)	.06 (.03)
active - passive	.20 (.17)	.10(.12)	.88 (.98)
excitable - calm	-.16 (-.15)	.02(.03)	.25 (.26)
motivated - aimless	.19 (.29)	.06(.09)	.23 (.23)
rational - intuitive	.12 (.11)	.09(.10)	.05 (.04)
cautious - rash	.30 (.33)	-.02(-.02)	-.06 (-.05)
aggressive - defensive	.03 (.02)	.12(.13)	.16 (.16)

Presentation of concepts

	Pretherapy	During*	Post-therapy
How I perceive myself	*	*	*
My ideal self	*	*	*
My parents	*	*	*
The group		*	
How I think the group perceives me		*	
The therapist		*	
How I think I was before I joined the group			*

* at intervals of eight weeks.

Table VIIIb: Concepts and scales used in this study with group therapists.

Concepts

How I perceive myself	How I think the group perceives me as an individual
My ideal self	How I think the group perceives me as a therapist
My parents	The group

How I think I was before I started the group

Scales and their factor loadings
(in brackets are the loadings reported by Osgood et al (1957))

	Evaluative	Potency	Activity
Optimistic - pessimistic	.32 (.37)	-.10(-.05)	.15 (.07)
sociable - unsociable	.42 (.42)	-.11(-.19)	.28 (.18)
successful - unsuccessful	.51 (.51)	.11(.08)	.36 (.29)
elated - depressed	.42 (.45)	.10(.07)	.20 (.17)
important - unimportant	.29 (.38)	.15(.04)	.33 (.31)
healthy - sick	.32 (.33)	-.05(-.03)	.05 (.04)
strong - weak	.31 (.30)	.55(.40)	.11 (.10)
severe - lenient	-.11 (-.25)	.31(.43)	.15 (.04)
brave - cowardly	-.10 (-.06)	.27(.34)	.06 (.06)
prohibitive - permissive	-.11 (-.16)	.22(.21)	-.01 (-.04)
serious - humorous	.01 (.01)	.19(.22)	.08 (.09)
masculine - feminine	-.10 (-.14)	.36(.47)	.09 (.03)
active - passive	.19 (.17)	.10(.12)	.92 (.98)
excitable - calm	-.13 (-.15)	.06(.03)	.19 (.26)
motivated - aimless	.15 (.29)	.06(.09)	.21 (.23)
rational - intuitive	.14 (.11)	.10(.10)	.10 (.04)
cautious - rash	.39 (.33)	-.06(-.02)	-.04 (-.05)
aggressive - defensive	.07 (.02)	.15(.13)	.19 (.16)

Presentation of concepts	Pretherapy	During	Post-therapy
How I perceive myself	*	*	*
My ideal self	*	*	*
My parents	*	*	*
How I think the group perceives me as an individual		*	
How I think the group perceives me as a therapist		*	
The group		*	
How I think I was before I started the group			*

* at intervals of eight weeks

sample the major individuals and problems involved in therapy-in-general.

In addition, as there has been no previous research requiring that therapists judge various concepts during the treatment term, it was decided to ask the therapists in the present study to complete several semantic differentials prior to commencing therapy, during therapy, and at post-therapy. Therefore, three therapists judged the concepts indicated in Table VIIIb at various points in time. Each concept employed the same 18 bipolar adjective scales that the patients rated; these scales and factor loadings being indicated in Table VIIIb. (Appendix F contains copies of the concepts judged by patients and therapists).

In the test form itself, concepts were rotated against scales in such a way that each concept appeared once with each scale, but with a maximum interval between successive appearances of both. The subject was asked to do his checking rapidly, without struggling over particular items, to give his "immediate impressions".

8.2.2. Treatment of the Data:

Recording the raw data for a single subject on a single testing yielded a matrix of N Columns (here, seven concepts) and i rows (here, 18 scales). The meaning of a particular concept to the subject, as defined by the operations of measurement here, is the profile of numbers in its column, or, more efficiently, the position in the n-dimensional space defined by the projection of these numbers onto the factors. Therefore, the maximum number of scores available for each subject was 1134.

Difference in meaning for two concepts is defined by the distance between their positions in this space, as computed by the generalized distance formula

$$D = \sqrt{\Sigma d^2}$$

in which d is the difference in allocation of the two concepts on a single scale. The more similar any two concepts are in connotative meaning, the smaller will be the value of D.

Change in meaning of the same concept at different times during therapy can be defined by the same operation except that d here refers to the differences in allocation of the same concept on the same scale at different testings.

8.3. Results and Discussion.

8.3.1. Change in the meaning of concepts over time for group psychotherapy patients.

Although the patients judged the concepts at various times throughout treatment, it was decided to concentrate on the comparison between responses prior to commencing therapy and responses at termination, as change from one testing to the next was not found to reach a significant level. Therefore, the analyses concentrate on pre- and post-therapy comparisons.

It can be seen from consulting Table VIIIc + d, which shows change in the meaning of the concepts used, that there were significant changes in patients' appraisals of four concepts employed: HOW I PERCEIVE MYSELF; MY PARENTS; THE THERAPIST; and HOW I THINK THE GROUP PERCEIVES ME. These concepts will therefore be discussed in detail.

HOW I PERCEIVE MYSELF.

Table VIIIc indicates that the patients' attitude towards self as measured by the concept HOW I PERCEIVE MYSELF, altered significantly from pre- to post-therapy on the Evaluative factor. It is of note also that the patients in Group 3, which was disbanded after 12 months of group psychotherapy, had altered their self-concept on this factor to a significant degree. Such a finding indicates that patients in the present study modified their attitude towards themselves and inspection of the data

Means and standard deviations of group psychotherapy patients' responses to the semantic differentials employed.   (Pre-Therapy/Post-Therapy)

	Evaluative		Potency		Activity		N
	mean	sd	mean	sd	mean	sd	
HOW I PERCEIVE MYSELF							
Group 1	3.82/3.60	0.77/0.77	4.66/4.99	0.77/0.95	4.96/4.89	0.21/0.81	6
Group 2	3.35/4.12	0.87/0.53	4.55/4.33	0.70/0.88	4.31/4.73	0.86/0.59	9
Group 3[1]	3.76/4.39	0.77/0.65	4.50/5.03	0.62/0.57	4.43/4.56	0.73/0.48	6
Group 1 and 2	3.46/3.79	0.82/0.66	4.60/4.57	0.68/0.90	4.51/4.77	0.74/0.63	15
MY IDEAL SELF							
Group 1	5.63/5.79	0.84/0.92	5.10/5.23	0.56/0.89	5.33/5.09	0.52/10.30	6
Group 2	6.12/6.25	0.63/0.50	4.91/4.81	0.81/0.69	5.41/5.35	0.55/0.71	9
Group 3	6.10/6.13	0.42/0.52	4.86/4.86	0.79/0.79	5.09/5.13	0.69/0.53	6
Group 1 and 2	5.97/6.02	0.72/0.75	5.02 /4.98	0.69/0.74	5.38/5.25	0.49/0.57	15
MY PARENTS							
Group 1	4.16/3.69	0.34/1.07	4.16/4.03	0.26/1.01	3.93/4.33	0.63/0.49	6
Group 2	3.81/4.24	0.65/0.68	2.70/4.13	0.42/0.45	4.47/4.35	1.33/0.82	9
Group 3	3.93/3.93	1.23/1.23	3.83/4.12	0.56/0.75	3.99/4.40	0.71/0.93	6
Group 1 and 2	3.99/4.05	0.57/0.82	3.91/4.09	0.42/0.66	4.33/4.40	1.10/0.69	15
THE GROUP							
Group 1	3.86/3.86	0.52/0.52	4.73/4.96	0.25/0.59	4.00/4.16	0.52/0.47	6
Group 2	4.64/4.52	0.77/0.59	4.36/4.52	0.66/0.94	4.95/4.97	0.43/0.35	8
Group 3	4.66/4.66	0.68/0.68	4.16/4.57	0.65/0.56	4.59/4.29	0.39/0.70	6
Group 1 and 2	4.21/4.15	0.82/0.68	4.36/4.62	0.58/0.83	4.43/4.51	0.77/0.71	14
HOW I THINK THE GROUP PERCEIVES ME							
Group 1	3.76/3.73	0.81/0.35	4.53/4.46	0.43/0.29	4.38/4.19	0.85/0.58	6
Group 2	3.90/4.02	0.53/0.71	4.28/4.64	0.38/0.35	4.38/4.31	0.82/0.81	8
Group 3	4.03/3.83	0.68/0.96	4.66/4.59	0.39/0.47	4.06/4.09	0.48/0.43	6
Group 1 and 2	3.80/3.84	0.62/0.60	4.32/4.50	0.46/0.40	4.26/4.14	0.88/0.81	14
THE THERAPIST							
Group 1	3.96/4.29	0.32/1.05	4.26/4.80	0.73/0.57	4.39/3.96	0.51/0.18	6
Group 2	5.23/5.31	0.60/0.65	4.80/5.19	0.69/0.68	4.78/4.64	0.82/0.69	8
Group 3	5.36/4.56	0.59/0.49	4.89/4.96	0.76/0.22	4.63/4.33	0.50/0.81	6
Group 1 and 2	4.74/4.89	0.79/0.91	4.61/4.99	0.71/0.62	4.59/4.34	0.69/0.61	14
HOW I THINK I WAS BEFORE I JOINED THE GROUP.[2]							
Group 1	3.80	0.84	4.10	0.66	3.93	0.65	6
Group 2	3.91	0.92	4.31	0.73	3.87	0.63	9
Group 1 and 2	3.88	0.84	4.20	0.67	3.94	0.61	15

[1] Note: Group 3 was disbanded following the therapist's death.
[2] Note: This concept was presented only at post-therapy.

Table VIIId: Change in the meaning of concepts: pre- and post-therapy
comparison for group psychotherapy patients.

CONCEPT	N	t Evaluative	Potency	Activity
HOW I PERCEIVE MYSELF				
Group 1	6	2.67**	2.16*	0.19
Group 2[1]	9	3.66****	2.50**	1.46
Group 3	6	2.99**	3.33**	0.13
Group 1 and 2	15	2.51**	2.28**	1.16
MY IDEAL SELF				
Group 1	6	0.20	0.75	0.59
Group 2	9	0.78	0.58	0.42
Group 3	6	0.17	0.52	0.66
Group 1 and 2	15	0.75	0.15	0.40
MY PARENTS				
Group 1	6	1.11	0.40	0.94
Group 2	9	1.75	2.41**	0.37
Group 3	6	0.66	2.77**	0.81
Group 1 and 2	15	0.23	0.73	0.30
THR GROUP				
Group 1	6	0.13	0.92	1.21
Group 2	8	0.81	0.66	0.10
Group 3	6	0.82	1.40	1.52
Group 1 and 2	14	0.99	1.16	0.21
HOW I THINK THE GROUP PERCEIVES ME				
Group 1	6	0.82	0.12	0.87
Group 2	8	0.63	2.07*	0.37
Group 3	6	0.41	0.16	0.11
Group 1 and 2	14	0.21	1.25	1.35
THE THERAPIST				
Group 1	6	0.22	2.17*	1.50
Group 2	8	0.17	1.68	0.99
Group 3	6	6.58*****	0.16	0.97
Group 1 and 2	14	0.29	2.77***	1.01

*   .05 level of significance (one-tailed t-test)
** .025 level of significance (one-tailed t-test)
*** .01 level of significance (one-tailed t-test)
**** .005 level of significance (one-tailed t-test)
***** .001 level of significance (one-tailed t-test)

[1] Note: Group 3 was disbanded following the therapist's death.

reveals that this movement was towards a more positive self-concept, this being consistent with the findings of Snygg and Combs (1949) and Luria (1959). It is further of interest that the patients also modified their self-concept on the Potency factor, perceiving themselves as significantly more "potent" or resolute after therapy. However, there was no significant change on the Activity factor of this concept.

MY PARENTS

The results in Table VIIIc also show that, while there were no significant changes in how patients perceived their parents on the Evaluative and Activity factors from pre- to post-therapy, Group 2 and 3 did show a significant change on the Potency factor, t his being in the direction of perceiving their parents as less "potent" at post-therapy. For these patients, the power of the "Parent" (Berne (1966))or "superego" diminished significantly as a result of therapy, suggesting further an increase in the patients' sense of self-direction and self-determination.

THE THERAPIST.

Group 1 had a significantly more positive attitude towards their therapist in terms of the potency of the therapist at termination and, when the results of Group 2 were also included in the comparison, the same result was found, although the result for Group 2 alone did not reach significance level. While there was no significant change on the Potency factor for Group 3, there was a significant change on the Evaluative factor. Although their treatment was terminated prematurely, it must be stressed that the patients' appraisal of this concept occurred prior to the therapist's death and the present result cannot be interpreted as a consequence of this event. Therefore, the data revealed that the therapist in each group was perceived by his group members as less "potent" at post-therapy, this reaching a statistically significant level for Group 1 and Group 1 and 2 combined.

HOW I THINK THE GROUP PERCEIVES ME.

It is apparent from Table VIIIc that there was a significant

difference in the responses of patients in Group 2 on the Potency factor of this concept between pre- and post-therapy, the data indicating that they felt others perceived them as significantly more "potent" as a result of therapy.

Looking at the results as a whole, it is apparent that only four of the concepts employed in this study reflected significant change in meaning to the patients as a result of therapy. Responses to the concept HOW I PERCEIVE MYSELF were found to change to a significant degree for all three groups on the Evaluative and Potency factors. As the Evaluative factor is regarded as being indicative of an individual's psychological adjustment (Endler (1961)), the movement towards a more positive self-attitude on this factor suggests that patients developed a more positive self-concept as a result of their group psychotherapy experience. It is of particular interest that this was the case for group 3 who did not complete the intended treatment term. The result of no significant change on the Activity factor would suggest that the patients perceived themselves as no more "active" as a result of therapy. All groups did, however, have a more positive self-regard as reflected by their responses on the Evaluative factor and perceived themselves as being more capable of action, as reflected by the Potency factor.

Consistent with this, it was found that patients judged two concepts - MY PARENTS and THE THERAPIST, as being significantly less "potent" at post-therapy. Given that the therapist is often likened to a parent-like figure in psychotherapy, it would appear that, as the patients perceived themselves more favourably as a result of therapy, they also perceived their parents and the therapist as less powerful.

Within the transactional analysis model of Berne (1966), these results could be interpreted as suggesting that initially, the patient

perceives himself as being a "Child". While his therapist and parents are both seen as "Parents", invested with power and authority over the patient's actions. However, as a result of therapy, the patient comes to adopt an "Adult" role, accepting responsibility for his own actions and future while the "power" of the therapist and parents diminishes accordingly. Alternatively, Rotter (1966) would contend that patients become more Internal as a result of therapy, perceiving themselves as having a significant role to play in determining the direction their lives take.

However, equally as important as those concepts which changed in connotative meaning over therapy, were those concepts which did not; namely , MY IDEAL SELF; THE GROUP; and, with the exception of Group 2, HOW I THINK THE GROUP PERCEIVES ME. Based on Luria(1959), one would not have anticipated much movement on the concept MY IDEAL SELF. Luria (1959) reports that the ideal self remains relatively constant over the course of study and the present results support this. Nevertheless, while the patients had a more positive self-valuation after therapy, it is apparent that this did not extend to how they thought the other group members perceived them or, indeed, how they perceived the group. These latter results indicate that, while the patients "re-ordered" the manner in which they perceived themselves, this did not alter, to a significant degree, how they felt other group members perceived them or how they perceived others in the group.

8.3.2. Change in the relationship between concepts over time for group psychotherapy patients.

Since it was found that some of the concepts changed in connotative meaning for the patients as a result of group psychotherapy, it would appear pertinent to examine the relationships between the concepts employed with a view to investigating relative movement within the semantic space. Therefore, four comparisons were made, as indicated in Table VIIIe: HOW I PERCEIVE MYSELF/(MY IDEAL SELF; THE THERAPIST/MY PARENTS; HOW I PERCEIVE

Table VIIIe: Change in the relationship between concepts from pre-therapy to post-therapy for group psychotherapy patients. (Consult Table VIIIc for the means and standard deviations appropriate to the present Table).

COMPARISON	N	t Evaluative	Potency	Activity
HOW I PERCEIVE MYSELF/MY IDEAL SELF				
Group 1	6	0.17	1.22	1.55
Group 2[1]	9	2.66**	2.50**	2.01*
Group 3	6	2.10*	0.14	0.11
Group 1 and 2	15	2.11*	2.15**	1.51
THE THERAPIST/MY PARENTS				
Group 1	6	1.93	1.50	0.46
Group 2	8	0.61	0.39	0.17
Group 3	6	0.45	0.82	0.91
Group 1 and 2	14	1.42	0.91	0.55
HOW I PERCEIVE MYSELF/HOW I THINK THE GROUP PERCEIVES ME				
Group 1	6	0.56	2.17*	0.17
Group 2	8	1.52	1.50	0.64
Group 3	6	0.59	0.48	0.74
Group 1 and 2	14	0.76	1.97*	0.45
HOW I PERCEIVE MYSELF/HOW I THINK I WAS BEFORE I JOINED THE GROUP (at pre-therapy) (at post-therapy)				
Group 1	6	2.31*	1.34	0.44
Group 2	9	0.47	0.85	0.92
Group 1 and 2	15	1.15	1.64	1.09

* .05 level of significance (one-tailed t-test)

** .025 level of significance (one-tailed t-test)

[1] Note: Group 3 was disbanded following the therapist's death.

MYSELF/ HOW I THINK THE GROUP PERCEIVES ME; and HOW I PERCEIVE MYSELF

(judged at pre-therapy)/ HOW I THINK I WAS BEFORE I JOINED THE GROUP (judged

at post-therapy).

Inspection of Table VIIIe reveals that there were significant

changes in the relationship between some of the comparisons made. While

there were no significant changes on any of the factors when comparing

THE THERAPIST and MY PARENTS it is apparent that the two concepts which

changed most in their relationship to each other were HOW I PERCEIVE MYSELF

and MY IDEAL SELF. Patients in Group 2 perceived greater congruence

between these concepts at post-therapy on all three factors; Group 3

perceived greater congruence on the Evaluative factor; and, while Group 1

showed no siginficant change in the relationship between these concepts, when

combined with Group 2, they showed greater congruence on the Evaluative

and Potency factors at termination.

Table VIIIe also indicates that the patients of Group 1 perceived

themselves, at termination, as significantly more similar to how they

thought others in the group perceived them, in terms of the Potency factor.

A similar result was found when the responses of Group 1 and 2 were combined

for this comparison.

In addition, it appears that, for Group 1, there was a significant

change in the relationship between HOW I PERCEIVE MYSELF (measured prior to

therapy) and HOW I THINK I WAS BEFORE I JOINED THE GROUP (measured at

termination). Their retrospective assessment of self prior to therapy was

significantly different from how they had perceived themselves prior to

therapy commencing.

8.3.3. Summary

It would therefore appear that despite the selection of

concepts thought to be relevant to psychotherapy and anticipated to be sensitive to change, only four concepts were found to change to a significant degree as a result of group psychotherapy. While therapy resulted in an increase in positive attitude towards self, this was accompanied by a corresponding devaluation of parents and therapist. Such a result is consistent with Luria (1959), Endler (1961) and Snygg and Combs (1949) who emphasized that psychological adjustment is greatly determined by the significance or connotative meaning of self.

However, the findings of Dies and Hess (1970a,b) are partially supported by the present results, even although the type of therapy was different. Dies and Hess (1970a) found that, in marathon psychotherapy, patients tend to express positive attitudes towards their group experience on the potency and activity dimensions, emphasizing such facets of experience as greater intimacy and interpersonal openness. The present study of conventional group psychotherapy found that patients had a more positive self-regard as reflected by the Evaluative factor but also, in agreement with Dies and Hess (1970a,b), on the Potency factor. However, this was how they perceived themselves __as a result of__ the group experience.

Further examination of the data also revealed that the relation-ship between the connotative meaning of concepts to patients did, on the whole, alter within the semantic space to a significant degree. As a result of therapy, while there was found to be a devaluation of parents and therapist as separate concepts, patients did not differentiate between these concepts to a significant level either prior to therapy or at terminat-ion. Likewise, there was no significant change in the relationship between HOW I PERCEIVE MYSELF and HOW I THINK THE GROUP PERCEIVES ME, with the exception of Group 2 on the Potency factor. This latter finding suggests that, although patients increased in positive attitude towards themselves as individuals, they did not think it had changed sufficient that others'

attitude towards them had also altered.

There was, however, found to be a significant change in the relationship between the concepts HOW I PERCEIVE MYSELF and MY IDEAL SELF on the Evaluative and Potency factors. It was found that the connotative meaning of these two concepts became more congruent as a result of therapy. That there was no overall change in the meaning of MY IDEAL SELF as a concept, and that there was a significant change in HOW I PERCEIVE MYSELF suggest that, while the ideal self remained relatively constant, the patients' concept of self shifted towards their ideal self.

A further comparison revealed that, with the exception of Group 1, there was no significant difference between how patients perceived themselves prior to therapy and how they thought, at termination, they had perceived themselves before commencing.

In conclusion, it would appear that patients' self-concept, as measured by the semantic differential technique, changed to a significant degree as a result of conventional group psychotherapy. Therefore, this finding supports the view that the process of psychotherapy, individual or group, is essentially a re-ordering and changing of the connotative meaning evoked by the concept HOW I PERCEIVE MYSELF. Further, it was found that the Evaluative and Potency factors were most sensitive to change, although the Evaluative factor accounts for most of the variance of the meaning construct. That it appears to reflect an individual's psychological adjustment makes the semantic differential technique of potential value in the evaluation of the efficacy of psychotherapy. Nevertheless, the results of the present study indicate that, even if concepts and scales are chosen which are relevant to psychotherapy, they are not necessarily sensitive to change as a result of therapy.

8.3.4. Change in the meaning and relationship between concepts over time for group psychotherapists.

Turning attention to the therapists in the present study, it can be seen from consulting Table VIIIf + g, that there were no significant changes in the connotative meaning of the concepts between pre- and post-therapy. One might, however, anticipate similar results if a larger sample of therapists were studied. After all, the primary aim of psychotherapy is for change in the patient and, therefore, any change by the therapist must be regarded as secondary to this aim.

It was surprising to find that there was significantly greater congruence between how the therapists perceived themselves and how they thought the group perceived them as an individual, on the Potency factor, in contrast to as a therapist, as a result of the therapy experience.

Since the sample of therapists was so small, this finding may be specific to the present study. Nevertheless, it does suggest that there may be some discrepancy between how a therapist thinks he is perceived as an individual and as a therapist by his group patients. There therefore arises the question of role adoption by a therapist and, from the therapist's point of view, there may be some ambiguity between being a therapist and a group member in the therapeutic situation.

8.3.5. Summary.

As the emphasis of psychotherapy is on the patients' self-concept and other concepts relative to their problems, it is not surprising that there were no significant changes in the connotative meaning of concepts to the therapists. It is therefore of particular interest that there was greater congruence between how the therapists perceived themselves and how they thought the group members perceived them as individuals, as a result of the therapy experience. That this congruence was on the Potency factor is

Means and standard deviations of group therapists' response to the semantic differentials employed. (Pre-Therapy/Post-Therapy)

	Evaluative mean	sd	Potency mean	sd	Activity mean	sd	N
HOW I PERCEIVE MYSELF	4.24/4.24	0.12/0.12	4.50/4.41	0.23/0.83	4.49/4.67	0.47/0.47	3
MY IDEAL SELF	3.75/3.92	0.12/0.12	4.66/4.74	0/0.12	5.00/5.42	0.71/0.12	3
MY PARENTS	4.50/4.50	0.71/0.71	4.58/4.41	0.59/0.35	4.66/4.92	0.23/0.12	3
HOW I THINK THE GROUP PERCEIVES ME AS AN INDIVIDUAL	3.75/3.83	0.12/0	4.75/4.41	0.12/0.12	4.49/4.17	0.23/0.43	3
HOW I THINK THE GROUP PERCEIVES ME AS A THERAPIST	4.33/4.33	0.24/0.24	4.92/4.95	0.12/0.35	4.16/4.25	0/0.12	3
THE GROUP	3.58/3.50	0.11/10.23	4.92/4.95	0.12/0.35	4.08/4.25	0.35/10.35	3

Table VIIIg: Change in the meaning of concepts: pre- and post-therapy comparison for group psychotherapists.

	N	t* Evaluative	Potency	Activity
HOW I PERCEIVE MYSELF	3	0.99	0.37	2.04
MY IDEAL SELF	3	0.99	1.39	1.61
MY PARENTS	3	0.70	1.73	0.99
THE GROUP	3	1.99	0.98	0.50
HOW I THINK THE GROUP PERCEIVES ME AS AN INDIVIDUAL	3	0.55	0.15	0.71
HOW I THINK THE GROUP PERCEIVES ME AS A THERAPIST	3	0.99	0.36	0.99

* one-tailed t-test

Change in the Relationship between Concepts from Pre-therapy to Post-therapy (group psychotherapists).

Comparison	N	t Evaluative	Potency	Activity
HOW I PERCEIVE MYSELF/MY IDEAL SELF				
Therapist 1, 2 and 3	3	2.57	0.17	0.13
HOW I PERCEIVE MYSELF/HOW I THINK THE GROUP PERCEIVES ME AS AN INDIVIDUAL				
Therapist 1, 2 and 3	3	0.55	5.19*	0.47
HOW I PERCEIVE MYSELF/HOW I THINK THE GROUP PERCEIVES ME AS A THERAPIST				
Therapist 1, 2 and 3	3	0.17	0.36	0.99

*   .025 level of significance (one-tailed t-test).

indeed surprising as it was not apparent when the therapists judged how they thought the group perceived them as a therapist.

8.4.   Conclusion

It would therefore appear to be, as suggested by Perlman (1968), that certain aspects or dimensions of personality, singly or in combination, may be susceptible to change under certain conditions. However, there would appear to be a distinction between "personal change" and "personality change": "personal change" involves modification or re-ordering of one or more aspects of an individual's feeling-thinking-acting and if "personality change" is an accumulated outcome, there exists a happy serendipity. The image of man evoked by such a view is that of a passive victim of unconscious impulses, trapped by biography and circumstances, and capable only of superficial change.

However, although in agreement with Perlman (1968) that certain aspects of personality, singly or in combination, may be susceptible to change under certain conditions, Mischel (1973) emphasizes the interdependence of behaviour and conditions, mediated by the constructions and cognitive activities of the person who generates them, and recognises the human tendency to invent constructs and to adhere to them as well as to generate subtly discriminative behaviours across settings and over time. Such an approach emphasizes the crucial role of situations but views them as informational inputs whose behavioural impact depends on how they are processed by the individual. It focuses on how such information processing hinges in turn, on the prior conditions which the individual has experienced. And it recognises that the individual's behaviour changes the situations of his life as well as being changed by them.

From this perspective, the terms "personal change" and "personality change" need not be pre-empted for the study of differences between

individuals in their consistent attributes. It fits equally well the

study of the individual's cognitive and behavioural activities as he

interacts with the conditions of his life.

CHAPTER 9

Conclusion

Psychotherapy is a difficult subject to study. Merely to ask such a seemingly straightforward question as "Is psychotherapy effective?" requires a series of definitions and explanations. Similarly, it is not easy to answer the questions "What is meant by psychotherapy?", "Effective with what kind of patients?", "What is meant by effective?" and the definitions chosen may strongly influence the results. The amazing variety of conceptualizations and procedures that define the clinical practice of psychotherapy parallels the diversity to be found in psychotherapy research. At present, there is no standard definition of what occurs in, or is distinctive of therapeutic process; no consensus about the intended effects of therapy, or the criteria of therapeutic outcome. As such, it must be recognized that while a single empirical study has value, it does not establish any fact or principle. It may increase by one step subjective confidence in some general proposition, it may provide strong suggestions as to possible relationships, or it may point to variables which appear to make substantial contributions to the variance, but no more.

Birtchnell (1978) and Garfield (1978), among others, further contend that there still exists within psychotherapy research, a belief that simple causal relationships can readily be elicited and are there for the taking. Thus, researchers continue to be concerned with the crudest of variables without appreciating the total life situation of the individuals being studied.

As well as the fallibility of the methodologies employed in psychotherapy research in terms of both validity and reliability, there further exist numerous problems which limit comparison of studies. For example, because of an inadequate appraisal of the patient's circumstances by the researcher, there is a lack of precisely comparable cases across

studies. Similarly, there is a lack of equivalent criteria of outcome attributable to the unreliability of the measures used.

Regarding the process of therapy, there are large variations in the amount of therapy received and in its quality, as well as differences in the duration and thoroughness of follow-up after termination; the process of change need not halt with the termination of therapy. In addition, another problem is that of variation in the nature of onset and in duration of disturbance in the patient and last, but not least, there exists the problem of definitions of disorder and criteria for improvement.

It is within such apparent confusion that the present investigation was initiated in an attempt to integrate process and outcome measures of patients' and therapists' experiences of group psychotherapy into a longitudinal study, following the participants from the start of the therapeutic contact through to termination and six months after termination. Although there has been much research on psychotherapy, the literature revealed a dearth, not only in attempts to combine "process" and "outcome" variables, but also on how patients and therapists experience the same therapy.

The research reported here attempted to systematize: patients' and therapists' expectations of themselves and each other in group psycho- therapy; second, their perception of themselves and each other throughout treatment; and third, to gather information about the similarities and differences between their perceptions, in relation to the outcome of treatment.

Initially, there were 22 patients drawn from three outpatient psychotherapy groups, with no inpatient members. This was subsequently

reduced to a sample of 15 patients following the death of a therapist.
The therapist in each group was the Consultant Psychiatrist to whom the
patients had been referred by their General Practitioner and discussions
with these therapists prior to initiating the study revealed that they had
similar aims and theoretical orientation in their group work, each utilizing
the Foulkes model within his group. As such, the therapists saw the group
as being the therapeutic medium and their own task was to nurture its
therapeutic potential by allowing the individuals in it to function increas-
ingly as active and responsible agents themselves. Therefore, the individual
patient was treated in the context of the group with the active participat-
ion of the group.

The research design employed was a repeated measures design
using interviews, several objective evaluations by the participants, and
observation of the patients and therapists in the group psychotherapy
situation from the start of the therapeutic contract, through to terminat-
ion and follow-up of patients. Patients and therapists were interviewed
prior to the first group meeting and, thereafter, at intervals of eight weeks,
until the end of therapy when they were again interviewed. If a patient
left within the treatment term, he was regarded as having terminated
therapy. In addition, the patients were interviewed six months after
terminating group psychotherapy.

The interviews developed were semi-structured with the aim of
allowing the respondent as much "freedom" in his responses as he felt
necessary and to assess various aspects of patients' and therapists'
experiences which were thought, based on the literature and "group notes" of
previous groups to be relevant to the process and outcome of group psycho-
therapy. Topics covered in these interviews were diverse in an attempt to
obtain an integrative appraisal of the participants at the various points

in time throughout therapy.

Apart from the interviews, patients and therapists completed Rotter's Internal-External Control Scale (Rotter (1966)) and several semantic differentials at various points in time; the patients also being asked to complete the Treatment Expectancies Questionnaire (Caine and Wijesinghe (1976)). Despite the complexity of the research design, it must be noted that compliance with the research protocol was excellent - no patient or therapist refused to co-operate at any stage of the investigation.

Nevertheless, as already alluded to, of the 22 original patients, one was lost due to accidental death in the second week of therapy, one group was disbanded after the death of the therapist and, of the remaining 15 patients, seven (47%) completed the treatment term of 18 months. Therefore, only 32% of the original sample of patients actually completed their treatment and, of those patients who terminated, 36% did so for reasons other than the treatment itself. Attendance by the patients at group meetings in relation to termination revealed the following: perfect attendance - no terminators; good attendance (i.e. missed one meeting in six) - 15% termination; poor attendance (i.e. missed two or more meetings in six) - 50% termination. There would therefore appear to be some relationship between attendance at group meetings and termination from group psychotherapy. In addition, patients' expectations of group psychotherapy and the therapists' expectations also appear to be relevant to this issue.

Expectations are a major determiner of human behaviour; the confirmation or non-confirmation of expectations having a significant effect on subsequent affective and cognitive behaviour. The construct "initial therapeutic expectancy" refers to the patient's prediction, made before treatment begins, concerning the likelihood that a given treatment programme

will help reduce the relevant target problem; Cartwright and Cartwright (1958) suggesting that several types of "expectancies" can be postulated of patient expectations of improvement or belief in psychotherapy.

Likewise, Kelly (1955) states that the patient's initial conceptualization will affect his behaviour during therapy, especially the early interviews, but, as this conceptualization changes, the patient's in-therapy behaviour should correspondingly change. It is, however, difficult to differentiate between what each participant expects and what he hopes for from therapy, as both cognitive and motivational aspects are contained in each. Treatment procedures and systems may often be invalidated by misunder-standings and false expectations (Ballinger (1971), Gordon et al (1979)).

Nevertheless, there are two main approaches to the study of patients' behaviour early in treatment; one emphasizes the patient's expectations of therapeutic gain, while the other focuses on the demand characteristics of therapy procedures. Studies of patient expectations have concentrated mainly on how the patient interprets his difficulties and how the experience of therapy fulfills his need to cope with these difficulties.

For instance, Garfield and Wolpin (1963), found that their sample of patients sought a therapist who would be sincere, sympathetic and competent, as well as realistic about the problems of the patient. In contrast, Begley and Lieberman (1970) found two clusters of patients holding widely separated sets of expectations of psychotherapy; at one extreme, expecting the therapist to be personally committed to helping them develop new ways of behaving, while at the other extreme, expecting the therapist to be objective and detached.

In addition, the patient's expectations regarding the duration and process of therapy, the therapist's role, and what is expected of himself

may differ considerably from the expectations of the therapist, Sloane et
al (1970) suggesting that such lack of congruence in expectations is predictive
of unsuccessful outcome of therapy and premature termination.

In the present study, it was found that patients and therapists
had differing expectations of what their approaching therapeutic contact
would consist of, what would be expected of them, and what the outcome of
therapy would be.

The patients, for example, anticipated a situation comparable
to individual psychotherapy, where the therapist would offer them individual
direction, and the other group members would perhaps be supportive. There-
fore, the therapist was anticipated to be an authority figure; the patients
expecting him to have control over what happened in the group meetings.
In contrast, the therapists perceived the group itself to be the main
source of help for each member and, at pre-therapy, emphasized the common-
alities among the prospective group members rather than their differences.

Gordon et al (1979) argue that reliance on professional purveyors
of the service may erroneously assume, albeit innocently, that what they
create in treatment will be, ipso facto, consistent with the needs of those
whom they serve. In the present study, there was found to be a striking
difference between the patients and therapists whether they regarded group
psychotherapy as the most suitable form of intervention. A large proportion
of the sample indicated a preference for medication or individual consultation,
although unsure whether these other forms of therapy would be any more
efficacious than what they had been offered. In contrast, the therapists
felt group psychotherapy was the most suitable treatment for each of the
patients.

Consistent with this discrepancy, patients and therapists had

differing conceptualizations of the difficulties faced by the patient

and differing expectations of the patient's role in his treatment. While

the patients tended to perceive the group as an extension of the consulting

room, as somewhere they would be "treated", the therapists emphasized

that the patient would have to use the group- both the therapeutic milieu and

the other group members - to assist himself. Furthermore, while the patients

described their difficulties as relatively recent in onset, the therapists

felt they were of a long-standing nature.

In the present study, it would therefore appear that patients

anticipated a psychiatric-medical treatment regime while the therapists

anticipated a psycho-social model. Nevertheless, while the patients,on

the whole, anticipated the "doctor-patient" relationship common to other

psychiatric and medical practices, it was possible to discern in the small

sample, possible "kinds" of patient about to commence group psychotherapy,

bearing in mind the comparable selection procedures reported by the

therapists.

Most of the patients anticipated that they would alter as a

result of group psychotherapy, but had differing expectations as to how this

would come about. While a number of patients emphasized the role they

themselves would play in their treatment, a larger proportion emphasized

the role of the therapist in determining the outcome of their therapy, at the

same time minimizing their own involvement in the therapeutic process. This

difference was subsequently found to relate to how patients experienced the

therapeutic situation.

Ryan and Gizynski (1971) and Sloane et al (1975) both conclude

that personal interaction with the therapist is reported by patients as

highly important in treatment and its outcome. Subsequently, Llewelyn and

and Hume (1979) found that patients report non-specific activities to be more useful than either psychotherapeutic or behavioural-type activities, irrespective of the type of therapy, and go on to say that they relate directly to the triad of therapeutic qualities of warmth, empathy, and gentleness which Rogers (1961) regards as "the necessary and sufficient conditions of therapeutic personality change".

The experience of psychotherapy emphasizes the ongoing participation in the therapeutic process as perceived by the participants. As such, this may include not only their perception of self and others, but also of the physical and social milieu. It is surprising, therefore, that there have been so few studies involving the participants' self-perception and perception of others in the process and outcome of psychotherapy.

The results of Jeske (1973) on patients' internal self-experience in therapy, indicated that patients who, when in the group, "identified" more often with the experiences reported by other group members had more favourable outcomes than those who felt little or no identification. Likewise, Saltzman et al (1976) reported a tendency towards better self-rated outcome among patients who felt a greater sense of "responsibility" for resolving their problems and altering their behaviour, in contrast to those who were more reliant on their therapists. It would appear that the patient's experience of involvement in treatment is indicative of treatment outcome; Bent et al (1976) further suggesting that patients who perceive their therapists as "active" and "involved" also have more favourable outcomes.

From the therapist's standpoint, therapists' observations of patient role engagement and his ratings of patient prognosis have been found to be correlated with treatment outcome. Therapist reports of patients' movement from talking about to experiencing feelings were reported by Gendlin et al (1960) to be positively related to improvement in individual

therapy, while Saltzman et al (1976) and Strupp et al (1963) found therapists' assessments of patient prognosis to be positively correlated with improvement.

Regarding the therapist's self-perceptions in the therapeutic process, there have been only two studies (Malan (1976), Ryan and Gizynski (1971)); both reporting that the therapist's awareness of his instrumental participation with patients is positively related to outcome. There is, however, conflictory evidence on the therapist's sense of involvement or "emotional availability", and patient improvement.

Nevertheless, it is clear that it is the participants' inter-personal perception of the therapy process which is vital for therapeutic outcome, and is important also with respect to the confirmation or dis-confirmation of prior expectations.

For instance, the present investigation suggested that, despite the small sample, it is possible to differentiate the patient likely to dropout of the group in the early stages, from the patient likely to continue. Despite the careful selection of patients to the group by the therapist, the potential dropout felt, or was made to feel, deviant in some way from the other group members in the initial group meetings; by his own report, felt that the progress of treatment was incompatible with his pre-therapy expect-ations; felt he gained little or no benefit from the group meetings; was perceived by the other group members as being destructive or contributing little to the group; and finally, he felt threatened by the group situation and unable to control it. On the other hand, the continuer was more likely to endure the initial stress of the therapy situation in order to overcome his anxiety; reported deriving benefit from comparing himself to others in the group, identifying himself with the experiences of others; and was perceived by the other group members as contributing in a constructive manner to the functioning of the group.

However, as the treatment term progressed and the group developed, the shift of emphasis from the individual to the group have relieved the pressure on some of the group members to attend and/or participate in the group. For instance, one patient who terminated felt he had been "ignored" by the other group members and, as a shift of emphasis to the group as a whole increased the possibility of being ignored further, he left.

Notwithstanding, the patients did feel that the emotional ties and relationships that developed in the group were important not only for the foundation of the group but also for its therapeutic functioning. Initially, all patients reported that the group meetings were very stressful, but those who felt able to tolerate anxiety in this situation felt this was an initial achievement on which to build. Obviously, patients' reports of benefit from the group meetings, per se, varied from individual to individual but, as therapy progressed, more patients reported increasing benefit from the meetings and, at the same time, perceiving the other group members as deriving greater benefit; patients concurring on the type of benefit being derived by each of the other group members.

Even so, patients who did terminate were perceived by the other group members and the therapists to be "failures"; this having a demoralizing effect on the others. The present sample coped with this by becoming more dependent on the group and cohesion increased within the group.

Turning attention to the therapists' reports during the treatment term, they were satisfied with the achievements of all their group members, but particularly those who remained in therapy - a finding reported also by Goldstein (1960). It was also clear in the present study that how pleased therapists were with the progress of each patient was influenced by their experience of the patients in the therapeutic setting itself. As the therapists learned about their patients through observation of their inter-

actions in the group, so the therapists' aims amd objectives for each group member were modified.

The present results would tend to suggest that therapists' perception of their group members during the treatment term were influenced more by actual interaction with the members than by the therapists' expectancies of that interaction. Such a finding supports previous research (e.g. Kumar and Pepinsky (1965), Lennard and Bernstein (1960), Sattler and Winget (1970), Saunders and Vitro (1971)). However, if there was sufficient discrepancy between his expectations and actual interaction with a patient, the therapist was more likely to be dissatisfied with the progress of treatment for that patient; a finding the aforementioned studies do not agree with. In four cases, it was apparent that the therapists had considerable difficulty in identifying the early terminator.

Given that early terminators subsequently do not seek further treatment (Riess and Brandt (1965), Grad and Lindenmayer (1977)), the present result suggests a need for further research on what bases therapists decide which treatment regime is most appropriate for a particular patient.

Consistent with the findings of Mintz et al (1973), Mintz and Luborsky (1971), and Luborsky (1971), the present study found it particularly difficult to compare patients' and therapists' evaluations of the quality of treatment. Comparison of the participants' experience of the same therapy revealed that they were not particularly in accord. However, both therapists and patients did identify the same patients as adopting the role of leader throughout therapy. It is of note that neither therapist was perceived by his group to be in that role, despite the report of one therapist that he felt he had adopted this role in the latter part of therapy. Such a finding highlights the difference between an individual monitoring and reporting his behaviour, and others monitoring the behaviour of that individual.

Such an issue is also raised by the finding that, on the surface, therapists and patients concurred on the type of benefit each member derived from the group at any one time. However, the group members agreed to a greater extent on the benefit derived by a particular patient; therapists being no better than their group members at perceiving what was happening to the patients in therapy.

Given that the relationship between the therapist and his patient and their perception of that relationship is the vehicle for therapeutic change, it is crucial to investigate the outcome of therapy. Malan (1973) argues that, in the investigation of any therapeutic technique, there is little point in studying other variables unless their relation to outcome can be established. Even so, reviews of the effects of psychotherapy have been controversial and influential. Eysenck ((1952), (1960), (1965), (1966), (1967)) argues that approximately two-thirds of neurotic patients improve, no matter how they are treated and whether they are treated or not, while Bergin (1971), contends that most forms of psychotherapy make patients worse as well as better. As no two individuals are exactly alike, no method of assessment based on general criteria is specific enough to give accurate results, Malan (1959) arguing that any method of assessment must do justice to very great quantitative differences and important qualitative ones.

There is constantly confirmation of the value of psychotherapy, if measures of change are employed as outcome variables. However, few studies have found differences in outcome between various forms of intervention. For instance, the carefully controlled study of Sloane et al (1975) found that across pre- to post-test measures of target symptoms and social and work adjustment, behaviour therapy was about as effective as psychoanalytically oriented psychotherapy. Patients in these groups had improved significantly more than those in a waiting list control group. There are, however, two possible interpretations

of these findings: first, that focused behavioural techniques are more successful at eliciting modest but consistent gains than are the techniques of insight therapy; or second, behavioural techniques may work more quickly to accentuate improvement in a greater variety of patients. As emphasized by Sloane et al (1975), the combination of patient and therapist is crucial; where it is wrong, therapy will be less effective or unsuccessful.

It remains, however, that changes in both behavioural and internal states are important. Retrieving numerous studies of patient character- istics and patient change, Truax and Carkhuff (1967) suggested that contradict- ions apparent in outcome research could be resolved by distinguishing between dynamic and symptomatic criteria. More recently, Malan (1976) devised an assessment of internal or dynamic changes as opposed to symptomatic or behavioural change, while Ross and Proctor (1973) and Wilson and Thomas (1973), working within a behavioural paradigm, reported that divergent processes are occurring in therapeutic change and support Malan (1959) that divergent methods of criterion measurement must compliment the divergency in individuals and in the change processes that occur within them.

Similar results have been reported in complex psychotherapy outcome studies employing factor analyses of multiple change criteria (e.g. Cartwright et al (1963), Gibson et al (1955), Forsyth and Fairweather (1961)). The main factors of these studies tend to be associated with the method of measurement or sources of observation used in gathering the data. More recently, the studies of Bergins et al (1975) and Mintz et al (1979) have only highlighted the complexity of the data.

Emphasizing the multiple effects of psychotherapy, Strupp and Hadley (1977) have attempted to develop a conceptual model which would cope adequately with the diverse changes that result from psychotherapy. Their

tripartite model suggests that outcome be viewed from three perspectives: society; the individual himself; and the mental health professional. As such, interpersonal and non-specific factors are still perceived to be stimulators of patient improvement, even in the more technical therapies (Llewelyn and Hume (1979)).

The present study attempted to gather information on the inter-personal factors that were perceived by the participants to have been important in group psychotherapy as well as evaluate pre- to post-therapy measures of change.

For example, it was found that patients and therapists did not agree on what the outcome of group psychotherapy was. The patients assessed the outcome on several criteria, on both a symptomatic level and also with regard to their attitude towards self and how they felt they were perceived by others. While all patients reported the value of learning that they, and their problems, were not "unique", "abnormal", or "in-valid", patients who terminated during the treatment term reported gains primarily on the symptomatic level, e.g. reduction of anxiety in an anxiety provoking situation but without knowing why.

Nevertheless, patients also recognized that group psychotherapy was no "magic cure" and, although they had come to appreciate the other group members during therapy, at post-therapy, they re-affirmed their belief in the therapist to control group meetings and the process of therapy. The therapists reported being satisfied with the choice of therapy for each patient and, although pleased with the progress of patients during therapy, reported being dissatisfied with the outcomes at post-therapy. It was apparent that the therapists felt the effects of group psychotherapy had been rather restricted for these particular patients, anticipating also that some would require psychiatric assistance in the future.

It was also of note that neither patients nor therapists felt that any patient had deteriorated as a result of group psychotherapy nor were there any instances of spontaneous remission. Admittedly, the present sample was small, but the results of Bergin (1966), Hadley and Strupp (1976), and Hartley et al (1976), would suggest that the present study was unusual in this respect. Nonetheless, there were "failures" perceived by both therapists and group members. While the group members felt the "failure" was such by his own design, this was in contrast to the therapist's view that it was the result of his inability to help the patient at this particular time.

Interviewing the patients six months after termination revealed that this period was as important as the whole of therapy itself with regard to the process of change. While the patients, on the whole, felt they had coped well since therapy, there had been some recurrence of initial difficulties. All but four patients felt that therapy had been successful and those four patients who felt it had not, sought professional assistance from the therapist in the intervening months.

Unfortunately, it was not possible to employ a longer follow-up or investigate the progress of those patients who did return to the therapist and, as such, the present investigation falls short. Amongst other deficiencies, which are no doubt apparent, this investigation was not controlled in any way; for instance, employing a waiting list control. However, in defence, the aim was to follow the progress of patients and therapists in "real" group psychotherapy. Analogue research, although valuable, has its own limitations and deficiencies (Freund (1972)), and it would not have been possible to devise an analogue design which would have encompassed the aims of the present study adequately.

Nevertheless, it is clear, despite the lack of experimental rigour (or perhaps because of it), that the process of group psychotherapy is both a

complex and subtle human interaction, as revealed by content analyses of the interviews using Guttman scale analysis. Not only were there differences found between patients' and therapists' expectations of the therapy, their experience of therapy, and their assessment of the outcome of group psychotherapy, but differences were also apparent within the patients' responses, in terms of patients liable to terminate group psychotherapy and those more likely to complete therapy.

Whilst the present investigation indicated differences between terminators and non-terminators both in their expectations and early experiences of therapy, it was suggested that it may be possible to identify the potential terminator, prior to commencing therapy. To further refine and develop the assessment of patients prior to group psychotherapy would be of particular value to therapists in the selection of patients suitable for group psychotherapy and perhaps also reduce the number of terminators from this type of treatment due to patients' inappropriate treatment "set".

For example, although the problem of attrition is faced by every therapist, investigations of why patients terminate prematurely are singularly lacking. To date, there have only been two studies of patients who drop out of group psychotherapy; both studies being retrospective in orientation.

Bach (1954) studied patients who dropped out of his private-practice therapy groups and concluded, on anecdotal evidence, that the primary factor was not so much the patient's personality structure as his particular role in the group. Those who left the group were considered deviant in some way by a majority of the other members and sought to evade the overt group pressures to change by dropping out. In contrast, Yalom (1966) found that patients drop out for varied and often multiple reasons and reported that, in his study, the most frequent reasons for premature termination were, in order of incidence: problems of intimacy, group deviancy, complications

arising from subgrouping, and early provocateurs. Yalom (1966) subsequently discussed his findings in terms of patient-specific problems which the patient brought with him to the group and problems arising within the group, emphasizing not only that premature termination from group therapy is a significant problem not only from the standpoint of the large number of therapeutic failures, but also from the standpoint of the deleterious effects on the rest of the group. However, as pointed out, both studies were retrospective in orientation and, from the therapist's standpoint, it would be invaluable if it was possible to identify the potential therapy dropout before treatment is commenced. The present investigation tentatively suggests that this may be possible and as such, offers an avenue for further research on identifying the potential dropout from therapy.

If measures of change are employed as outcome variables in psychotherapy research, then the patients in the present study did alter as a result of group psychotherapy, by self-report, therapists' report, and by their responses to several objective measures.

With respect to the interviews, application of the Kolomogorov-Smirnov two-sample test to the Guttman scales common to both pre- and post-therapy interviews, indicated that there were significant differences in patients' responses at pre- and post-therapy.

The Guttman scale which had altered most was the patients' assessment of the important factors in therapy and attribution of change at termination. At pre-therapy, patients had devalued the role of the other group members and, to some extent, themselves in terms of what they might contribute to therapy, and emphasized the importance of the therapist, claiming that the therapist would be responsible for the outcome of therapy, this suggesting considerable dependency on the therapist. At post-therapy, patients had become aware of, and acknowledged, the importance of their own

contribution to therapy and, although not devaluing the therapist and other group members, felt they themselves were responsible for therapy outcome; the difference between pre- and post-therapy being significant at the .01 level (one-tailed test).[1]

Three other Guttman scales were found to have altered to a significant level on application of the Kolomogorov-Smirnov two-sample test; each being significant at the .05 level (one-tailed test). Patients' attitude towards their problems had altered significantly, from patients reporting that they were unable to cope with problems, that they were unable to anticipate problems, and that they had more problems than others, to reporting, at post-therapy, that they felt more able to cope with problems, felt they had no more problems than other people, and that they were more able to anticipate where and when problems might arise and either take steps to avoid the problem or prepare themselves to meet the problem.[2]

The second Guttman scale which had altered significantly was the patients' assessment of the amount of decisions they made and how they thought others perceived them on this matter. At post-therapy, patients felt they had significantly fewer decisions to make than at pre-therapy, although the situations in which they had to make decisions had not altered. In addition, they felt the majority of other people had to make similar decisions, which was in contrast to their evaluation prior to therapy.[3]

The third Guttman scale which had altered to a significant degree was the patients' sense of personal freedom. At both pre- and post-therapy, the patients valued their personal freedom. However, at post-therapy, they felt they had significantly greater freedom than they had prior to group psycho-therapy. Also, the patients felt the amount of restrictions they had on their freedom had decreased.[4]

[1] $KD = 10$, $N = 15$ [2] $KD = 7$, $N = 15$ [3] $KD = 8$, $N = 15$ [4] $KD = 9$, $N = 15$

Of the four areas in which there had been significant alterations between pre- and post-therapy assessment, namely: the important factors in therapy and attribution of change at termination; attitude towards problems; amount of decisions; and freedom; the first is applicable especially to the group psychotherapy situation, while the latter three are applicable to both individual and group psychotherapy. Therefore, another avenue of further research would be to investigate the progress of patients in individual psychotherapy, adopting a similar procedure as in the present investigation, with a view to comparing the individual and group psychotherapy process.

Apart from changes in response to the interviews, patients' responses to the psychological tests also changed between pre- and post-therapy.

There has been considerable research focused on the effects of psychotherapy on the individual's expectancy for Internal or External control of reinforcement, arising from Rotter's (1954) suggestion that changing expectancy is a prime function of psychotherapy. Therefore, from the social learning viewpoint of Rotter, the purpose of therapy is to increase the patient's ability to solve his own problems; such a viewpoint being consistent with the theoretical orientation of the therapists who participated in the present study. Nevertheless, the findings of Harrow and Ferrante (1969), Gillis and Jesser (1970), Levenson (1973) in the psychotherapy situation, and the results of Dua (1970) and Park et al (1975) in the educational setting, all imply that Externality is related to poor psychological adjustment and that psychotherapy can be effective in modifying an individual's expectancy, such that patients improving with treatment tend to perceive themselves as having greater control over their lives. The present study was consistent with this, patients' response to Rotter's Internal-External Control Scale indicating a movement in the direction of Internality from pre- to post-therapy. As a whole, the present sample effectively modified their expectancy as a result of therapy.

However, those who modified their expectancy to a significant level were the patients who successfully completed group psychotherapy (t = 3.33, N = 8,significance level = .01).

Analysis of the semantic differential data revealed, in common with the research of Luria (1959), Dymond (1954), Dies and Hess (1970b), and Harder et al (1979), among others, that patients' self-concept, as measured by the semantic differential technique, altered to a significant degree as a result of group psychotherapy, on both the Evaluative and Potency factors. Patients had a more favourable attitude towards self and also perceived themselves as more capable. In addition, the connotative meaning of HOW I PERCEIVE MYSELF and MY IDEAL SELF became significantly more congruent as a result of therapy, although patients did not feel that others' attitude towards them had also altered.

However, data gathered from the Treatment Expectancies Questionnaire appears, initially, to be counter to the aforementioned results. At pre-therapy, there was no significant difference in responses to the TEQ between patients who subsequently either completed therapy successfully or terminated (t = 0.20, N = 15, NS), although patients who later completed therapy were more favourable to a psychological treatment orientation. But, comparison of such patients' responses at pre- and post-therapy revealed they were more favourable to a behavioural treatment orientation at post-therapy than they were prior to commencing group psychotherapy (t = 2.94, N = 8, significance level = .025).

As no other study has, to date, employed the TEQ in a pre- post research design, two tentative conclusions are advanced for the present result: first, the movement towards a behavioural treatment orientation may be peculiar to the present small sample or alternatively, patients' understanding of the etiology of their difficulties may not, ipso facto,

enable them to cope any more efficiently with these difficulties. If further research suggested that this result was not attributable only to the present sample and the second interpretation was adopted, it would tend to suggest that psychological therapy has two main factors: a cognitive one and a behavioural one. Within such a framework, group psychotherapy was found to be of limited behavioural efficacy in this investigation; such an interpretation being consistent with the social learning approach to psychotherapy which emphasizes the role of cognition in behaviour change (Mahoney (1974), (1977), and Kazdin (1979)).

As will be recalled, patients' attitude towards their problems changed significantly as a result of group psychotherapy and, taken in conjunction with the TEQ data, suggests the importance not only of therapy itself, but also the value of applying what is gained in therapy to everyday life. The present results indicate that, valuable though group psychotherapy was for patients in altering their attitudes in several respects, its effect on their lives outwith the group may have been rather limited, and indeed, was reported as such by both patients and therapists.

It is apparent, therefore, that patients did change as a result of group psychotherapy and this was reflected in their responses to the interviews and tests. To a lesser degree, they were also perceived to have changed by the other group members and the therapists.

Notwithstanding, the general conclusion to be drawn from this investigation must be that group psychotherapy is a particularly intricate and subtle form of human interaction which is dependent not only on treatment technique but also on the personal qualities and commitment each participant brings to the group and devotes to the group. It is also apparent from the results that there is no simple measure of what

happens in group psychotherapy not of what constitutes change in a patient. Change is clearly not uniform, and may vary both quantitatively and qualitatively between patients.

The present study has, however, emphasized the need to acknowledge the expectations of the patient and his attitude towards his forthcoming treatment as important variables in his commitment to therapy, his attendance, and the outcome of therapy for that patient. Further, not only must these factors be acknowledged, but it is suggested that they be taken into consideration when selecting patients for therapy. In addition, it is tentatively suggested that it may be possible to identify the potential terminator _prior_ to commencing group psychotherapy, based on his attitudes towards therapy in general and, more particularly, his expectations of his forthcoming therapeutic contact.

Nonetheless, the present investigation has numerous deficiencies, not least of which is a small sample and lack of experimental control. However, the aim was to describe rather than manipulate therapy, even although it could be argued that by asking the participants to focus on certain aspects of their experience manipulated the therapy process.

Bearing in mind such deficiencies, the obvious development from this research is to refine and develop the design with the aim not only of improving the selection of patients for this type of treatment, but also of maximizing the correct identification of the potential dropout. What is apparent, however, is the need to develop clearer and more straightforward formulations concerning the effects of more sharply delineated therapeutic interventions and the forces facilitating or impeding therapeutic change.

In the end, it is a significant human experience but knowledge of the ingredients of such an experience and how an optimal match between patients and therapist can be achieved is, as yet, very scant. Although it may not be possible to instrument it in a highly controlled and predictable way, the search would no doubt reveal the limitations of our approaches, the reasons for failures, and perhaps a better understanding of what, at least in principle, are the most promising conditions.

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APPENDICES

Patients' Reactions to the Death of the Group Therapist.

Introduction

The Present Study

Summary and Discussion

For the late Dr. Astor B. Sclare.

Introduction

The meaning of death is varied and may differ not only between individuals but also within the same person. The Concise Oxford Dictionary defines life as "a state of functional activity peculiar to organized matter" and defines death as "the end of life". Death and dying are not, however, merely biological events but possess psychological and social features. Our socially repressive orientation towards death promotes almost neurotic concerns about it, with death being voiced in whispered terms and viewed from as great a distance as possible. In addition, like the concept of life, death is relative to time and space. Rarely, however, does an individual die without someone having known him. Those who are left are often bereaved and can gain much support from their relatives and friends, despite the distress of the acute crisis of their loss.

It is perhaps because of this distress that studies of bereavement are few and far between. Not only are bereavement studies small in number, but they also predominantly report the bereavement reactions of widows (eg Parkes (1972), Hinton (1967), Levy and Sclare (1976)). In addition, bereavement studies tend to be biased towards instances where the death has been premature or unexpected (eg Dewald (1965), Rosenthal (1947), Alexander (1977)).

Nevertheless, there are several models of loss and mourning (eg. Gorer (1965), Lindemann (1944), Marris (1958) and Bowlby (1961)), each providing a conceptualization of mourning that proceeds from an initial stage of shock and disbelief through a period of disorganization and gradual working through to, in favourable cases, a state of healthy reorganization. The clinical significance of grief and suffering in mourning is well described; the absence or distortion of grief work being of etiological importance in a wide variety of psychiatric phenomena.

All models of mourning do, however, have the following common properties:

1. they identify mourning as a definite syndrome with a psychological and somatic symptomatology.

2. the bereaved tends to withdraw, often with loss of contact with reality, eg. inability to comprehend the loss, brooding over remains, etc.

3. the syndrome may appear immediately after the crisis; it may be delayed; it may be exaggerated or it may be apparently absent.

The extent to which the syndrome is expressed appears to be influenced by whether the death is unexpected or not. Although Bauer (1977) argues that death may be absolutely unexpected or only relatively unexpected with respect to the time of death, grief reactions have been found to be less intense if the bereaved are in some way prepared for the death, eg. prolonged illness beforehand or known disease. What this preparation involves is not clear, but several investigators have alluded to the dissolution of the social structure in which the person has been living and relinquishing of their bonds with the lost object (Wretmark (1959), Raphael (1978)). It is of note that the dead are regarded as "objects' in the literature, as distinct from people.

Studies of the process of mourning (eg. Parkes (1972), Levy and Sclare (1976)) indicate that the initial reaction tends to be one of numbness and stupefaction, sometimes of emotional relief. By four to eight weeks, the bereaved begin to express guilt feelings often feeling that they should have done more to prevent the death. Frequently there is anger against the deceased for having left them, or simply because the survivor's life has been altered. If the medical services have been involved, there is sometimes anger at the hospital or doctor for "not doing their job properly". Often the bereaved develop physical symptoms, eg. headaches, abdominal complaints, generalized aches, anorexia nervosa, hair loss, which not only accompany depression, but may develop further into psychosomatic disorders. Eissler (1976) found that prolonged

mourning is linked to gastro-intestinal complaints and Hinton (1967) has

found that ulcerative colitis, asthma, and other conditions have come on following

a bereavement. The final stage of readjustment is of such a variable nature

that it is not possible to put a time limit on it. For some individuals, it

may take months, while for others it may take years, for them to gain a new

identity for themselves.

Turning to what happens when a patient or therapist dies, only one

study could be found reporting the therapist's response to the sudden death of

a group member (Levinson (1972)), one of analysands', who were themselves

trainee analysts, reactions to the death of their analyst (Alexander (1977)),

and one of a group's reaction to the death of their therapist (Shwed (1980)).

In contrast, there is much psychoanalytic literature suggesting that many patients

continue in fantasy to maintain their relationships with their therapists

(Dewald (1965)), that loss is a recurrent and nuclear issue in psychotherapy

(Dumont (1966), Wolff (1977)), and that the reactions of psychoneurotics to

their therapist's death are manifested at the emotional level of development

reached in each of them (Rosenthal 1947)).

The question of whether psychoneurotics or psychotics react any

differently from so-called normals has been investigated. Bromberg and Schilder

(1936) found that neither neurosis nor psychosis produce an attitude which

cannot be found also in the so-called normal. But neurosis and psychosis can

bring specific attitudes clearer into the foreground. For instance, a prominent

fear in the neurotic is a dread of sudden death by himself or of a person who

is close to him. Many of the reactions to bereavement of so-called normals can be

regarded as bordering on neurotic in that they experience exaggerations of

common emotions or reactions of a more neurotic character. Therefore, that

elusive, perhaps non-existent, boundary between normal and neurotic feelings and

behaviour is even more difficult to determine in this context than it usually is.

Whether there are any sex differences in bereavement reactions, previous research suggests that there are no differences between how men and women react to bereavement. Eisler (1976), Clayton et al (1968) and Levy and Sclare (1976) all suggest that men and women experience the same bereavement symptoms.

The one study of most relevance to the present, describing a group's reaction to the sudden death of the therapist, is that of Shwed (1980). He found that, when the psychiatrist died, his patients reacted with shock and disbelief. Each member was encouraged to see another psychiatrist in the practice for supportive counselling and most accepted. During these sessions, the patients' responses ranged from hysterical disbelief to resigned acceptance. Despite some resistance to a new therapist continuing the group, most terminated within the next three years, having reached the stage of referring to the late therapist occasionally, but within a realistic context.

The Present Study

The present study arose out of a research project aimed at investigating:

a) patients' and therapists' expectations of themselves and each other before they start therapy, and

b) patients' and therapists' perceptions of themselves and each other throughout treatment,

in relation to outcome.

The progress of a group which had been under study came to an abrupt end when the therapist died unexpectedly. The therapist had been conducting groups for the previous 25 years and when he died, the present group had been meeting regularly for the past twelve months. At the time of the therapist's death, the group members had been at the stage of working through their problems

in the group setting and applying what they had learned in the group to their everyday lives, reporting back to the group how they were progressing.

The group itself was an outpatient, psychoneurotic group with no inpatient members and met for 1½ hours every week. At the time of the therapist's death, none of the members had been in the group for more than twelve months and it had been understood by all of them that the treatment term was to have been 18 months. In addition, no group member was receiving any medication concurrent with group therapy.

The theoretical orientation adopted by the therapist in the group was that of Foulkes' model: namely,that the group is the therapeutic medium and the therapist's task is that of nurturing its therapeutic potential by allowing the individuals in it to function increasingly as active and responsible agents themselves. Hence the individual is treated within the context of the group with the active participation of the group.

With regard to the objectives of the group, the therapist saw the aim of his group as being to encourage the individuals in it to attempt to resolve their current difficulties in the light of their previous life experiences through discussion with others similar to themselves. As such, the therapist felt there was a need for minimal participation on his part in an attempt to allow the group to work together.

The group meeting following the therapist's death.

Following the sudden death of the therapist, the author was approached by the group members individually and collectively, to try and arrange a group meeting as they had received no communication from the outpatient clinic regarding their future treatment. It was explained to them by the author that she had been a member of the group as a researcher, a fact made clear to them when she first joined the group, and was not employed by the Health Authority,

but she would try and find out the position.

The author contacted the outpatient clinic explaining the patients' concern and it was agreed that the author would conduct one group meeting, following which the group would be disbanded. The outpatient clinic felt it would be best if the group members contacted the clinic only if they really felt they needed to do so. No other form of continuous therapy - group or otherwise, was proposed by the clinic. The aims of this final group meeting were therefore twofold: to attempt to at least partially resolve the initial reactions of the group members to the death of the therapist, and to inform the group members that the group was going to be disbanded.

This meeting took place as usual in the late therapist's office and there were several recurrent themes which ran through the meeting:

1. the loss of a support system and the resultant isolation, e.g. "Part of me is now missing".

2. abandonment by the therapist of the patients as a group and as individuals, e.g."He's left us all behind".

3. anger at the outpatient clinic for disbanding the group, e.g. "No one cares in this hospital".

4. the work of the group was destroyed, e.g. "It has all been wasted".

5. guilt expressed about non-attendance at meetings and self-reproachment for behaviour in meetings, e.g. "It was selfish of me to be so childish at times".

6. uncertainty about their future welfare, e.g. "Where do we go from here?"

Following that group meeting, the members never met together again as a therapeutic group. Three members did keep in touch with each

Other for the next month, but thereafter, there was no contact among the members.

Within the overall framework of research, it was decided, given these developments, to investigate the patients' reactions to the therapist's death and subsequent adjustment to their new situation. Given the lack of research on this particular topic, the author developed an interview intended to explore aspects of bereavement reactions which studies of bereaved individuals in the general population (eg Parkes (1972), Clayton et al (1968), Gorer (1965)) had found to be important as well as areas the author felt might be relevant for the present situation.

At the therapist's death, there had been 12 group members, excluding the therapist and the author, nine of whom agreed to participate, at a later date, in the interview. Of the three "non-participators", one woman refused and two men could not be contacted.

Therefore, two months after the therapist's death, the six men and three women who had agreed to see the author, returned to the out-patient clinic to be interviewed individually. Each member participated in a semi-structured interview (see Appendix A.1) designed to investigate the following areas: their previous experience of bereavement, how they perceived their relationship with the late therapist, their preparedness for the therapist's death, their grief reaction, i.e. their emotional well-being following the death, the resolution of their grief reaction, identification with the late therapist, their physical well-being since the bereavement, contact with the other group members and/or the outpatient clinic, attitude towards self since the bereavement, and coping and the future.

Each interview was tape-recorded, to be transcribed and

analysed at a later date.

Treatment of the interview data and results.

As the research design being employed up till the therapist's death had been using Guttman Scale analysis for analyses of various interview protocols, it was decided to subject the bereavement interview data to the same type of analysis. The point of using Guttman Scale analysis is that, given a large amount of qualitative data from a small sample, Guttman Scale analysis can be used to modify such data into an Interval scale for basic statistical analyses. While Guttman(1944) argues that the responses to a scale have 85% or greater consistency to be a valid and reliable measure for a particular sample, in the present study, the criterion suggested by Edwards (1957) of 90% or greater consistency was adopted as a more conservative measure, given the small sample size.

Therefore, from the ten initial sections of the interview, ten possible scales were determined and subjected to Guttman Scale analysis in an attempt to indicate the consistency of the responses to the bereavement interview for the present sample. Of the ten possible scales, nine were found to have 100% consistency, while one had 89% consistency, as indicated in Figure 1.

Figure 1.: Guttman scales derived from the bereavement interview and their consistencies.

Guttman scale	Consistency
Perceived relationship with the late therapist	100%
Preparedness for the therapist's death	100%
Grief reaction	100%
Resolution of grief reaction	100%
Identification with the late therapist	100%
Physical well-being following the bereavement	100%
Contact with the other group members and/or the outpatient clinic	100%
Attitude towards self since bereavement	100%
Coping and the future	100%
Previous experience of bereavement	89%

(The Guttman scales derived from this analysis are in Appendix A.2).

Given the consistency of the scales, it is possible to discuss the content of each scale in detail.

Perceived relationship with the late therapist.

While eight out of the nine patients felt the therapist had been involved in their lives in a professional capacity, and one patient felt the therapist had not been involved at all, none of the patients perceived the realtionship they had had with the late therapist as that of "doctor and patient". Four men felt he had been a substitute father figure, two men felt he had been a brother to them, and the three women felt he had been a close friend. It is therefore not surprising to find the there was a relationship between how the patients perceived their relationship with the late therapist and how dependent they had felt on him. Six patients (three men and three women) felt they had been dependent on the therapist, while three men felt they had not been dependent on him.

Related to how the patients perceived their relationship with the late therapist and their dependence on him, was how prepared they felt they had been for the therapist's death.

Preparedness for the therapist's death:

The three women all felt they had lost an essential support system when the therapist died and wondered initially what would happen to themselves while one man, feeling he had also lost an essential support system, described his initial reaction as one of disbelief. The other five men also described their initial reaction as one of disbelief; one man was shocked that the therapist had died and four men did not want to accept the therapist's death.

Asked if they would have reacted any differently had the

therapist's death been anticipated, four patients (two men and two women) felt they would not have reacted any differently; the other five patients (four men and one woman) said they would have tried to prepare themselves for the separation and grief reaction.

Grief reaction:

Following an initial numbness and denial, both men and women in the present study had found themselves thinking about the late therapist, but there the similarity ended. Five out of the six men had found them- selves trying to avoid thinking about the late therapist as they had felt anxious or guilty about how they had behaved towards the therapist in the past, feeling that his death had caused them to become withdrawn or depressed. The three women, on the other hand, had not found themselves trying to avoid thinking about the late therapist, did not feel anxious or guilty about how they had behaved towards the late therapist, and did not feel that his death had caused them to become depressed or withdrawn.

Noting this difference and how important a role sympathy, condolences and other expressions of grief feelings are in our culture, there was also a striking difference in the way the patients resolved their grief.

Resolution of grief reaction:

While both the men and women had found themselves recollecing previous occasions with the therapist and felt that, in adjusting to their new situation, they had to play a greater role in determining their own lives, there was a difference in whether they allowed their feelings of grief to be seen by others and, indeed, shared with others.

All six men felt they had to hide their feelings from others. Asked why, they said it would have upset their families to think they could form such an emotional attachment to the therapist, perhaps even arousing jealousy in their relatives. In addition, four of the men felt it was

"unmanly" to show grief feelings. However, the three women did not feel they had to hide their feelings of grief from others and had been surprised at how much comfort it had brought them. In one instance, it had brought the patient emotionally closer than she had previously been to her family. Identification with the late therapist:

It transpired that all six men and one woman had found, subsequent to the therapist's death, when encountering problems, they had taken the solution they felt the therapist would have thought the best, described instances where they had felt the presence of the late therapist, or had thought they saw or heard him, and had not found themselves adopting any of the therapist's mannerisms.

In contrast, two women found, when encountering problems, they did not take the solution they thought the therapist would have suggested, and did not describe instances where they had felt the presence of the late therapist, or thought they had heard or seen him. However, they reported adopting the therapist's habit of parking close to vehicles - something which the group had previously teased the therapist about.
Physical well-being following the bereavement:

Turning to the physical well-being of the patients since the death, it was found that none of the patients had been attending their General Practitioner on a regular basis prior to the therapist's death. Subsequent to the therapist's death, three men had a recurrence of ulcerative colitis and had to receive attention from their doctor. It is of interest that these men had been referred from their G.P.'s to the therapist with ulcers, one of the presenting symptoms of their neurosis.

In contrast, none of the women in this study had to receive any attention from their G.P. after the death.
Contact with the other group members and/or the Outpatient Clinic:

While three group members (two men and one woman) had kept in

touch with each other for a short time after the therapist's death, all but one man did not contact the Outpatient Clinic. When asked about this, the patients expressed a range of emotions from disgust at the Clinic to anger at the way the group was disbanded, with no encouragement to seek supportive counselling from the other therapists. It is of note that the one patient who did go back to the clinic felt very dissatisfied with the session he had and subsequently never returned.

Attitude towards self since bereavement:

Given that the patients felt they had lost a father figure, someone who accepted them, or an advisor, it was interesting to note that six patients (three men and three women) felt they were letting themselves down and, when in need of assistance, were relying either on themselves or on their spouse. However, the other three men felt ashamed of how they treated the therapist prior to his death and had sought pity from others, feeling isolated with no one to turn to for help.

Related to this was how the patients felt they had coped since the therapist's death and how they perceived their future.

Coping and the future:

How the patients felt they had coped since the therapist's death and how they saw their future was also interesting. While four out of the six men felt they had coped well since the therapist's death, and two had coped badly, they all saw their future as trying to continue doing as they thought the therapist would have wanted them to do. In contrast, the three women felt they had coped badly, two were unsure of how they would proceed and one had decided to take greater control of her life.

Bearing in mind the differences found in response to the bereavement interview, it is of note that the one area covered which did not appear to be as significant for the present sample was the patients'

previous experience of bereavement.

Previous experiences of bereavement.

Three patients (two men, one woman) had not experienced the death of someone important in their lives or of a parent, either in childhood or more recently (excluding the therapist), one female patient experienced bereavement only in childhood and five patients (four men, one woman) had experienced bereavement both in childhood and more recently. However, all patients were agreed that their reactions to a bereavement varied enormously. It did not necessarily follow that the closer the deceased was to the patient, the more intense was their response to the death.

Summary and Discussion:

The present study has found that, in contrast to the findings of Clayton et al (1968) and Eissler (1976), that there may be a sex difference in how patients react to the therapist's death and their subsequent adjustment, with due reservations for the small sample involved in the present investigation.

The men in this study felt the relationship they had with the therapist prior to his death was one of father and child or that of brothers and, when the therapist died, they reacted by trying to avoid thinking about the therapist, feeling guilty for behaviour towards the therapist in the past and predominantly felt they had to hide their feelings from others, with the result they felt isolated and on their own. In addition, three men had a recurrence of psychosomatic illness which had been one of the reasons for their referral to the psychiatrist in the first instance.

The statement by Grõen (1947) that the onset of ulcerative colitis occurs at times of "acute love-loss and painful humiliation" may be of relevance to the current findings, but whether these patients'

ulcerative colitis was directly linked with the therapist's death or not, it is not possible to determine. The present study, like previous research, can only suggest that there may be a positive correlation between the onset or recurrence of psychosomatic illness and bereavement reaction. In addition, while the men in the sample felt they had "coped well" since the therapist's death, it appeared that to cope well meant to deny their grief reaction expression to others and to become withdrawn or depressed.

In contrast, the women in this study did not avoid thinking about the late therapist, did not hide their feelings of grief from others and, in general, appeared to allow the mourning process to run its course. They felt it was acceptable, and indeed beneficial, to express their grief and share their reaction with others, but it is of note that they felt they had coped badly since the death.

Admittedly, the present sample was small, but the influence our culture has on the behaviour of men and women in bereavement may be of relevance here. Some investigators (eg Dewald (1955), Malinak et al (1979))would argue that, despite the prevalence of men to try and appear "strong" by not showing grief, this can lead to pathology at a later date. On the other hand, it is acceptable for women to express their grief. It is of interest, however, that the women in the present study felt they had not coped well, suggesting perhaps that they were judging how they felt against the apparent behaviour they observed in the men.

Nevertheless, there were some similarities in the patients' reactions. Following an initial reaction of numbness and denial, there followed feelings of abandonment by the therapist who had been an important support system in their lives. Some patients felt rejected by the therapist and, in all cases, there was anger expressed at the Outpatient

Clinic for disbanding the group.

This anger may have acted as a catalyst in that they all felt they would have to play a greater role in determining their own lives - one of the original objectives of their therapy. In this instance, it would appear that the therapist's death and the disbandment of the group was an important therapeutic event for all the patients involved, not only for their own personal development, but also for the realization that doctors are not above personal illness and death, despite the fact many wish to believe in this fiction.

In conclusion, it would appear that the death of the therapist poses a powerful paradox: the "omnipotent rescuer" (Bernstein et al (1973)), who is perhaps uniquely equipped to assist with a crisis of such magnitude, not only can never do so again, but is indeed its cause. Bearing this in mind, the findings of the present study indicate the importance of some form of counselling or support for patients following the death of their therapist. Although the sample was small, there appeared to be a sex difference in bereavement reactions and suggests that such aid might require different objectives according to the sex of the patient. Obviously there are individual differences, but there would appear to be a need for further research initially to validate the present results and later to perhaps identify suitable forms of bereavement counselling.

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Bereavement Interview

Previous Experiences of Bereavement.

1. Did you experience the death of a parent of someone important
    to you when you were a child?
    If yes - How did you react? When did this take place?

2. Have you experienced the death of a parent or someone important
    to you more recently - apart from the therapist?
    If yes - How did you react? When did this happen?

Perceived Relationship with the Therapist.

3. What kind of relationship do you feel you had with the
    therapist?
    Why do you think this?

4. Do you think you were dependent on the therapist in any way?
    Why do you think this?

5. How involved do you think the therapist was with your life?
    Why do you think this?

Preparedness for the Therapist's Death.

6. How do you feel you were affected by the suddenness of the
    therapist's death?

7. What was your initial reaction to his death?
    Why do you think this was?

8. Do you think you would have acted differently had his death
    been anticipated?
    If yes - Why?

Grief Reaction

9. Have you found yourself thinking about the therapist at any
    time since his death?

10. Have you had any feelings of guilt about how you felt or
     behaved towards the therapist prior to his death?
     If yes - When? Why?

11. Have you found yourself anxious at any time about how you
     felt or behaved towards the therapist?
     If yes - When? Why?

12. Have you found yourself trying to avoid thinking about the
     therapist's death?
     If yes - When? Why?

13. Have you felt that the therapist's death has caused you to
     become depressed or withdrawn at any time?
     If yes - When? Why do you think this was?

Resolution of Grief Reaction.

14.   Do you feel you have had to hide your feelings from others?
        If yes - When? From whom? Why?

15.   Have you, at any time, recollected previous occasions with
        the therapist?
        If yes - When? Which ones? Why do you think these particular
        times?

16.   How do you feel you are adjusting to your new situation?
        Why do you think this?

Identification with the Therapist.

17.   Have you found that, at any times, when encountering problems,
        you have taken the solution you think the therapist would have
        chosen?
        If no - Why not?
        If yes - When? Which problems? What solution did you choose?
        Why? What were the alternatives?

18.   Have there been any instances where you have felt the presence
        of the therapist or have thought you saw or heard him?
        If yes - When? How did you react?

19.   Have you found yourself adopting any of the therapist's
        mannerisms?
        If yes - When? What?

Physical Well-Being following the Therapist's Death.

20.   Before the therapist's death, were you attending a doctor
        on a regular basis for any treatment?
        If yes - How often? What for?

21.   Have you had any physical problems develop since his death?
        If yes - What? When? Have you had these problems before
        at any time?

22.   Have you consulted a doctor at any time since the therapist's
        death?
        If yes - When? What for?

Contact with the other Group Members and/or the Outpatient Clinic.

23.   Have you been in touch with any of the other group members since
        the therapist's death?
        If yes - Who? When? Did you find it of help?

24.   Have you, at any time since the therapist's death, contacted
        the out-patient clinic?
        If yes - When? Who did you contact? Did you find it of help?

Attitude towards Self since Bereavement.

25.   How do you think the therapist's death has affected your
      life situation, e.g. do you find yourself turning towards your
      family or a friend for assistance, or not at all?

26.   How do you feel towards yourself since the therapist died?
      Why?

27.   Do you feel you have lost anything since his death?
      If yes - What? Why?

Coping and the Future.

28.   How do you feel you have coped since the therapist's death?
      Why?

29.   How do you think you will now proceed?
      Why? How?

APPENDIX A.2

Guttman scale analysis of bereavement interview

<u>Previous experiences of bereavement</u> - 89% consistency, interview questions 1,2.

56%   had experienced the death of a parent or other significant person to

      them in childhood and also more recently.

33%   had not experienced the death of a parent or other significant person

      to them in either childhood or more recently.

11%   had experienced the death of a parent or other significant person to

      them in childhood but not more recently.

<u>Perceived relationship with the late therapist</u> - 100% consistency, interview
questions 3, 4, 5.

45%   felt that the relationship they had with the late therapist was that of

      a father and child, that they were dependent on him for his support,

      but felt he was only involved in their lives from his professional

      standpoint of being a therapist.

22%   felt that the relationship they had with the late therapist was that of

      brothers, that they were dependent on him for his support, but felt he

      was only involved in their lives from his professional standpoint of

      being a therapist.

22%   felt that the relationship they had with the late therapist was that of

      friendship, that they were not dependent on him for his support, and

      felt he was only involved in their lives from his professional standpoint

      of being a therapist.

11%   felt that the relationship they had with the late therapist was that of

      friendship, that they were not dependent on him for his support, and felt

      that he was in no way involved in their lives.

<u>Preparedness for the therapist's death</u> - 100% consistency, interview questions
6, 7, 8.

45%   felt they had lost an essential support system when the therapist died,

      described their initial reaction as one of disbelief, and felt they would

      not have reacted any differently if the therapist's death had been

      anticipated.

22%   felt they did not want to accept that the therapist had died, described

        their initial reaction as one of disbelief, and felt they would have

        reacted differently if the therapist's death had been anticipated.

22%   felt they did not want to accept that the therapist had died, described

        their initial reaction as one of wondering what would happen to themselves,

        and felt they would have reacted differently if the therapist's death

        had been anticipated.

11%   felt shocked by the therapist's death, described their initial reaction

        as one of wondering what would happen to themselves, and felt they would

        have reacted differently if the therapist's death had been anticipated.

Grief reaction - 100% consistency, interview questions 9, 10, 11, 12, 13.

56%   had found themselves thinking about the late therapist since his death,

        did not have any feelings of guilt about how they had felt or behaved

        toward the late therapist, nor had they felt anxious about how they

        had felt or behaved toward the late therapist, had not found themselves

        trying to avoid thinking about the late therapist, and did not feel that

        his death had caused them to become depressed or withdrawn.

22%   had found themselves thinking about the late therapist since his death,

        did not have any feelings of guilt about how they had felt or behaved

        toward the late therapist, nor had they felt anxious about how they felt

        or behaved toward the late therapist, but they had found themselves trying

        to avoid thinking about the late therapist, and felt his death had caused

        them to become depressed or withdrawn.

22%   had found themselves thinking about the late therapist since his death,

        had feelings of guilt about how they had felt or behaved toward the late

        therapist, had also felt anxious about how they had felt or behaved toward

        the late therapist, had found themselves trying to avoid thinking about

        the late therapist, and felt his death had caused them to become depressed

        or withdrawn.

Resolution of grief reaction - 100% consistency, interview questions 14, 15, 16.

45%   felt they had to hide their feelings of grief from others, had found themselves recollecting previous occasions with the late therapist, and felt that, in adjusting to their situation, they had come to the realization that they had to cope on their own.

33%   felt they did not have to hide their feelings of grief from others, had found themselves recollecting previous occasions with the late therapist, and felt that, in adjusting to their situation, they had to come to grips with themselves before they could manage to cope.

11%   felt they did not have to hide their feelings of grief from others, had found themselves recollecting previous occasions with the late therapist, and felt that, in adjusting to their situation, they had come to the realization that they had to cope on their own.

11%   felt they had to hide their feelings of grief from others, had found themselves recollecting previous occasions with the late therapist, and felt that, in adjusting to their situation, the loss was too great for them to adjust to.

Identification with the late therapist -   100% consistency, interview questions 17, 18. 19.

56%   had found that, when encountering problems, they had taken the solution they thought the late therapist would have chosen, described instances where they had felt the presence of the late therapist, or had thought they saw or heard him, and had not found themselves adopting any of the late therapist's mannerisms.

22%   had found that, when encountering problems, they had taken the solution they thought the late therapist would have chosen, described instances where they had felt the presence of the late therapist, or thought they saw or heard him, and had found themselves adopting some of the late therapist's mannerisms.

11%   had not found that, when encountering problems, they had taken the

        solution they thought the late therapist would have chosen, did not

        describe instances where they felt the presence of the late therapist,

        or had thought they saw or heard him, and had not found themselves

        adopting any of the late therapist's mannerisms.

11%   had found that, when encountering problems, they had taken the solution

        they thought the late therapist would have chosen, did not describe

        instances where they had felt the presence of the late therapist, or

        had thought they saw or heard him, and had not found themselves adopting

        any of the late therapist's mannerisms.

Physical well-being -100% consistency, interview questions 20, 21, 22.

67%   had not been attending their GP on a regular basis prior to the

        therapist's death, had no physical problems develop since the

        therapist's death, and had not consulted their GP since the therapist's

        death.

33%   had not been attending their GP on a regular basis prior to the

        therapist's death, did have physical problems develop since the

        therapist's death, and had consulted their GP about these problems

        since the therapist's death.

Contact with the other group members and/or the outpatient clinic - 100%

consistency, interview questions 23, 24.

67%   had not been in touch with any of the other group members nor had they

        contacted the outpatient clinic since the therapist's death.

22%   had been in touch with some of the other group members but had not

        contacted the outpatient clinic since the therapist's death.

11%   had been in touch with some of the other group members and had also

        contacted the outpatient clinic since the therapist's death.

Attitudes toward self since bereavement - 100% consistency, interview questions

25, 26, 27.

23%   felt they were relying on their spouse for assistance since the

        therapist's death, felt they were having to be objective with themselves

as they felt they were letting themselves down, and felt they had lost a father figure.

22%   felt they were having to rely on themselves since the therapist's death, felt they were having to be objective with themselves as they felt they were letting themselves down, and felt they had lost an advisor.

22%   felt they were isolated with no one to turn to for assistance since the therapist's death, felt they were having to be objective with themselves as they felt they were letting themselves down, and felt they had lost a father figure.

11%   felt they were isolated with no one to turn to for assistance since the therapist's death, felt sorry for themselves and sought pity, and felt they had lost a father figure.

11%   felt they were having to rely on themselves since the therapist's death, felt ashamed of how they had treated the therapist when alive, and felt they had lost someone who accepted them.

11%   felt they were having to rely on themselves since the therapist's death, felt ashamed of how they had treated the therapist when alive, and felt they had lost an advisor.

Coping and the future -100% consistency, interview questions 28, 29.

45%   felt they had coped well since the therapist's death, and said they would continue to try and do what they thought the therapist would have wanted them to do.

33%   felt they had coped badly since the therapist's death, and said they did not know how they would continue.

11%   felt they had coped badly since the therapist's death, and said they would now have to transfer responsibility for themselves onto themselves.

11%   felt they had coped well since the therapist's death, and said they would now have to transfer responsibility for themselves onto themselves.

Patient Interview before Group Therapy.

Knowledge of Group Psychotherapy.

1. Have you tried to find out about group therapy?
    (If yes: How? What did you find)
    (If no: Why not?)

2. Do you think group therapy can help people?
    (If yes: In what ways? Why?
    (If no: Why not?).

3. Have you been in any therapy groups before?
    (If yes: When? Did it help you?)

4. Is there something about group therapy which appeals to you
    as a form of help?
    (If yes: What? Why?)
    (If no: Why not?)

5. Do you feel you know all you need to know about group therapy?
    (If yes: Why?)
    (If no: Why not?)

6. Do you think the therapist should tell you more about what happens
    in group therapy?
    (If yes: Why? What kind of information do you think you should
     be told?)
    (If no: Why not?)

7. Do you feel the therapist has added anything to what you already know
    about group therapy?
    (If yes: What?)

8. Have you discussed what group therapy is with someone other than
    the therapist?
    (If yes: Who? Why? Did you find it helpful?)
    (If no: Why?)

Expectations of Group Psychotherapy.

9. Do you think there are going to be people similar to yourself in
    the group meetings?
    (If yes: Why?)
    (If no: Why not?)

10. Do you think you will learn anything about yourself from the group
    meetings?
    (If yes: How? What do you think you will learn?)
    (If no: Why not?)

11. Do you see yourself as having to work hard when in the group?
    (If yes: Why? In what ways? With what aim?)
    (If no: Why not?)

12. Do you think the group will be able to solve your problems?
    (If yes: Why? How?)
    (If no: Why not?)

13. Do you feel that group therapy will alter your life?
    (If yes: How? Why?)
    (If no: Why not?)

14. How do you think the therapist will be in the group, e.g. like
    a teacher, doctor, friend, etc.?
    (Why?)

15. Is that how you would like him to be?
    (If yes: Why?)
    (If no: Why not?)

16. Do you think it is an important part of therapy that the patients
    feel the therapist has control over what happens in the group?
    (If yes: Why?)
    (If no: Why not?)

17. How do you think you may be affected by some of the things that
    will happen to you in the group, e.g. upset, surprised, etc.?
    (Why?)

18. Do you think you will have to reveal your "true self" in the group?
    (If yes: Why?)
    (If no: Why not?)

19. Do you think you will keep some things to yourself in the group?
    (If yes: Why? What kinds of things?)
    (If no: Why not?)

20. Do you think you would prefer another type of treatment?
    (If yes: Why? What would you prefer?)
    (If no: Why not?)

21. How do you feel about joining a group, e.g. nervous, happy,
    excited, etc.?
    (Why?)

Subjective Adjustment

22. Do you think you lead a normal life?
    (If yes: How? Why do you think this?)
    (If no: Why not?)

23. Do you think others see you as leading a normal life?
    (If yes: How? Why do you think this?)
    (If no: Why not?)

24. Do you feel you get on well with other people?
    (If yes: What makes you think so?)
    (If no: Why not? What makes you think this?)

25. Do you feel you have the number of friends you would like to
    have, would you like more, or would you like fewer friends?
    (Why?)

26. Do you feel you need to alter your lifestyle from what it is at
    present?
    (If yes: Why? What would you alter? How would you go about
    doing this?)
    (If no: Why not? Are you happy with it the way it is?)

27. Do you feel that others think you should alter your lifestyle
    from what it is at present?
    (If yes: Why? In what ways?)
    (If no: Why not?)

28. Do you see yourself as being an "ill" person?
    (If yes: Why? How?)
    (If no: Why not?)

29. Would you like to be different from how you are?
    (If yes: Why? How?)
    (If no: Why not?)

Future and Planning

30. Do you think about your future?
    (If yes: Why? Does it appeal to you? In what ways?)
    (If no: Why not?)

31. Do you plan ahead in your everyday life?
       (If yes: Why? In whay ways? Does it help you?)
       (If no: Why not?)

32. Do you think others see you as someone who plans ahead?
    (If yes: How? In what ways?)
    (If no: Why not?)

Locus of Control

33. Do you feel you control what happens to you in life or that
    it is controlled by some other source?
    (Why do you think this?)

34. Do you feel that sometimes you do not have enough control over
    the direction your life is taking?
    (If yes: Why? In what ways do you feel this?)
    (If no: Why not?)

Freedom

35. Do you value your freedom?
    (If yes: Why?)
    (If no: Why not?)

36. Do you feel you have much freedom?
    (If yes: Why?)
    (If no: Why not?)

37. Do you feel you have many restrictions on your freedom?
    (If yes: Why?)
    (If no: Why not?)

Decision-making

38. Do you feel you have to make many decisions every day?

39. Do you find it difficult to make decisions?
     (If yes: Why? What kind do you feel most difficult?)
     (If no: Why not?).

40. Would you prefer if someone else made your decisions for you?
     (If yes: Why?)
     (If no: Why not?)

41. Do you feel you have to make more decisions than other people, less
     decisions than others, or about the same?
     (Why?)

42. Do you think others see you as someone who has to make many or few
     decisions?
     (Why?)

Responsibility

43. In general, do you feel you have a lot of responsibilities, e.g.
     at home, at work, etc.?
     (If yes: Why?)
     (If no: Why not?)

44. What would you consider yourself responsible for?
     (Why?)

45. How do you think this compares with other people?
     (Why?)

46. Do you think others see you as having responsibilities, e.g. at
     home, at work, etc.?
     (If yes: Why?)
     (If no: Why not?)

Independence and Dependence

47. Do you think you are an independent person?
     (If yes: Why? In what ways?)
     (If no: Why not?)

48. Do you think others see you as being independent?
     (If yes: Why? In what ways?)
     (If no: Why not?)

49. Do you like doing things on your own?
     (If yes: Why? What kinds of things?)
     (If no: Why not?)

50. Do you like having people around you most of the time?
     (If yes: Why?)
     (If no: Why not?)

51. Which do you prefer - doing things on your own or being with others?

52. Is this from choice?

53. Do you think that you are sometimes too dependent on others?
     (If yes: Why? On whom? In what ways?)
     IIf nò: Why not?)

54. Do you think this is about the same for other people too?
(If yes: Why?)
(If no: Why not?)

Problem Handling

55. Do you find that problems often crop up in your everyday life,
e.g. at home, work, etc.?

56. How do you feel you cope when problems arise?
(Why?)

57. Do you find you sometimes need help in dealing with problems?
(If yes: Why is this, do you think?)
(If no: Why not?)

58. If you see a problem arising, do you wait till it occurs or take
measures to prevent it?
(Why?)

59. Would you describe yourself as someone who goes "looking" for
problems?
(If yes: Why?)
(If no: Why not?)

60. Do you sometimes feel that your problems are the result of fate?
(Why?)

61. Do you think that the majority of other people have similar
problems to you?
(Why?)

62. Do you seem to have more problems, less problems, or about the same
problems as you used to have?
(Why is this, do you think?)

Expectations for After Termination of Therapy.

63. Do you think you will change as a result of group therapy?
(If yes: Why?)
(If no: Why not?)

64. Would you like to change?
(If yes: Why? In what ways would you like to change?)
(If no: Why not?)

65. Do you think others would like to see you change?
(If yes: How? In what ways?)
(If no: Why not?)

66. Do you feel it is important for you to get something out of therapy?
(If yes: Why? What?)
(If no: Why not?)

67. Do you think you will have an important part to play as to whether
group therapy helps you or not?
(Why?)

68.   Do you think the therapist will have an important part to play
as to whether group therapy helps you or not?
(Why?)

69.   Do you think the other group members will have an important part
to play as to whether group therapy helps you or not?
(Why?)

70.   To who or what do you think you will attribute how you are
after having been to therapy?
(Why?)

Patient Interview during Group Therapy*

*at eight week intervals.

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1. Since I saw you last, what do you think has been happening
    in the group meetings?
    (Why?)

2. Do you think anything has happened to you?
    (If yes: What? How?)
    (If no: Why not?)

3. Do you feel that you are getting anything out of the group
    meetings?
    (If yes: What? How?)
    (If no: Why not?)

4. How about the other members - do you think they are getting something
    out of the group meetings?
    (If yes: Who? What? How?)
    (If no: Why not?)

5. Do you feel the group meetings are doing what you thought they
    would do?
    (If yes: Can you expand on this?)
    (If no: Why not?)

6. Do you feel that some people are participating more so than others
    in the group meetings?
    (If yes: Who? Why do you think this?)
    (If no: Why not?)

7. Do you think there are any leaders in the group?
    (If yes: Who? Why?)
    (If no: Why not?)

8. Do you see yourself as a leader in the group?
    (If yes: Why? How?)
    (If no: Why not?)

9. Are you enjoying the group meetings?
    (Why?)

Patient Interview at termination of Group Therapy

Knowledge of group psychotherapy

1. Do you think the therapist should have told you more about what
    happens in group therapy?
    (If yes: Why? What kind of information do you think you should have
                    been told?)
    (If no: Why not?)

2. What do you think people should know before coming to group therapy?
    (Why?)

3. In retrospect, do you feel you were told enough about group therapy
    before coming to the first meeting?
    (Why?)

4. Did you discuss what was happening in the group with others outside
    the group?
    (If yes: Who? Why? Did you find it of help?)
    (If no: Why not?)

Fulfilment of initial expectations of group therapy

5. Do you think that there were people similar to you in the group?
    (If yes: Why?)
    (If no: Why not?)

6. Do you think you learned about yourself in the group meetings?
    (If yes: How? What do you think you learned?)
    (If no: Why not?)

7. Do you see yourself as having had to work hard when in the group?
    (If yes: Why? In what ways? With what aim?)
    (If no: Why not?)

8. Do you think the group was able to solve your problems?
    (If yes: Why? How?)
    (If no: Why not?)

9. Do you feel that group therapy has altered your life?
    (If yes: Why? How?)
    (If no: Why not?)

10. How do you think the therapist was in the group, e.g. like a teacher,
    friend, doctor, etc.?
    (Why do you think this?)

11. How did you think the researcher was in the group?
    (Why do you think this?)

12. Do you think it was an important part of therapy for patients to
    believe that the therapist had control over what happened in the group?
    (If yes: Why?)
    (If no: Why not?)

13. How do you think you were affected by some of the things that
    happened to you in the group, e.g. surprised, upset, etc.?
    (Why?)

14. Do you think that you revealed your true self in the group?
    (If yes: Why? In what ways?)
    (If no: Why not?)

15. Do you think you kept some things to yourself in the group?
    (If yes: Why? What kind of things?)
    (If no: Why not?)

16. In retrospect, do you think you would have preferred another kind
    of treatment?
    (If yes: Why? What would you have preferred?)
    (If no: Why not?)

17. Do you think, if given a choice, you would go to group therapy again?
    (If yes: Why?)
    (If no: Why not?)

18. Would you encourage someone with problems similar to your own to go
    to group therapy?
    (If yes: Why?)
    (If no: Why not?)

Subjective adjustment

19. Do you think that you lead a normal Life?
    (If yes: How? Why do you think this?)
    (If no: Why not?)

20. Do you think others see you as leading a normal life?
    (If yes: How? Why do you think this?)
    (If no: Why not?)

21. Do you feel you get on well with other people?
    (Why do you think this?)

22. Do you feel you have the number of friends you would like to have?
    Would you like more, or would you like fewer?
    (Why?)

23. Do you feel you have altered your lifestyle at all from what it was
    before joining the group?
    (If yes: Why? In what ways? How has this come about?)
    (If no: Why not?)

24. Do you feel that others thought you should alter your lifestyle from
    what it was?
    (If yes: Why?)
    (If no: Why not?)

25. Did you see yourself as being an "ill" person?
    (If yes: Why?)
    (If no: Why not?)

26. Do you see yourself now as being an "ill" person?
    (If yes: Why?)
    (If no: Why not?)

27. Do you think others saw you as being an "ill" person?
    (If yes: Why?)
    (If no: Why not?)

28.   Do you think others see you now as being an "ill" person?
      (If yes: Why?)
      (If no: Why not?)

Perception of change

29.   Do you think you have changed as a result of group therapy?
      (If yes: Why? How? In what ways?)
      (If no: Why not?)

30.   Did you want to change?
      (If yes: Why? In what ways?)
      (If mo: Why not?)

31.   Do you think others wanted you to change?
      (If yes: Why? How? In what ways?)
      (If no: Why not?)

32.   Was it important for you to get something out of therapy?
      (If yes: Why? What?)
      (If no: Why not?)

33.   Do you think you had an important part to play as to whether
      group therapy helped you or not?
      (If yes: Why? How?)
      (If no: Why not?)

34.   Do you think the therapist had an important part to play as to
      whether group therapy helped you or not?
      (If yes: How? Why?)
      (If no: Why not?)

35.   Do you think the other group members had an important part to
      play as to whether group therapy helped you or not?
      (If yes: How?   Why?)
      (If no: Why not?)

36.   To who or what do you attribute how you are after having been to
      the group?
      (Why?)

Future and planning

37.   Do you think about your future?
      (If yes: Why? Does it appeal to you?)
      (If no: Why not?)

38.   Do you plan ahead in your everyday life?
      (If yes: In what ways? Does it help you?)
      (If no: Why not?)

39.   Do you think others see you as someone who plans ahead?
      (If yes: How? In what ways?)
      (If no: Why not?)

Locus of Control

40.   Do you think you control what happens to you in life or that it is
      controlled by some other source?
      (Why do you think this?)

41. Do you feel that sometimes you do not have enough control over
the direction your life is taking?
(Why?)

Freedom

42. Do you value your freedom?
(If yes: Why?)
(If no: Why not?)

43. Do you feel you have much freedom?
(If yes: Why?)
(If no: Why not?)

44. Do you feel you have many restrictions on your freedom?
(If yes: Why? In what ways?)
(If no: Why not?)

Decision-making

45. Do you feel you have to make many decisions every day?

46. Do you find it difficult to make decisions?
(If yes: Why? What kind do you find most difficult?)
(If no: Why not?)

47. Would you prefer if someone else made your decisions for you?
(If yes: Why?)
(If no: Why not?)

48. Do you feel you have more decisions to make, less, or about the
same as other people?
(Why?)

49. Do you think others see you as having to make many or few
decisions?
(Why?)

Responsibility

50. In general, do you think you have many responsibilities at home,
at work, etc.?
(If yes: Why?)
(If no: Why not?)

51. In general, what would you consider yourself responsible for at
home, at work, etc.?

52. How do you think this compares with other people?
(Why?)

53. Do you think others see you as having many responsibilities?
(If yes: Why? In what ways?)
(If no: Why not?)

Independence and Dependence

54. Do you think you are an independent person?
(If yes: Why? In what ways?)
(If no: Why not?)

55. Do you think others see you as being an independent person?
     (If yes: Why? In what ways?)
     (If no: Why not?)

56. Do you like doing things on your own?
     (If yes: Why? What kinds of things?)
     (If no: Why not?)

57. Do you like having people around you most of the time?
     (If yes: Why?)
     (If no: Why not?)

58. Which do you prefer - being on your own or with others?
     (Why?)

59. Is this from choice?

60. Do you think you are sometimes too dependent on others?
     (If yes: Why? Who?)
     (If no: Why not?)

Problem-Handling

61. Do you find problems often arise in your everyday life, at home,
     at work, etc.?

62. How do you feel you cope when problems arise?
     (Why?)

63. Do you find you sometimes need help in dealing with them?
     (Why?)

64. If you see a problem arising, do you wait till it happens or take
     measures to try and prevent it?
     (Why?)

65. Would you describe yourself as someone who goes "looking" for
     problems?
     (If yes: Why?)
     (If no: Why not?)

66. Do you sometimes feel that your problems are the result of fate?
     (Why?)

67. Do you think that the majority of people have similar problems to you?
     (If yes: Why?)
     (If no: Why not?)

68. Do you seem to have more problems, the same, or fewer than you used to?
     (Why is this do you think?)

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Follow-up Interview for Group Psychotherapy Patients

1.   Have you had any recurrence of the problems that initially brought
      you to the therapist?

2.   Have you seen the therapist since you terminated therapy for help?

3.   How do you think you have coped since you terminated therapy?

4.   Six months after termination, do you see your treatment as
      having been successful?

Therapist Interview before Group Therapy

Discussion of each patient.

1. Do you think this patient will attend the group meetings regularly?
    (If yes: Why?)
    (If no: Why not?)

2. Do you think group therapy is the most suitable treatment for this
    patient, irrespective of what is available in this hospital?
    (If yes: Why?)
    (If no: Why not?)

3. How would you describe the problems of this patient at present?

4. What would you like to see happen to this patient as a result of
    group therapy?
    (Why?)

5. What do you think you will see happen to this patient as a result
    of group therapy?
    (Why?)

6. How do you think this patient will participate in the group?
    (Why?)

7. Do you think you personally can help this patient?
    (If yes: Why? How?)
    (f no: Why not?)

8. If group psychotherapy was not available, what might you have
    suggested for this patient, given the full spectrum of alternatives
    rather than what is available in this hospital?
    (Why?)

Training of the Therapist

9.   How would you describe your approach to group psychotherapy?

10. Is this based on your training?

11. What was your training?

12. Do you feel you are successful as a therapist?
     (If yes: Why? What makes you think so?)
     (If no: Why not?)

Role adoption   by the therapist.

13. What kind of role would you like to adopt in the group?
     (Why?)

14. What kind of role do you think you will adopt in the group?
     (Why?)

15. Are there any patients you feel you might be able to help moreso
     than others in the group?
     (If yes: Who? Why? How?)

Personal expectations of the therapist.

16. Do you think you might personally change as a result of the group
     meetings?
     (If yes: Why? How?)
     (If no: Why not?)

17. Do you feel you might learn about yourself as a result of the
     group meetings?
     (If yes: Why? What? How?)
     (If no: Why not?)

Therapist's locus of control.

18. Do you think you control what happens to you in life or that
     it is controlled by some other source?
     (Why?)

19. Do you feel you sometimes do not have enough control over the
     direction your life is taking?
     (Why?)

Therapist Interview during Group Therapy*

*at eight week intervals

1. Do you think that each patient is benefitting from the group
   meetings?
   (If yes: How? In what ways?)
   (If no: Why not?)

2. Do you feel that the group meetings are achieving what you thought
   they would achieve with each patient?
   (Why?)

3. Are the patients as you thought they would be in the group meetings?
   (Why?)

4. Do you feel that some patients are participating moreso than others
   in the group meetings?
   (If yes: Who? Why?)

5. Do you think there are any leaders in the group?
   (If yes: Who? Why?)
   (If no: Why not?)

6. Do you see yourself as a leader in the group?
   (If yes: Why? How?)
   (If no: Why not?)

7. Do you feel that you, personally, are getting something out of the
   group meetings?
   (If yes: What? How?)
   (If no: Why not?)

8. Are you enjoying the group meetings?

9. How do you see your role in the group meetings?

Therapist Interview at termination of Group Therapy

Discussion of each patient

1.   Do you feel that each patient has changed since joining the group?
     (If yes: Why? How?)
     (If no: Why not?)

2.   Do you feel satisfied with each outcome?
     (If yes: Why?)
     (If no: Why not?)

3.   Are these outcomes what you would have liked?
     (If yes: Why?)
     (If no: Why not?)

4.   Are these outcomes what you would have expected?
     (If yes: Why?)
     (If no: Why not?)

5.   How important a role do you think you, the other group members, and the
     group experience, played in the outcome for each patient?
     (Why?)

6.   In retrospect, is there anyone you would now have rather offered
     an alternative form of treatment?
     (If yes: Who? Why? What would you suggest?)

7.   Do you feel that group therapy was the most suitable treatment
     for each patient?

8.   How do you think each patient participated in the group?
     (Why?)

9.   Are there any patients you feel may require help of this nature again
     in the future?
     (If yes: Who? Why? What for?)

Personal expectations of the therapist

10. Do you feel you have changed as a result of the group?
     (If yes: Why? How?)
     (If no: Why not?)

11. Do you feel you have learned anything about yourself as a result of
     the group?
     (If yes: What? Why?)
     (If no: Why not?)

Therapist's locus of control

12. Do you feel you control what happens to you in life or that it is
     controlled by some other source?
     (Why?)

13. Do you feel that sometimes you do not have enough control over the
     direction your life is taking?
     (Why?)

Role adaptation by the therapist

14. What kind of role do you think you adopted in the group?
     (Why?)

15. Is this the kind of role you wanted to adopt?

16. Are there any patients you feel you have been able to help moreso
     than others in the group?
     (If yes: Who? How? Why?)

Guttman Scale Analysis of Patient Interview before Group Psychotherapy*.

*Note: this analysis is based on Groups 1 and 2, N = 15.

<u>Information Seeking</u>:   100% consistency, interview questions, 1, 8.

53%   did not try to find out about group therapy and did not discuss

            group therapy with anyone other than the doctor.

40%   did not try to find out about group therapy but did discuss group

            therapy with some one other than the doctor.

 7%   did try and find out about group therapy and did discuss group

            therapy with someone other than the doctor.

<u>Effect of the Group on one's Life and Alternative Treatment</u>: 100 % consistency,

interview questions 13, 20.

46%   did not feel that group therapy would change their lives and thought

            they would prefer another type of treatment.

40%   felt group therapy would change their lives and felt they would not

            prefer another type of treatment.

14%   felt that group therapy would change their lives but that they would

            prefer another type of treatment.

<u>Expectations of Self in the Group:</u>   93% consistency, interview questions

10, 11.

53%   felt they would learn about themselves in the group meetings and

            that they would have to work hard when in the group.

33%   felt they would not learn about themselves in the group meetings and

            that they would not have to work hard when in the group.

14%   felt they would learn about themselves in the group meetings but they

            would not have to work hard when in the group.

<u>Expected Emotional Involvement in the Group:</u>   93% consistency, interview

questions 17, 18, 19.

30%   felt they would be upset by some of the things that might happen to

            them in the group, did not think they would have to reveal their real

            self when in the group, and felt they would keep some things to

            themselves in the group.

28%   felt they would experience a wealth of emotions by some of the things

            that might happen to them in the group, thought they would have to

            reveal their real self when in the group, but would try to keep some

            things to themselves in the group.

14%   felt they would be affected adversely by some of the things that might

happen to them in the group, felt they would have to reveal their real

self when in the group, but would try to keep some things to themselves

in the group.

14%   felt they would be surprised by some of the things that might happen

to them in the group, did not think they would have to reveal their

real self when in the group, and did not think they would keep some

things to themselves in the group.

7%   felt they would be surprised by some of the things that might happen

to them in the group, did not think they would have to reveal their

real self in the group, but did not think they would keep some things

to themselves in the group.

7%   felt they would be upset by some of the things that might happen to

them in the group, felt they would not have to reveal their real self

when in the group, and felt they would keep some things to themselves

in the group.

Normality (self and others' perception of self): 93% consistency, interview

questions 22, 23.

49%   did not think that they lead a normal life and did not think others see

them as leading normal lives.

37%   felt they do lead normal lives and that others see them as leading

normal lives.

14%   did not think they lead a normal life, but others see them as leading

a normal life.

Need to Alter Lifestyle (self and others' perception of self):   93% consistency,

interview questions 26, 27.

86%   felt they needed to alter their lifestyle from what it is at present

and that others think they should alter their lifestyle from what it is

at present.

7%   felt they did not need to alter their lifestyle from what it is at

present and did not think that others felt they should alter their life-

style from what it is at present.

7%   felt they needed to alter their lifestyle from what it is at

present but did not think that others felt they should alter their

lifestyle from what it is at present.

Difficulties in Decision Making and Preference for Another Person to Decide:

93% consistency, interview questions 39, 40.

49%   found it difficult to make decisions and would prefer if someone else

made the decisions for them.

36%   did not find it difficult to make decisions and would not prefer if

someone else made the decisions for them.

21%   found it difficult to make decisions but would not prefer it if

someone else made the decisions for them.

Independence (self and others' perception of self):   93% consistency,

interview question 47, 48.

50%   felt they were an independent person and that others saw them as

independent.

36%   did not see themselves as independent people and did not think that

others saw them as independent people.

14%   did not see themselves as independent people; but felt others saw

them as independent people.

Group Dependency and Company Preference: 93% consistency, interview

questions 49, 50, 51, 52.

37%   liked doing things on their own, liked having people around them

most of the time, but their preference was being with other people

rather than on their own - this preference being from their own choice.

21%   did not like doing things on their own, did not like having people

around them most of the time, but their preference was being on their

own rather than with other people - this preference being of their

own choice.

21%   liked doing things on their own, did not like having people around

them most of the time, but their preference was being on their own rather

than with other people - this preference being of their own choice.

14%   liked doing things on their own, liked having people around them
      most of the time, but their preference was being on their own rather
      than with other people - this preference being from choice.

7%   did not like doing things on their own, did not like having people
      around them most of the time, but their preference was being on their
      own rather than with other people - this preference not being of their
      own choice.

Use and Abuse of Group Therapy and Previous Experience in Groups: 93%

consistency, interview questions 2, 3, 4.

44%   did think group therapy could help people, felt that group therapy
      appealed to them as a form of treatment, and had not been in any
      group before.

21%   did think group therapy could help people, felt that group therapy
      appealed to them as a form of treatment, and had been in groups before.

21%   thought that group therapy could help people, did not feel that
      group therapy appealed to them as a form of treatment, and had not
      been in any groups before.

14%   did not think that group therapy could help people, did not feel
      that group therapy appealed to them as a form of treatment, and had
      not been in any groups before.

Expectations of the Group Situation: 93% consistency, interview questions

9, 21.

65%   did not think that there would be people similar to themselves in
      the group meetings, and felt apprehensive about joining a group.

14%   thought there would be people similar to themselves in the group
      meetings, and felt apprehensive about joining a group.

7%   felt there would be people similar to themselves in the group
      meetings, and felt curious about joining a group.

7%   felt there would be people similar to themselves in the group meetings,
      and felt frightened about joining a group.

7%   felt there would be people similar to themselves in the group

      meetings, but felt they themselves did not want to join a group.

Expectations of the Therapist in the Group: 93% consistency, interview,

questions 14, 15, 16.

37%   saw the therapist as an advisor, wanted him in that role, and felt

      it important that he has control in the group.

21%   saw the therapist as a doctor, did not want him in that role, and did

      not feel it was important for him to have control in the group.

21%   saw the therapist as a coordinator, wanted him in that role, and

      felt it important that he has control in the group.

14%   saw the therapist as being an onlooker, wanted him in that role, but felt

      it important that he has control in the group.

7%   saw the therapist as a doctor, did not want him in that role, and felt

      it important that he has control in the group.

Desire to be Different and Concept of "Illness":   93% consistency, interview

questions 28, 29.

65%   saw themselves as being "ill" and wanted to be different from what they

      were.

21%   did not see themselves as being "ill" and did not want to be different

      from what they were.

14%   did not see themselves as being "ill", but wanted to be different

      from what they were.

Locus of Control: 93% consistency, interview questions 33, 34.

59%   did not feel they controlled what happens to them in life and felt they

      sometimes did not have enough control over the direction their life

      is taking.

27%   felt they control what happens to them in life and felt they did have

      enough control over the direction their life is taking.

14%   felt they did control what happens to them in life but felt they

      sometimes did not have enough control over the direction their life is

      taking.

Freedom: 93% consistency, interview questions, 35, 36, 37

54%   valued their freedom, felt they did not have much freedom, and felt they

      had many restrictions on their freedom.

32%   valued their freedom, felt they had much freedom, but at the same time,

      felt they had many restrictions on their freedom.

7%   valued their freedom, did not feel they had much freedom, but did

      not feel they had many restrictions on their freedom.

7%   did not value their freedom, did not feel they had much freedom, but

      did not feel they had many restrictions on their freedom.

Amount of Responsibility (self and others' perception of self):   93%

consistency, interview questions 43, 46.

27%   felt they had no responsibilities at all and did not think other

      people saw them as responsible people.

36%   felt they had responsibilities at home but not at work, and felt that

      other people saw them as being responsible people.

14%   felt they had responsibilities in the home but not at work, and did not

      think other people saw them as responsible people.

14%   felt they had responsibilities at work but not at home, and felt other

      people saw them as responsible people.

7%   felt they had responsibilities both at home and at work, but did not think

      other people saw them as responsible people.

Dependency on Other People and Dependency Compared to Others: 93%

consistency, interview questions 53, 54.

38%   felt they were sometimes too dependent on other people and did not

      think this was about normal for other people.

35%   felt they were sometimes too dependent on other people and felt this

      was about normal for other people.

27%   felt they were not dependent on other people and did not think this was

      about normal for other people.

Coping Abilities and Compared to Previously: 93% consistency, interview

questions 56, 57, 62.

44% felt they coped badly when problems arose, felt they needed help in

dealing with their problems, and felt they had less problems than

they used to have.

42% felt they coped well when problems arose, felt they needed help in

dealing with their problems, and felt they had more problems than they

used to have.

7% felt they coped well when problems arose, felt they did not need help

in dealing with their problems, and felt they had more problems than

they used to have.

7% felt they coped badly when problems arose, felt they needed help in

dealing with their problems, and felt they had the same problems as

they used to have.

Desire to Change (self and others' perception of self): 93% consistency,

64, 65.

84% felt they would like to change and felt others would like to see them

change.

14% felt they would not like to change and felt others would not like to

see them change.

7% felt they would like to change but felt others would not like to see

them change.

Possibility of Realistic Change: 93% consistency, interview questions 63, 66.

79% felt they would change as a result of group therapy and felt it important

to get something out of group therapy.

14% did not think they would change as a result of group therapy but felt

it important to get something out of group therapy.

79% did not think they would change as a result of group therapy and did not

feel it important to get something out of the group.

Friendship Pattern: 86% consistency, interview questions 24, 25

65% felt they got on well with other people and felt they would like

more friends than they had.

21% felt they did not get on well with other people and felt they had the

number of friends they would like to have.

7% felt they got on well with other people and felt they had the number

of friends they would like to have.

7% felt they got on well with other people and felt they would like

less friends than they had.

Future and Planning: 86% consistency, interview questions 30, 31, 32.

38% thought about their future, planned ahead in their everyday lives, and

felt others saw them as someone who plans ahead.

35% did not think about their future, did not plan ahead in their

everyday lives, and did not think others saw them as someone who

plans ahead.

27% thought about their future, did not plan ahead in their everyday lives,

and did not think others saw them as someone who plans ahead.

Amount of Decisions (self and others' perception of self): 86% consistency,

interview questions 38, 42, 41.

52% felt they had to make many decisions every day, felt that others saw

them as making few decisions, and felt they had to make fewer decisions

than other people.

27% felt they did not make many decisions every day, felt that others saw

them as making many decisions, and felt they had to make more

decisions than other people.

14% felt they had to make many decisions every day, felt that others

saw them as making few decisions, and felt they had to make the same

amount of decisions as other people.

7% felt they had to make many decisions every day, felt that others saw them

as making few decisions, and felt they had to make more decisions than

other people.

Type and Amount of Responsibility Compared to others: 86% consistency, interview

questions 44, 45.

37% felt responsible for their families and felt this was less than for other

people.

21%   felt responsible for their homes and doing as they were told at work, and felt this was about the same for other people.

21%   felt they were responsible for their homes and doing as they were told at work, but felt this was more than for other people.

14%   did not consider themselves responsible for anything in particular, and felt they had more responsibilities than other people.

 7%   did not consider themselves responsible for anything in particular, and felt they had less responsibilities than other people.

Frequency of Problems Compared to Others: 86% consistency, interview questions 55, 61.

32%   felt that problems most often arose at home and not at work, and that the majority of other people has similar problems to them.

27%   felt that problems arose both at home and at work, and that the majority of other people had similar problems to them.

27%   felt that problems arose neither at home nor at work, and that the majority of other people did not have similar problems to them.

 7%   felt that problems arose both at home and at work, and that the majority of other people did not have similar problems to them.

 7%   felt that problems arose at work but not at home, and that the majority of other people had similar problems to them.

Attitude to Problems: 86% consistency, interview questions 58, 59, 60.

46%   felt they would take steps to avoid a problem if they saw it arising, would describe themselves as going "looking" for problems, and felt that their problems were sometimes the result of fate.

27%   felt they would wait if they saw a problem arising, would not describe themselves as going "looking" for problems, and did not feel that their problems were sometimes the result of fate.

27%   felt they would wait if they saw a problem arising, would describe themselves as going "looking" for problems, and felt that their problems were sometimes the result of fate.

Important Factors in Therapy and Attribution of Termination of Therapy:

86% consistency, interview questions, 67, 68, 69, 70.

56%   felt the therapist, the other group members, and they themselves had an important part to play as to whether group therapy helped them or not, but would attribute how they were at termination to themselves.

30%   felt the therapist, the other group members, and they themselves had an important part to play as to whether group therapy helped them or not, but would attribute how they were at termination to the therapist.

7%   did not feel the therapist, the other group members, or they themselves had an important part to play as to whether group therapy helped them or not, but they would attribute how they were at termination to themselves.

7%   felt that only the therapist had an important part to play as to whether group therapy helped them or not, but they would attribute how they were at termination to themselves.

Adequacy of Information: 79% consistency, interview questions 5, 6, 7.

65%   did not feel they knew all they needed to know about group therapy, did not think the doctor should have told them more about what happens in group therapy, and did not feel that the doctors had added anything to what they already knew about group therapy.

21%   felt they knew all they needed to know about group therapy, felt the doctor should have told them more about what happens in group therapy, and felt the doctor had added to what they already knew about group therapy.

7%   did not feel they knew all they needed to know about group therapy, felt the doctor should have told them more about what happens in group therapy, and felt the doctor had added to what they already knew about group therapy.

7%   did not feel they knew all they needed to know about group therapy, did not think the doctor should have told them more about what happens in group therapy, but felt the doctor had added to what they already knew about group therapy.

Guttman Scale Analysis of Patient Interviews during Group Psychotherapy.

Guttman scale analysis of patient interview
during group psychotherapy

Interview number 1.

N = 14.

Patient's perception of himself in the group process: 93% consistency,

interview questions 2, 3, 8.

37%   felt they were changing for the better as a result of what they

were getting out of the group and also perceived themselves as

leaders in the group.

28%   felt they were changing for the better as result of what they

were getting out of the group but did not perceive themselves as

being leaders in the group.

28%   did not feel they were changing at all as a result of the

group, feeling that they were getting nothing out of the group

and did not perceive themselves as leaders in the group.

7%   did not feel they were changing at all as a result of the group,

did, however, feel they got something out of the group, and did

not perceive themselves as leaders in the group.

Patient's perception of the group process in relation to his initial
expectations: 93% consistency, interview questions 1, 5, 9.

37%   thought that the group had been getting to know each other and

developing trust, did not feel the group meetings were doing as

they had anticipated before joining the group, and did not feel

they were enjoying the group meetings.

28%   thought that the group was not very forthcoming, that the group

meetings were doing as they had anticipated before joining the

group, but did not feel they were enjoying the group meetings.

14%   were questioning the purpose of the group, feeling a sense of

"patients" and "therapist", did feel that the group meetings were as

they had anticipated before joining the group, and felt they

were enjoying the group meetings.

14%   thought that the group was not very forthcoming, thought that the

group meetings were as they had anticipated before joining the

group, and felt they were enjoying the group meetings.

7%   felt that the group had been getting to know each other and

developing trust, did not feel that the group meetings were as they

had anticipated before joining the group, but felt they were

enjoying the group meetings.

Patient's perception of the other group members in relation to the
group process: 93% consistency, interview questions 4, 6, 7.

The patients felt that -

33%   were not getting anything out of the group meetings, did not feel

that some people were participating moreso than others, and did

not think there were any leaders in the group.

31%   were getting something out of the group meetings, did not feel

that some people were participating moreso than others, and did not

think there were any leaders in the group.

21%   were getting something out of the group meetings, that some

people were participating moreso than others, but did not think

there were any leaders in the group.

14%   were getting something out of the group meetings, that some people

were participating moreso than others in the group, and that there

were leaders in the group.

Guttman scale analysis of patient interview
during group psychotherapy

Interview number 2

N = 12

Patient's perception of himself in the group process: 92% consistency,
interview questions 2, 3, 8.

28%   did not feel they were changing at all as a result of the group,

         feeling they were getting nothing out of the group, and did not

         perceive themselves as leaders in the group.

28%   felt they were changing as a result of the group, felt they were

         getting nothing out of the group meetings themselves, and did

         not perceive themselves as leaders in the group.

28%   felt they were changing for the better as a result of what they

         were getting out of the group and also perceived themselves as

         leaders in the group.

16%   felt they were changing for the better as a result of what they

         were getting out of the group but did not perceive themselves

         as leaders in the group.

Patient's perception of the group process in relation to his initial
expectations: 92% consistency, interview questions 1, 5, 9

36%   thought that the group had been getting to know each other and

         developing trust, did not feel that the group meetings were doing as

         they had anticipated before joining the group, and did not feel they

         were enjoying the group meetings.

16%   were questioning the purpose of the group, feeling a sense of

         "patients" and "therapists", felt the group meetings were as they

         had anticipated before joining the group, and felt they were

         enjoying the group meetings.

16%   felt the group was stagnating, that the group meetings were as they

         had anticipated before joining the group, but felt they were

         enjoying the group meetings.

16%   felt the group was not very forthcoming, that the group meetings

         were as they had anticipated before joining thegroup, and felt

         they were enjoying the group meetings.

8%   felt the group was not very forthcoming, that the group meetings were not as they had anticipated before joining the group, but felt they were enjoying the group meetings.

8%   felt the group had been getting to know each other and developing trust, did not feel the group meetings were doing as they had anticipated before joining the group, but felt they were enjoying the group meetings.

Patient's perception of the other group members in relation to the group process: 92% consistency, interview questions 4, 6, 7

The patients felt that -

38%   were not getting anything out of the group meetings, did not feel that some people were participating moreso than others, in the group, and did not think there were any leaders in the group.

38%   were getting something out of the group meetings, did not feel that some people were participating moreso than others in the group, and did not think there were any leaders in the group.

16%   were getting something out of the group meetings, that some people were participating moreso than others in the group, and felt that there were leaders in the group.

8%   were getting something out of the group meetings, that some people were participating moreso than others in the group, but felt that there were no leaders in the group.

Guttman scale analysis of patient interview
during group psychotherapy

Interview number 3

N = 9

<u>Patient's perception of himself in the group process:</u> 100% consistency, interview questions 2, 3, 8.

40%   felt they were changing for the better as a result of what they were getting out of the group, and did not perceive themselves as leaders in the group.

27%   did not feel they were changing at all as a result of the group, feeling they were getting nothing out of the group, and did not perceive themselves as leaders in the group.

20%   felt they were changing for the better as a result of what they were getting out of the group and also perceived themselves as leaders in the group.

13%   did not feel they were changing at all but were getting something out of the group, and did not perceive themselves as leaders in the group.

<u>Patient's perception of the group process in relation to his initial expectations:</u> 89% consistency, interview questions 1, 5, 9.

23%   thought that the group was not very forthcoming, that the group meetings were as they had anticipated before joining the group, and that they were enjoying the group meetings.

22%   felt that the group was stagnating, that the group meetings were as they had anticipated before joining the group, and that they were enjoying the group meetings.

22%   felt the group was getting to know each other and developing trust, that the group meetings were as they had anticipated before joining the group, and that they were enjoying the group meetings.

11%   felt the group was getting to know each other and developing trust that the group meetings were not as they had anticipated before joining the group, and felt that they were enjoying the group meetings.

11%   felt the group was getting to the roots of peoples' problems with people getting insight, that the group meetings were not as they had anticipated before joining the group, and felt that they were not enjoying the group meetings.

11%   felt the group was getting to know each other and developing trust,

that the group meetings were not as they had anticipated before joining

the group, and felt that they were not enjoying the group meetings.

Patient's perception of the other group members in relation to the group process:

78% consistency, interview questions, 4, 6, 7.

The patients felt that -

36%   were not getting anything out of the group meetings, did not feel

that some people were participating moreso than others, and did not

think there were any leaders in the group.

36%   were getting something out of the group meetings, did not feel that

some people were participating moreso than others, and did not think

there were any leaders in the group.

14%   were getting something out of the group meetings, did feel that some

people were participating moreso than others, and felt that there

were leaders in the group.

7%   were getting something out of the group meetings, did feel that some

people were participating moreso than others, but felt there were no

leaders in the group.

Guttman scale analysis of patient interview
during group psychotherapy

Interview number 4

N = 9

Patient's perception of himself in the group process: 100% consistency, interview questions 2, 3, 8.

45%   felt they were changing for the better as a result of what they were getting out of the group, and did not see themselves as leaders in the group.

22%   did not think they had changed at all, having got nothing out of the group, and did not see themselves as leaders in the group.

22%   felt they were changing for the better as a result of what they were getting out of the group, and also perceived themselves as leaders in the group.

11%   did not think they had changed at all but were getting something out of the group meetings, and did not perceive themselves as leaders in the group.

Patient's perception of the group process in relation to his initial expectations: 100% consistency, interview question 1,5, 9.

34%   felt the group was stagnating, felt the group meetings were not as they had anticipated before joining the group, but felt they were enjoying the group meetings.

33%   felt the group was getting to the roots of people's problems and that people were getting some insight, felt the group meetings were as they had anticipated before joining the group, and that they were enjoying the group meetings.

11%   felt the group was getting to the roots of people's problems and that people were getting some insight, that the group meetings were as they had anticipated before joining the group, but they were not enjoying the group meetings.

11%   felt the group was getting to the roots of people's problems and that people were getting some insight, that the group meetings were not as they had anticipated before joining the group, and felt that they were not enjoying the group meetings.

11%   were questioning the purpose of the group, feeling there was a

        sense of "patients" and "therapists", felt the group meetings were

        as they had anticipated before joining the group, and felt they

        were enjoying the group meetings.

Patient's perception of the other group members in relation to the group
process: 78% consistency, interview questions, 4, 6, 7.

The patients felt that -

56%   were getting something out of the group meetings, did not feel

        that some people were participating moreso than others, and did

        not think there were any leaders in the group.

33%   were not getting anything out of the group meetings, did not feel

        that some people were participating moreso than others, and did not

        think there were any leaders in the group.

11%   were getting something out of the group meetings, did feel that

        some people were participating moreso than others, and felt there

        were leaders in the group.

Guttman scale analysis of patient interview
during group psychotherapy

Interview number 5

N = 7

Patient's perception of himself in the group process: 100% consistency,
interview questions 2, 3, 8.

30%   felt they were changing for the better as a result of what they
were getting out of the group, and also perceived themselves as
leaders in the group.

28%   felt they had not changed at all, felt they were getting nothing out
of the group meetings, and did not perceive themselves as leaders in
the group.

28%   felt they were changing for the better as a result of what they
were getting out of the group, and did not perceive themselves as
leaders in the group.

14%   did not feel they were changing but were getting something out of
the group, and did not perceive themselves as leaders in the group.

Patient's perception of the group process in relation to his initial
expectations: 86% consistency, interview questions 1, 5, 9.

44%   felt the group was getting to the roots of people's problems and
that people were getting some insight, that the group meetings
were as they had anticipated before joining the group, and felt
they were enjoying the group meetings.

28%   felt the group was getting to the roots of people's problems and
that people were getting some insight, that the group meetings were
not as they had anticipated before joining the group, and felt that
they werenot enjoying the group meetings.

28%   felt the group was not very forthcoming, that the group meetings
were as they had anticipated before joining the group, amd felt that
they were enjoying the group meetings.

Patient's perception of the other group members in relation to the group process:
72% consistency, interview questions 4, 6, 7.

The patients felt that -

44% were getting something out of the group meetings, did not think some

people were participating moreso than others, and did not think there

were any leaders in the group.

28% were not getting anything out of the group meetings, did not think

some people were participating moreso than others, and did not think there

were any leaders in the group.

14% were getting something out of the group meetings, did think that

some people were participating moreso than others in the group,

and felt there were leaders in the group.

14% were getting something out of the group meetings, did not think that

some people were participating moreso than others, and felt there

were leaders in the group.

Guttman scale analysis of patient interview
during group psychotherapy.

Interview number 6

N = 7

<u>Patient's perception of himself in the group process:</u> 100% consistency, interview questions 2, 3, 8.

57%   felt they were changing for the better as a result of what they were getting out of the group, and did not perceive themselves as leaders in the group.

29%   did not feel they were changing at all although they were getting something out of the group, and did not perceive themselves as leaders in the group.

14%   felt they were changing for the better as a result of what they were getting out of the group, and perceived themselves as being leaders in the group.

<u>Patient's perception of the group process in relation to his initial expectations:</u> 100% consistency, interview questions 1, 5, 9

71%   felt the group was getting to the roots of people's problems and that people were getting some insight, that the group meetings were as they had anticipated before joining the group, and that they were enjoying the group meetings.

29%   felt the group was getting to the roots of people's problems and that people were getting some insight, that the group meetings were as they had anticipated before joining the group, but they were not enjoying the group meetings.

<u>Patient's perception of the other group members in relation to the group process:</u> 100% consistency, interview questions 4, 6, 7.

The patients felt that -

69%   were getting something out of the group meetings, did not think some people were participating moreso than others, and did not think there were any leaders in the group.

20%   were getting something out of the group meetings, did not think there were some people participating moreso than others, and felt there were leaders in the group.

11% were not getting anything out of the group meetings, did not think some people were participating moreso than others, and did not think there were any leaders in the group.

Guttman scale analysis of patient interview
during group psychotherapy

Interview number 7

N = 7

Patient's perception of himself in the group process: 100% consistency, interview questions 2, 3, 8.

44%   felt they were changing for the better as a result of what they were getting out of the group, and felt they were leaders in the group.

28%   felt they were changing for the better as a result of what they were getting out of the group, and did not perceive themselves as leaders in the group.

14%   felt they were not changing at all and were getting nothing out of the group, and did not perceive themselves as leaders in the group.

14%   felt they were not changing at all but were getting something out of the group, and did not perceive themselves as leaders in the group.

Patient's perception of the group process in relation to his initial expectations: 100% consistency, interview questions 1, 5, 9

71%   felt the group was drawing to a close, that the group meetings were as they had anticipated before joining the group, and that they enjoyed the group meetings.

29%   felt the group was drawing to a close, that the group meetings were not as they had anticipated before joining the group, and that they did not enjoy the group meetings.

Patient's perception of the other group members in relation to the group process: 100% consistency, interview questions 4, 6, 7.

The patients felt that -

58%   were getting something out of the group meetings, did not think some people were participating moreso than others, and did not think there were any leaders in the group.

22%   were not getting anything out of the group meetings, did not think some people were participating moreso than others in the group, and did not think there were any leaders in the group.

20%   were getting something out of the group meetings, did not think some people were participating moreso than others, but did think there were leaders in the group.

Guttman scale analysis of post-therapy interview
for group psychotherapy patients.

N = 15

Effect of the group on one's life and alternative treatment - 100%

consistency, interview questions 9, 16.

40% felt that group therapy had altered their lives and, in retrospect, would not have preferred another type of treatment.

33% felt that group therapy had altered their lives but in retrospect, would have preferred another kind of treatment.

27% did not feel that group therapy had altered their lives but, in retrospect, would not have preferred another type of treatment.

Fulfilment of initial expectations of self in the group - 100% consistency,

interview questions 6, 7.

72% felt they had learned about themselves in the group meetings and felt they had had to work hard when in the group.

14% felt they had learned about themselves in the group but did not feel they had had to work hard when in the group.

14% felt they had not learned about themselves in the group meetings and did not feel they had had to work hard when in the group.

Normality (self and others' perception of self) - 100% consistency,

interview questions 19, 20.

53% felt they did lead a normal life and that others saw them as leading a normal life.

33% did not feel they lead a normal life and did not think that others saw them as leading a normal life.

14% did not feel that they lead a normal life but felt that others saw them as leading a normal life.

Need to alter lifestyle (self and others' perception of self) - 100%

consistency, interview questions 23, 24.

80% felt they had altered their lifestyle from what it was before joining the group and that others thought they should alter their lifestyle from what it was before joining the group.

20% did not feel they had altered their lifestyle from what it was before joining the group and did not feel that others thought they should alter their lifestyle from what it was before joining the group.

Difficulties in decision making and preference for another person to decide - 100% consistency, interview questions 46, 47.

53%   did not find it difficult to make decisions and would not prefer it if someone else made decisions for them.

27%   found it difficult to make decisions but would not prefer it if someone else made decisions for them.

20%   found it difficult to make decisions and would prefer it if someone else made decisions for them.

Independence (self and others' perception of self) - 100% consistency, interview questions 54, 55.

60%   saw themselves as being independent and felt that others saw them as being independent.

20%   did not see themselves as being independent and felt that others did not see them as being independent.

20%   did not see themselves as being independent but felt that others saw them as being independent.

Group dependency and company preference - 100% consistency, interview questions 56, 57, 58, 59.

33%   liked doing things on their own, liked having people around them most of the time, and preferred having people around them most of the time - this preference being from choice.

27%   liked doing things on their own, liked having others around them most of the time, and preferred being on their own - this preference being from choice.

27%   liked doing things on their own, did not like having others around them most of the time, and preferred being on their own - this preference being from choice.

13%   did not like doing things on their own, did not like having others around them most of the time, and preferred being on their own - this preference being from choice.

Locus of Control - 100% consistency, interview questions 40, 41.

60%   felt they controlled what happened to them in life and did not feel

       that sometimes they did not have enough control over the direction

       their lives were taking.

20%   felt they controlled what happened to them in life but felt that

       sometimes they did not have enough control over the direction their

       lives were taking.

20%   felt they did not control what happened to them in life and felt that

       sometimes they did not have enough control over the direction their

       lives were taking.

Freedom - 100% consistency, interview questions 42, 43, 44.

73%   valued their freedom, felt they had much freedom, but also felt

       they had many restrictions on their freedom.

13%   valued their freedom, did not feel they had much freedom but

       also did not feel they had many restrictions on their freedom.

7%   did not value their freedom, did not feel they had much freedom,

       but also did not feel they had many restrictions on their freedom.

7%   valued their freedom, did not feel they had much freedom and also

       felt they had many restrictions on their freedom.

Fulfilment of the possibility of realistic change - 100% consistency,

interview questions 29, 32.

67%   felt they had changed as a result of group therapy and that they

       had got something out of group therapy.

20%   felt they had not changed as a result of group therapy but felt

       they had got something out of group therapy.

13%   felt they had not changed as a result of group therapy and did

       not feel they had got anything out of group therapy.

Frequency of problems and compared to others - 100% consistency, interview

questions 61, 67.

53%   felt that problems arose both at home and at work and felt that the

       majority of people had similar problems to them.

26%   felt that problems arose neither at home nor at work and felt that

       the majority of people had similar problems to them.

14% felt that problems arose at home but not at work and felt that the majority of people had similar problems to them.

7% felt that problems arose neither at home nor at work and did not feel that the majority of people had similar problems to them.

Fulfilment of expected emotional involvement in the group - 93% consistency, interview questions 13, 14, 15.

26% felt thay had been surprised by some of the things that happened to them in the group, did not reveal their true self in the group but, at the same time, had not kept some things to themselves.

26% felt they had been adversely affected by some of the things that happened to them in the group, had revealed their true self in the group but, at the same time, had kept some things to themselves.

20% had experienced a wealth of emotions due to some of the things that happened to them in the group, had revealed their true self in the group but, at the same time, had kept some things to themselves.

14% had been upset by some of the things that happened to them in the group, had not revealed their true self in the group, and had kept some things to themselves.

14% had been upset by some of the things that happened to them in the group, had revealed their true self in the group but, at the same time, had kept some things to themselves.

Amount of responsibility (self and others' perception of self) - 93% consistency, interview questions 50, 53.

40% felt they had responsibilities at home but not at work, and felt that others saw them as having many responsibilities.

32% did not feel they had responsibilities either at home or at work, and did not think that others saw them as having many responsibilities.

14% felt they had responsibilities both at home and at work but did not think that others saw them as having many responsibilities.

14%   felt they had responsibilities both at home and at work and felt that

others saw them as having many responsibilities.

Coping abilities and compared to previously - 93% consistency, interview

questions 62, 63, 68.

40%   felt they coped well when problems arose, sometimes needed help

in dealing with them, and felt they had less problems than they used

to have.

33%   felt they coped well when problems arose, did not sometimes need

help in dealing with them, and felt they had more problems than they

used to have.

20%   felt they coped badly when problems arose, sometimes needed help in

dealing with them, and felt they had less problems than they used

to have.

7%   felt they coped well when problems arose, sometimes needed help in

dealing with them, and felt they had more problems than they used to have.

Desire to change (self and others' perception of self) - 93% consistency,

interview questions 30, 31.

87%   felt they had wanted to change and that others had wanted them to

change.

13%   had not wanted to change and felt that others had not wanted them

to change.

Friendship pattern - 93% consistency, interview questions 21, 22.

60%   felt they got on well with other people and would like more friends

than they had.

33%   did not feel they got on well with other people but felt they had the

number of friends they would like to have.

7%   felt they got on well with other people and felt they had the

number of friends they would like to have.

Future and planning - 93% consistency, interview questions 37, 38, 39.

47%   thought about their future, planned ahead in their everyday lives,

and thought that others saw them as someone who plans ahead.

33%   did not think about their future, did not plan ahead in their

        everyday lives, and did not think that others perceived them as

        someone who plans ahead.

14%   thought about their future, did not plan ahead in their everyday

        lives, and did not think others saw them as someone who plans

        ahead.

6%   thought about their future, did not plan ahead in their everyday

        lives, but thought that others saw them as someone who plans ahead.

Type and amount of responsibility compared to others - 93% consistency,

interview questions 51, 52.

27%   considered themselves responsible for the running of the house

        and felt this was the same for other people.

27%   considered themselves responsible for the family and felt this was

        less than for otherpeople.

20%   considered themselves responsible for the running of the house but

        felt this was more than for other people.

20%   did not consider themselves responsible for anything and felt this

        was less than for other people.

6%   considered themselves responsible for doing as they were told at

        work and felt this was more than for other people.

Concept of "illness" in restrospect and at post-therapy (self and others'
perception of self) -   93% consistency, interview questions 25, 26, 27, 28.

40%   in retrospect, saw themselves as being "ill", at post-therapy, saw

        themselves as being "ill", felt that others, both at post-therapy and

        in retrospect, saw them as being "ill".

33%   in retrospect, saw themselves as being "ill", at post-therapy, did

        not see themselves as being "ill", felt that others, in retrospect, saw

        them as being "ill", and felt that at post-therapy, others

        did not see them as being "ill".

20%   neither in retrospect nor at post-therapy saw themselves as

being "ill", or thought that others saw them as being "ill".

7%   in retrospect, saw themselves as being "ill", at post-therapy, did

not see themselves as being "ill", and felt that others saw them, neither

in retrospect nor at post-therapy, as being "ill".

<u>Perception of the therapist's role and his control in the group</u> - 93%

consistency, interview questions 10, 12.

47%   saw the therapist as an adviser in the group but felt it was an

important part of therapy for patients to believe that the therapist

has control over what was happening inthe group.

40%   saw the therapist as a doctor in the group and felt it was an

important part of therapy for patients to believe that the

therapist has control over what was happening in the group.

13%   saw the therapist as a doctor in the group and did not feel it was

an important part of therapy for patients to believe that the

therapist has control over what was happening in the group.

<u>Patients' perception of the expedience of group therapy for others similar
to themselves</u> - 93: consistency, interview questions 5, 8, 17, 18.

40%   felt there had been people similar to themselves in the group,

felt the group was able to solve their problems, felt, if given a

choice, they would go back to group therapy again, and would encourage

someone with problems similar to their own to go to group therapy.

20%   felt there had been people similar to themselves in the group,

felt the group was not able to solve their problems, felt, if

given a choice, they would go back to group therapy again, and would

encourage someone with problems similar to their own to go to group

therapy.

20%   did not feel there had been people similar to themselves in the

group, felt the group was not able to solve their problems, did not

feel that, if given a choice, they would go back to group therapy

again, and would not encourage someone with problems similar to their

own to go to group therapy.

13%   felt that there had been people similar to themselves in the group,
felt the group was not able to solve their problems, did not feel
that, if given a choice, they would go back to group therapy again,
and would not encourage someone with problems similar to their own
to go to group therapy.

7%   felt that there were people similar to themselves in the group,
did not feel the group was able to solve their problems, felt that,
if given a choice, they would go back to group therapy again, and
would encourage someone with problems similar to their own to go to
group therapy.

Attitude to problems - 87% consistency, interview questions 64, 65, 66.

40%   felt that, if they saw a problem arising, they would wait till it
happened, would not describe themselves as going "looking" for
problems and did not feel that sometimes their problems were the
result of fate.

33%   felt that, if they saw a problem arising, they would try and prevent
it, would describe themselves as going "looking" for problems, and
felt that sometimes their problems were the result of fate.

27%   felt that, if they saw a problem arising, they would try and prevent
it, would not describe themselves as going "looking" for problems,
and did not feel that sometimes their problems were the result of
fate.

Important factors in therapy and attribution at termination of therapy -
87% consistency, interview questions 33, 34, 35, 36.

40%   felt they themselves, the therapists and the other group members
had an important part to play as to whether group therapy helped them
or not and would attribute how they were at termination to the group
experience.

33%   felt they themselves, the therapist and the other group members
had an important part to play as to whether group therapy helped
them or not and attributed how they were at termination to themselves.

13%   felt they themselves and the other group members, excluding the

        therapist, had an important part to play as to whether group

        therapy helped them or not and attributed how they were at

        termination to themselves.

7%   felt nobody had an important part to play as to whether group

        therapy helped them or not and attributed how they were at termination

        to themselves.

7%   felt they alone had an important part to play as to whether group

        therapy helped them or not and attributed how they were at termination

        to themselves.

Amount of decisions (self and others' perception of self) - 80% consistency,
interview questions 45, 49, 48.

60%   felt they had to make many decisions everyday, thought that others

        saw them as making few decisions, and felt they had about the same

        decisions to make as other people.

20%   felt they did not have to make many decisions every day, thought

        that others saw them as m,aking many decisions and felt they had

        to make more decisions than other people.

13%   felt they had to make many decisions every day, felt that others saw

        them as making many decisions, but felt they had less decisions to

        make than other people.

7%   felt they had to make many decisions every day, felt others saw them

        as making many decisions, and felt they had more decisions to make

        than other people.

Satisfaction with the information given about the group before starting -
80% consistency, interview questions 3, 1, 2, 4.

33%   felt they were not told enough about group therapy before joining

        the group, yet did not feel the doctor should have told them more

        about what happens in group therapy, felt people should know about

        the "success rate" of group therapy before joining a group, and did

        not discuss what was happening in the group with others outside of

        the group.

33%   felt they were told enough about group therapy before joining the

        group, yet felt the doctor should have told them more about what

        happens in group therapy, felt people should know what the aims

        of the group are for them as individuals, and did discuss what

        was happening in the group with others outside of the group.

27%   felt they were not told enough about group therapy before joining

        the group, felt the doctor should have told them more about what

        happens in the group, felt that people should know what the aims

        of the group are for them as individuals, and did discuss what was

        happening in the group with others outside of the group.

7%   felt they were not told enough about group therapy before joining

        the group, felt the doctor should have told them more about what

        happens in group therapy, felt that people should know what the aims

        of the group are for them as individuals, and did not discuss

        what was happening in the group with others outside of the group.

Guttman scale analysis of follow-up interview
for group psychotherapy patients.

N = 15.

Assessment six months after therapy termination - 100% consistency,

interview questions 1,2,3,4.

27%   had some recurrence of initial problems, had not seen the therapist

since termination, felt they had coped well since termination, and

saw therapy as having been successful.

27%   had some recurrence of initial problems, had seen the therapist

since thermination for help, felt they had coped well since

termination, and saw therapy as having been successful.

27%   had no recurrence of initial problems, had not seen the therapist

since termination, felt they had coped badly since termination,

and did not see therapy as having been successful.

13%   had no recurrence of initial problems, had not seen the therapist

since termination, felt they had coped well since termination and

saw therapy as having been successful.

6%   had no recurrence of initial problems, had not seen the therapist

since termination, felt they had coped well since termination, and

did not see therapy as having been successful.

Guttman scale analysis of therapist interview before
group psychotherapy.*

* note: this analysis is based on the responses of Therapist 1 and 2.

Therapists'attitude towards group psychotherapy - 100% consistency, interview questions 9, 10, 11, 12.

100%   (i.e. both therapists) saw the group as a place where patients could interact with one another, where they felt safe enough to reveal things which are relatively intimate but very important, and where they could accept the criticism and support of the other group members; felt this approach was based on their training, and felt they were successful as therapists.

Therapists' expectations of their role in the group - 100% consistency, interview questions 13, 14.

50%   (i.e. one therapist) felt he would like to adopt the role of conductor in the group and would adopt this role successfully.

50%   (i.e. one therapist) felt he would like to adopt the role of conductor in the group but would actually adopt the role of leader when in the group.

Therapists' expectations of personal change as a result of the group - 100% consistency, interview questions 16, 17.

100%   (i.e. both therapists) felt they would personally change as a result of the group and felt they would learn about themselves as a result of the group.

Therapists' locus of control - 100% consistency, interview questions 18, 19.

100%   (i.e. both therapists) felt they controlled what happened to them in life and that they at no time felt they did not have enough control over the direction their lives took.

Therapists' assessment of their group therapy patients.

Expedience of group psychotherapy for the patient and possible alternative treatment - 100% consistency, interview questions 2, 8.

The therapists thought that for -

44%   group therapy was the most suitable treatment for the patient, irrespective of what was available in the hospital; the best alternative being individual psychotherapy.

14%   group therapy was the most suitable treatment for the patient,
        irrespective of what was available in the hospital;   the best
        alternative being behaviour therapy.

14%   group therapy was the most suitable treatment for the patient,
        irrespective of what was available in the hospital;   and, as this
        was the last resort, there were no alternatives.

14%   group therapy was the most suitable treatment for the patient,
        irrespective of what was available in the hospital, the best
        alternative being drug therapy.

7%   group therapy was the most suitable treatment for the patient,
        irrespective of what was available in the hospital;   the best
        alternative being psychodrama.

7%   group therapy was not the most suitable treatment for the patient;
        the best alternative being behaviour therapy.

Therapists' optimistic and realistic expectations of change in the patients -

100% consistency, interview questions 4, 5.

The therapists felt that for -

27%   they would like to see the patient separate emotionally from their
        parents, but felt there would only be partial separation.

24%   they would like to see the patient gain insight into his difficulties,
        but felt this would only be partially achieved.

21%   they would like to see expansion of the patient's social relationships,
        and felt that the patient would achieve these aims.

14%   they would like to see the patien gain insight into his difficulties ,
        but felt there would be no change in the patient.

7%   they would like to see the patient emigrate, and felt the patient
        would leave the group when it became too threatening.

7%   they would like to see expansion of the patient's social relationships,
        but felt the patient would leave the group when it became too
        threatening.

Attendance and participation of the patients in the group as anticipated by the therapists -   95% consistency, interview questions 1, 6.

The therapists thought that -

20%   would not attend the group regularly and would participate on an

intellectual level when in the group.

20%   would attend the group regularly and would listen rather than verbalize

when in the group.

20%   would attend the group regularly but would act out when in the

group.

20%   would attend the group regularly and would participate in the group

as the therapist's assistant.

14%   would attend the group regularly and would seek support and

reassurance when in the group from the other group members.

6%   would attend the group regularly and would verbalize rather than

listen when in the group.

Problems of the patient and anticipated clinical involvement with the patient - 93% consistency, interview questions 3, 7, 15.

The therapists thought that -

30%   had difficulties in relating to authority figures, that they could

not personally help these patients much, and that these patients

would not gain as much from the group experience as other members.

28%   had identity difficulties, that they could not help these patients

much personally, but these patients would gain much from the group

experience.

14%   had difficulties in relation to low self-esteem, that they could

not personally help these patients much, and that these patients

would not gain as much from the group experience as other members.

14%   had difficulties in relation to social isolation, that they could

not personally help these patients much, and that these patients

would gain much from the group experience.

7%   had problems of a hysterical nature, that they could not

personally help these patients much, and that these patients would

not gain as much from the group experience as other members.

7%   had problems of a hysterical nature, that they could not personally

help these patients much, but these patients would gain much from

the group experience.

Guttman scale analysis of therapist interviews during group psychotherapy.

Guttman scale analysis of therapist interview
during group psychotherapy

Interview number 1

<u>Therapist's perception of himself in the group process:</u>   100% consistency,

interview questions 6, 7, 8.

100%   (i.e. both therapists) perceived themselves as leaders in the

group, felt they were personally getting something out of the

group meetings,and were enjoying the group meetings.

<u>Therapist's perception of the group members in relation to his initial</u>
<u>expectations:</u>   93% consistency, interview questions 2, 3, 9.

The therapists felt that for –

44%   the group meetings were achieving what they thought they would

achieve, that the members were as they had anticipated before the

members joined the group, and felt that their role, as therapist,

was to give these members a realistic view of life.

14%   the group meetings were achieving what they thought they would

achieve, that the members were as they had anticipated before the

members joined the group, and felt that their role, as therapist,

was to show these members that doctors are not magicians.

14%   the group meetings were achieving what they thought they would

achieve, that the members were as they had anticipated before the

members joined the group, and felt that their role, as therapist,

was to give these members support.

14%   the group meetings were not achieving what they thought they

would achieve, that the members were as they had anticipated

before the members joined the group, and felt that their role, as

therapist, was to give these members support.

7%   the group meetings were not achieving what they thought they would

achieve, that the members were not as they had anticipated before

the members joined the group, and felt that their role, as

therapist, was to act as a model father figure for these members.

7%   the group meetings were not achieving what they thought they

would achieve, that the members were as they had anticipated before

the members joined the group, and felt that their role, as therapist,

was to act as a model father figure for these members.

Therapist's perception of the group members in relation to the group process:

100% consistency, interview questions 1, 4, 5.

The therapists felt that –

64%   were benefitting from the group meetings, did not think that these members were participating moreso than others, and did not perceive these members as leaders in the group.

22%   were benefitting from the group meetings, did feel these members were participating moreso than others, but did not perceive these members as leaders in the group.

7%   were not benefitting from the group meetings, did not think these members were participating moreso than others, and did not perceive these members as leaders in the group.

7%   were benefitting from the group meetings, did think these members were participating moreso than others, and perceived these members as leaders in the group.

Guttman scale analysis of therapist interview
during group psychotherapy

Interview number 2

Therapist's perception of himself in the group process: 100% consistency, interview questions 6, 7, 8.

100%   (i.e. both therapists) did not perceive themselves as leaders in the group, felt they were personally getting something out of the group meetings, and were enjoying the group meetings.

Therapist's perception of the group members in relation to his initial expectations: 92% consistency, interview questions 2, 3, 9.

The therapists felt that for -

42%   the group meetings were achieving what they thought they would achieve, that the members were not as they had anticipated before the members joined the group, and felt that their role, as therapist, was to give these members support.

21%   the group meetings were achieving what they thought they would achieve, that the members were not as they had anticipated before the members joined the group, and felt that their role as therapist, was to give these members a realistic view of life.

21%   the group meetings were achieving what they thought they would achieve, that the members were not as they had anticipated before the members joined the group, and felt that their role, as therapist, was to act as a model father figure for these members.

8%   the group meetings were achieving what they thought they would achieve, that the members were as they had anticipated before the members joined the group, and felt their role, as therapist, was to act as a model father figure for these members.

8%   the group meetings were achieving what they thought they would achieve, that the members were not as they had anticipated before the members joined the group, and felt that their role, as therapist, was to show these members that doctors are not magicians.

<u>Therapist's perception of the group members in relation to the group process</u>:

92% consistency, interview questions 1, 4, 5.

The therapists felt that -

58% were benefitting from the group meetings, did not think these

    members were participating moreso than others, and did not perceive

    these members as leaders in the group.

25% were not benefitting from the group meetings, did not think these

    members were participating moreso than others, but did perceive

    these members as leaders in the group.

17% were not benefitting from the group meetings, did not think

    these members were participating moreso than others, and did not

    perceive these members as leaders in the group.

Guttman scale analysis of therapist interview
during group psychotherapy.

Interview number 3

<u>Therapist's perception of himself in the group process</u>:   100% consistency,

interview questions 6, 7, 8.

100%   (i.e. both therapists) did not perceive themselves as leaders in

the group, felt they were personally getting something out of the

group meetings, and were enjoying the group meetings.

<u>Therapist's perception of the group members in relation to his initial</u>
<u>expectations</u>:   89% consistency, interview questions 2, 3, 9.

The therapists felt that for -

45%   the group meetings were achieving what they thought they would

achieve, that the members were as they had anticipated before the

members joined the group, and felt that their role, as therapist,

was to give these members support.

22%   the group meetings were achieving what they thought they would

achieve, that the members were not as they had anticipated before

the members joined the group, and felt that their role, as therapist,

was to give these members a realistic view of life.

22%   the group meetings were achieving what they thought they would

achieve, that the members were not as they had anticipated before the

members joined the group, and felt that their role,as therapist,

was to act as a model father figure for these members.

11%   the group meetings were achieving what they thought they would

achieve, that the members were as they had anticipated before the

members joined the group, and felt that their role, as therapist,

was to act as a model father figure for these members.

<u>Therapist's perception of the group members in relation to the group process</u>:

89% consistency, interview questions 1, 4, 5.

The therapists felt that -

45%   were benefitting from the group meetings, did not think these members

were participating moreso than others, and did not perceive these

members as leaders in the group.

22%   were not benefitting from the group meetings, did not think these
        members were participating moreso than others, and did not perceive
        these members as leaders in the group.

22%   were benefitting from the group meetings, did think these members
        were participating moreso than others, and perceived these members
        as leaders in the group.

11%   were not benefitting from the group meetings, did think these
        members were participating moreso than others, but did not perceive
        these members as leaders in the group.

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Guttman scale analysis of therapist interview
during group psychotherapy

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Interview number 4

Therapist's perception of himself in the group process: 100% consistency, interview questions 6, 7, 8.

100%   (i.e. both therapists) did not perceive themselves as leaders in

the group, felt that they were personally getting something out of

the group meetings, and were enjoying the group meetings.

Therapist's perception of the group members in relation to his initial expectations: 78% consistency, interview questions 2, 3, 9.

The therapists felt that for -

45%   the group meetings were achieving what they thought they would

achieve, that the members were as they had anticipated before the

members joined the group, and felt that their role, as therapist,

was to give these members support.

22%   the group meetings were achieving what they thought they would

achieve, that the members were as they had anticipated before the

members joined the group,and felt that their role, as therapist,

was to give these members a realistic view of life.

22%   the group meetings were achieving what they thought they would

achieve, that the members were not as.they had anticipated before the

members joined the group, and felt that their role, as therapist,

was to act as a model father figure for these members.

11%   the group meetings were achieving what they thought they would

achieve, that the members were as they had anticipated before the

members joined the group, and felt that their role, as therapist,

was to act as a model father figure.

Therapist's perception of the group members in relation to the group process:

78% consistency, interview questions 1, 4, 5.

The therapists felt that -

45%   were benefitting from the group meetings, did think these members

were participating moreso than others, but did not perceive these

members as leaders in the group.

22%   were not benefitting from the group meetings, did not think these

           members were participating moreso than others, and did not perceive

           these members as leaders in the group.

22%   were benefitting from the group meetings, did think these members

           were participating moreso than others, and perceived these members

           as leaders in the group.

Guttman scale analysis of therapist interview
during group psychotherapy.

Interview number 5

<u>Therapist's perception of himself in the group process</u>: 100% consistency, interview questions 6, 7, 8.

100%   (i.e. both therapists) did not perceive themselves as leaders in the group, felt that they were personally getting something out of the group meetings, and were enjoying the group meetings.

<u>Therapist's perception of the group members in relation to his initial</u>
<u>expectations</u>: 86% consistency, interview questions 2, 3, 9

The therapists felt that for -

30%   the group meetings were achieving what they thought they would achieve, that the members were as they had anticipated before the members joined the group, and felt that their role, as therapist, was to give these members support.

28%   the group meetings were achieving what they thought they would achieve, that the members were as they had anticipated before the members joined the group, and felt that their role, as therapist, was to give these members a realistic view of life.

14%   the group meetings were achieving what they thought they would achieve, that the members were not as they had anticipated before the members joined the group, and felt that their role, as therapist, was to act as a model father figure to these members.

14%   the group meetings were achieving what they thought they would achieve, that the members were as they had anticipated before the members joined the group, and felt that their role, as therapist, was to act as a model father figure to these members.

14%   the group meetings were achieving what they thought they would achieve, that the members were as they had anticipated before the members joined the group and felt that their role, as therapist, was to show these members that doctors are not magicians.

Therapist's perception of the group members in relation to the group process:

86% consistency, interview questions 1, 4, 5.

The therapists felt that -

58% were benefitting from the group meetings, felt that these members were participating moreso than others, but did not perceive these members as leaders in the group.

14% were not benefitting from the group meetings, did not think these members were participating moreso than others, and did not perceive these members as leaders in the group.

14% were benefitting from the group meetings, felt these members were participating moreso than others, and perceived these members as leaders in the group.

14% were not benefitting from the group meetings, felt these members were participating moreso than others, but did not perceive these members as leaders in the group.

Guttman scale analysis of therapist interview
during group psychotherapy.

Interview number 6

<u>Therapist's perception of himself in the group process</u>: 100% consistency, interview questions 6, 7, 8.

50%   (i.e. one therapist) did not perceive himself as leader in the

group, felt he was personally getting something out of the group

meetings, and was enjoying the group meetings.

50%   (i.e. one therapist) did perceive himself as leader in the group,

felt he was personally getting something out of the group meetings,

and was enjoying the group meetings.

<u>Therapist's perception of the group members in relation to his initial</u>
<u>expectations</u>: 100% consistency, interview questions, 2, 3, 9.

The therapists felt that for -

55%   the group meetings were achieving what they thought they would

achieve, that the members were as they had anticipated before the

members joined the group, and felt that their role, as therapist,

was to give these members a realistic view of life.

15%   the group meetings were achieving what they thought they would

achieve , that the members were not as they had anticipated before

the members joined the group, and felt that their role, as therapist,

was to act as a model father figure for these members.

15%   the group meetings were achieving what they thought they would achieve,

that the members were as they had anticipated before the members

joined the group, and felt that their role, as therapist, was to

act as a model father figure for these members.

15%   the group meetings were achieving what they thought they would

achieve, that the members were as they had anticipated before

the members joined the group, and felt that their role, as therapist,

was to give these members support.

<u>Therapist's perception of the group members in relation to the group process</u>:

100% consistency, interview questions 1, 4, 5.

The therapists felt that -

86%   were benefitting from the group meetings, felt these members
        were participating moreso than others, but did not perceive these
        members as leaders in the group.

14%   were benefitting from the group meetings, felt these members were
        participating moreso than others, and perceived these members as
        leaders in the group.

Guttman scale analysis of therapist interview
during group psychotherapy.

Interview number 7

Therapist's perception of himself in the group process: 100% consistency,

interview questions 6, 7, 8.

50%   (i.e. one therapist) did not perceive himself as a leader in the

group, felt he was personally getting something out of the group

meetings, and was enjoying the group meetings.

50%   (i.e. one therapist) did perceive himself as leader in the group,

felt he was personally getting something out of the group meetings,

and was enjoying the group meetings.

Therapist's perception of the group members in relation to his initial

expectations: 100% consistency, interview questions 2, 3, 9.

The therapists felt that for -

55%   the group meetings were achieving what they thought they would

achieve, that the members were as they had anticipated before the

members joined the group, and felt that their role, as therapist,

was to give these members a realistic view of life.

15%   the group meetings were achieving what they thought they would

achieve, that the members were not as they had anticipated before

the members joined the group, and felt that their role, as therapist,

was to act as a model father figure for these members.

15%   the group meetings were achieving what they thought they would

achieve, that the members were as they had anticipated before the

members joined the group, and felt that their role, as therapist, was

to act as a model father figure for these members.

15%   the group meetings were achieving what they thought they would

achieve, that the members were as they had anticipated before

the members joined the group, and felt that their role, as therapist,

was to give these members support.

Therapist's perception of the group members in relation to the group process:

100% consistency, interview questions 1, 4, 5.

The therapists felt that -

86%   were benefitting from the group meetings, felt these members were participating moreso than others, but did not perceive these members as leaders in the group.

14%   were benefitting from the group meetings, felt these members were participating moreso than others, and perceived these members as leaders in the group.

Guttman scale analysis of post-therapy
interview for group psychotherapists.

Therapists' perception of his role in the group -   100% consistency, interview questions 14, 15.

50%   (i.e. one therapist)felt he had adopted the role of leader in the group but had wanted to adopt the role of facilitator.

50%   (i.e. one therapist)felt he had adopted the role of facilitator in the group, this being the role he wanted to adopt.

Therapists' perception of personal change as a result of the group - 100% consistency, interview questions 10,11.

50%   (i.e. one therapist) felt he had not changed as a result of the group nor had he learned anything about himself as a result of the group.

50%   (i.e. one therapist) felt he had changed as a result of the group and had learned about himself as a result of the group.

Locus of control - 100% consistency, interview questions 12, 13.

100%   (i.e. both therapists) felt they controlled what happened to them in life and did not feel that sometimes they did not have enough control over the direction their lives were taking.

Fulfilment of the therapist's optimistic and realistic expectations of change in the patient -   100% consistency, interview questions 3, 4.

The therapists felt that for -

67%   the outcome was a they would have liked and also was as they expected.

27%   the outcome was not as they would have liked nor was it as they expected.

6%   the outcome was not as they would have liked but it was as they expected.

Suitability of therapy for the patient and future prognosis - 93% consistency, interview questions 7, 6, 9.

The therapists felt that for -

40%   group therapy was the most suitable treatment, that, in retrospect, they would not have rather offered an alternative form of treatment,

but felt these members would require help of this nature again in the future.

40%   group therapy was the most suitable treatment, that, in retrospect, they would not have rather offered an alternative form of treatment, and felt that these members would not require help of this nature again in the future.

20%   group therapy was not the most suitable treatment, that, in retrospect, they would not have rather offered an alternative form of treatment, and felt these members would not require help of this nature again in the future.

Participation by the patient in the group and attribution of change at termination as perceived by the therapist -   93% consistency, interview questions 8, 6, 5.

The therapists felt that -

26%   had listened rather than verbalized in the group, that they, as therapists, had not been able to help these members moreso than others in the group, and felt that they, as therapists, had played the most significant role in the outcome for these members.

20%   had acted out in the group, that they, as therapists, had not been able to help these members moreso than others in the group, and felt that they, as therapists, had played the most significant role in the outcome for these members.

20%   had acted as the therapist's assistant in the group, that they, as therapists, had not been able to help these members moreso than others in the group, and felt that the other group members had played the most significant role in the outcome for these members.

20%   had verbalized rather than listened in the group, that they, as therapists, had been able to help these members moreso than others in the group, and felt that the group experience itself played the most significant role in the outcome for these members.

7% had acted as therapist's assistant in the group, that they, as

therapists, had been able to help these members moreso than others

in the group, and felt that the group experience itself had played

the most significant role in the outcome for these members.

7% had sought support and reassurance in the group, that they, as

therapists, had been able to help these members moreso than others in

the group, and felt that the group experience itself had played the

most significant role in the outcome for these members.

Therapist's perception of change in the patient and satisfaction with outcome -

87% consistency, interview questions 1,2.

The therapists felt that -

33% had not changed since joining the group and they were not

satisfied with the outcome.

20% had changed their jobs but they were not satisfied with the outcome.

20% had improved their social relationships and they were satisfied with

the outcome.

13% had separated, to some extent, emotionally from their parents but

they were not satisfied with the outcome.

7% had gained some insight into their problems but they were not

satisfied with the outcome.

7% had improved their social relationships but they were not satisfied

with the outcome.

Rotter's Locus of Control Scale.

Social Reaction Inventory

This is a questionnaire to find out the way in which certain important events in our society affect different people. Each item consists of a pair of alternatives lettered a or b. Please select the one statement of each pair (and only one) which you more strongly <u>believe</u> to be the case as far as you're concerned. Be sure to select the one you actually believe to be more true rather than the one you think you should choose or the one you would like to be true. This is a measure of personal belief; obviously there are no right or wrong answers.

Your answer, either a or b to each question on this inventory, is to be reported beside the question.

Please answer these items <u>carefully</u> but do not spend too much time on any one item. Be sure to find an answer for every choice. For each numbered question make an x on the line beside either the a or b, whichever you choose as the statement most true.

In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the one you more strongly believe to be the case as far as you're concerned. Also try to respond to each item <u>independently</u> when making your choice; do not be influenced by your previous choices.

Remember

Select that alternative which you <u>personally believe to be more true.</u>

<u>I more strongly believe that:</u>

1 (a) Children get into trouble because their parents punish them too much.

  (b) The trouble with most children nowadays is that their parents are too easy with them.

2 (a) Many of the unhappy things in people's lives are partly due to bad luck.

  (b) People's misfortunes result from the mistakes they make.

3 (a) One of the major reasons why we have wars is because people don't
        take enough interest in politics.

   (b) There will always be wars, no matter how hard people try to prevent
        them.

4 (a) In the long run, people get the respect they deserve in this world.

   (b) Unfortunately, an individual's worth often passes unrecognised no
        matter how hard he tries.

5 (a) The idea that teachers are unfair to students is nonsense.

   (b) Most students don't realise the extent to which their grades are
        influenced by accidental happenings.

6 (a) Without the right breaks, one cannot be an effective leader.

   (b) Capable people who fail to become leaders have not taken advantage
        of their opportunities.

7 (a) No matter how hard you try, some people just don't like you.

   (b) People who can't get others to like them don't understand how
        to get along with others.

8 (a) Heredity plays the major role in determining one's personality.

   (b) It is one's experiences in life which determine what they're like.

9 (a) I have often found that what is going to happen will happen.

   (b) Trusting to fate has never turned out as well for me as making
        a decision to take a definite course of action.

10 (a) In the case of the well prepared student, there is rarely, if ever,
        such a thing as an unfair test.

   (b) Many times, exam questions tend to be so unrelated to course work
        that studying is really useless.

11 (a) Becoming a success is a matter of hard work, luck has little or
        nothing to do with it.

   (b) Getting a good job depends mainly on being in the right place at the
        right time.

12 (a) The average citizen can have an influence in government decisions.

   (b) This world is run by the few people in power, and there is not much
        the little guy can do about it.

13 (a) When I make plans, I am almost certain that I can make them work.

   (b) It is not always wise to plan too far ahead because many things
        turn out to be a matter of good or bad fortune anyhow.

14 (a) There are certain people who are just no good.

   (b) There is some good in everybody.

15 (a) In my case getting what I want has little or nothing to do with luck.

(b) Many times we might just as well decide what to do by flipping a coin.

16 (a) Who gets to be the boss often depends on who was lucky enough to be in the right place first.

(b) Getting people to do the right thing depends upon ability; luck has little or nothing to do with it.

17 (a) As far as world affairs are concerned, most of us are the victims of forces we can neither understand nor control.

(b) By taking an active part in political and social affairs the people can control world events.

18 (a) Most people can't realise the extent to which their lives are controlled by accidental happenings.

(b) There really is no such thing as "luck".

19 (a) One should always be willing to admit his mistakes.

(b) It is usually best to cover up one's mistakes.

20 (a) It is hard to know whether or not a person really likes you.

(b) How many friends you have depends upon how nice a person you are.

21 (a) In the long run the bad things that happen to us are balanced by the good ones.

(b) Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22 (a) With enough effort we can wipe out political corruption.

(b) It is difficult for people to have much control over the things politicians do in office.

23 (a) Sometimes I can't understand how teachers arrive at the grades they give.

(b) There is a direct connection between how hard I study and the grades I get.

24 (a) A good leader expects people to decide for themselves what they should do.

(b) A good leader makes it clear to everybody what their jobs are.

25 (a) Many times I feel that I have little influence over the things that happen to me.

(b) It is impossible for me to believe that chance or luck plays an important role in my life.

26 (a) People are lonely because they don't try to be friendly.

(b) There's not much use in trying too hard to please people, if they like you, they like you.

27 (a) There is too much emphasis on athletics in high school.

(b) Team sports are an excellent way to build character.

28 (a) What happens to me is my own doing.

(b) Sometimes I feel that I don't have enough control over the direction my life is taking.

29 (a) Most of the time, I can't understand why politicians behave the way they do.

(b) In the long run the people are responsible for bad government on a national as well as on a local level.

Treatment Expectancies Questionnaire.

Treatment Expectancies Questionnaire (TEQ)

The following are statements about the way many people feel about treatment. Please show how far you agree with these statements by <u>circling</u> the answers as follows:

T means you feel the statement is true.

PT means you feel the statement is possibly true.

PF means you feel the statement is possibly false.

F means you feel the statement is false.

<u>Please answer every item</u>

1. Treatment does not solve your problems but makes you able to cope with them.

        T   PT   PF   F

2. Just talking will never help me overcome my basic fears.

        T   PT   PF   F

3. Nobody will cure you, you've got to live with your problems.

        T   PT   PF   F

4. I don't understand how people can have difficulties in getting on with each other.

        T   PT   PF   F

5. I don't think talking over emotional problems serves any useful purpose.

        T   PT   PF   F

6. Everybody's problems are different so it wouldn't help me to discuss mine with other patients.

        T   PT   PF   F

7. Physical treatment (like tablets, etc.) is the best form of treatment for people with psychiatric illness.

        T   PT   PF   F

8. I think that what I need is training in how to overcome my symptoms.

        T   PT   PF   F

9. Only a specialist in mental treatments will be able to help me get better.

        T   PT   PF   F

10. I have never felt any pressing need to talk about my emotional problems.

        T   PT   PF   F

11. I can't see how other patients in treatment can help to cure anybody else except by chance or accident.

        T   PT   PF   F

12. I have to learn to stop always thinking about myself when in the company of others.

T PT PF F

13. There would be much less mental illness if people exerted more control over themselves.

T PT PF F

14. I am the only person who can do anything about my problems.

T PT PF F

15. The mere fact of understanding my illness will make me better.

T PT PF F

16. What I need is for the doctor or therapist to tell me what I am doing wrong and what I should do about it.

T PT PF F

17. I definitely feel that there is somebody who can cure me.

T PT PF F

18. Learning to relax in difficult situations is an important part of treatment.

T PT PF F

19. I only expect my symptoms to change after treatment and not myself as a person.

T PT PF F

20. The personality of the therapist or doctor does not matter in treatment since it is his specialised knowledge that really counts.

T PT PF F

21. Treatment is really being <u>taught</u> how to deal with difficult situations.

T PT PF F

22. The doctor or therapist should always give direct advice to his patients.

T PT PF F

23. Thinking about yourself too much can make you ill.

T PT PF F

24. I have come for treatment partly because I have difficulties in understanding what life is all about.

T PT PF F

25. It is an important part of treatment for patients to believe that the doctors are all powerful.

T PT PF F

26. Being myself and disclosing my weaknesses is an important part of treatment.

                                            T   PT   PF   F

27. A patient should not be expected to discuss really personal problems with the other patients.

                                            T   PT   PF   F

28. It is important for the doctor not to show his real feelings to the patient.

                                            T   PT   PF   F

Semantic differentials and instructions.

Semantic Differential Instructions
_____

This is how you use these scales:

If you feel that the feature of the person(s) is <u>very closely related</u> to the
one end of the scale, you should place the check mark as follows:

fair:__X__:_____:_____:_____:_____:_____:_____: unfair

or

fair:_____:_____:_____:_____:_____:_____:__X__: unfair

If you feel that the feature of the person(s) is <u>quite closely related</u> to one
or the other end of the scale (but not extremely, you should place your
check mark as follows:

fair:_____:__X__:_____:_____:_____:_____:_____: unfair

or

fair:_____:_____:_____:_____:_____:__X__:_____: unfair

If you feel that the feature of the person(s) seems <u>only slightly related</u>
to one side as opposed to the other side (but is not really neutral), then
you should check as follows:

fair:_____:_____:__X__:_____:_____:_____:_____: unfair

or

fair:_____:_____:_____:_____:__X__:_____:_____: unfair

The direction towards which you check, of course, depends upon which of the
two ends of the scale seem most characteristic of the person(s) you are
judging.

If you consider the feature to be <u>neutral</u> on the scale, both sides of the
scale <u>equally associated</u> with the feature,or if the scale is <u>completely
irrelevant</u>, unrelated to the feature, then you should place your check
mark in the middle space:

fair:_____:_____:_____:__X__:_____:_____:_____: unfair

IMPORTANT
_____

1. Please place your check marks <u>in the middle of the spaces</u>, not on the
    boundaries:

    _____:__X__:_____:_____:_____:X_____:_____: unfair
       THIS   **NOT THIS**

2.   Be sure you check every scale. <u>Do not omit any</u>.

3.   Never put more than one check mark on a single scale.

Make each item a separate and independent judgment. It is your first impression, the immediate "feelings" about the item, that I want. On the other hand, please do not be careless, because I want your true impressions.

HOW I PERCEIVE MYSELF

optimistic	:___:___:___:___:___:___:___:	pessimistic
weak	:___:___:___:___:___:___:___:	strong
active	:___:___:___:___:___:___:___:	passive
unsociable	:___:___:___:___:___:___:___:	sociable
lenient	:___:___:___:___:___:___:___:	severe
excitable	:___:___:___:___:___:___:___:	calm
unsuccessful	:___:___:___:___:___:___:___:	successful
brave	:___:___:___:___:___:___:___:	cowardly
aimless	:___:___:___:___:___:___:___:	motivated
elevated	:___:___:___:___:___:___:___:	depressed
permissive	:___:___:___:___:___:___:___:	prohibitive
rational	:___:___:___:___:___:___:___:	intuitive
unimportant	:___:___:___:___:___:___:___:	important
serious	:___:___:___:___:___:___:___:	humorous
rash	:___:___:___:___:___:___:___:	cautious
sick	:___:___:___:___:___:___:___:	healthy
masculine	:___:___:___:___:___:___:___:	feminine
defensive	:___:___:___:___:___:___:___:	aggressive

MY IDEAL SELF

optimistic	:___:___:___:___:___:___:___:	pessimistic
weak	:___:___:___:___:___:___:___:	strong
active	:___:___:___:___:___:___:___:	passive
unsociable	:___:___:___:___:___:___:___:	sociable
lenient	:___:___:___:___:___:___:___:	severe
excitable	:___:___:___:___:___:___:___:	calm
unsuccessful	:___:___:___:___:___:___:___:	successful
brave	:___:___:___:___:___:___:___:	cowardly
aimless	:___:___:___:___:___:___:___:	motivated
elevated	:___:___:___:___:___:___:___:	depressed
permissive	:___:___:___:___:___:___:___:	prohibitive
rational	:___:___:___:___:___:___:___:	intuitive
unimportant	:___:___:___:___:___:___:___:	important
serious	:___:___:___:___:___:___:___:	humorous
rash	:___:___:___:___:___:___:___:	cautious
sick	:___:___:___:___:___:___:___:	healthy
masculine	:___:___:___:___:___:___:___:	feminine
defensive	:___:___:___:___:___:___:___:	aggressive

MY   PARENTS

optimistic	:___:___:___:___:___:___:___:	pessimistic
weak	:___:___:___:___:___:___:___:	strong
active	:___:___:___:___:___:___:___:	passive
unsociable	:___:___:___:___:___:___:___:	sociable
lenient	:___:___:___:___:___:___:___:	severe
excitable	:___:___:___:___:___:___:___:	calm
unsuccessful	:___:___:___:___:___:___:___:	successful
brave	:___:___:___:___:___:___:___:	cowardly
aimless	:___:___:___:___:___:___:___:	motivated
elevated	:___:___:___:___:___:___:___:	depressed
permissive	:___:___:___:___:___:___:___:	prohibitive
rational	:___:___:___:___:___:___:___:	intuitive
unimportant	:___:___:___:___:___:___:___:	important
serious	:___:___:___:___:___:___:___:	humorous
rash	:___:___:___:___:___:___:___:	cautious
sick	:___:___:___:___:___:___:___:	healthy
masculine	:___:___:___:___:___:___:___:	feminine
defensive	:___:___:___:___:___:___:___:	aggressive

THE   GROUP

optimistic	:___:___:___:___:___:___:___:	pessimistic
weak	:___:___:___:___:___:___:___:	strong
active	:___:___:___:___:___:___:___:	passive
unsociable	:___:___:___:___:___:___:___:	sociable
lenient	:___:___:___:___:___:___:___:	severe
excitable	:___:___:___:___:___:___:___:	calm
unsuccessful	:___:___:___:___:___:___:___:	successful
brave	:___:___:___:___:___:___:___:	cowardly
aimless	:___:___:___:___:___:___:___:	motivated
elevated	:___:___:___:___:___:___:___:	depressed
permissive	:___:___:___:___:___:___:___:	prohibitive
rational	:___:___:___:___:___:___:___:	intuitive
unimportant	:___:___:___:___:___:___:___:	important
serious	:___:___:___:___:___:___:___:	humorous
rash	:___:___:___:___:___:___:___:	cautious
sick	:___:___:___:___:___:___:___:	healthy
masculine	:___:___:___:___:___:___:___:	feminine
defensive	:___:___:___:___:___:___:___:	aggressive

HOW   I   THINK   THE   GROUP   PERCEIVES   ME

optimistic	:___:___:___:___:___:___:___:	pessimistic
weak	:___:___:___:___:___:___:___:	strong
active	:___:___:___:___:___:___:___:	passive
unsociable	:___:___:___:___:___:___:___:	sociable
lenient	:___:___:___:___:___:___:___:	severe
excitable	:___:___:___:___:___:___:___:	calm
unsuccessful	:___:___:___:___:___:___:___:	successful
brave	:___:___:___:___:___:___:___:	cowardly
aimless	:___:___:___:___:___:___:___:	motivated
elevated	:___:___:___:___:___:___:___:	depressed
permissive	:___:___:___:___:___:___:___:	prohibitive
rational	:___:___:___:___:___:___:___:	intuitive
unimportant	:___:___:___:___:___:___:___:	important
serious	:___:___:___:___:___:___:___:	humorous
rash	:___:___:___:___:___:___:___:	cautious
sick	:___:___:___:___:___:___:___:	healthy
masculine	:___:___:___:___:___:___:___:	feminine
defensive	:___:___:___:___:___:___:___:	aggressive

THE   THERAPIST

optimistic	:___:___:___:___:___:___:___:	pessimistic
weak	:___:___:___:___:___:___:___:	strong
active	:___:___:___:___:___:___:___:	passive
unsociable	:___:___:___:___:___:___:___:	sociable
lenient	:___:___:___:___:___:___:___:	severe
excitable	:___:___:___:___:___:___:___:	calm
unsuccessful	:___:___:___:___:___:___:___:	successful
brave	:___:___:___:___:___:___:___:	cowardly
aimless	:___:___:___:___:___:___:___:	motivated
elevated	:___:___:___:___:___:___:___:	depressed
permissive	:___:___:___:___:___:___:___:	prohibitive
rational	:___:___:___:___:___:___:___:	intuitive
unimportant	:___:___:___:___:___:___:___:	important
serious	:___:___:___:___:___:___:___:	humorous
rash	:___:___:___:___:___:___:___:	cautious
sick	:___:___:___:___:___:___:___:	healthy
masculine	:___:___:___:___:___:___:___:	feminine
defensive	:___:___:___:___:___:___:___:	aggressive

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HOW I THINK I WAS BEFORE I JOINED THE GROUP

optimistic	:___:___:___:___:___:___:___:	pessimistic
weak	:___:___:___:___:___:___:___:	strong
active	:___:___:___:___:___:___:___:	passive
unsociable	:___:___:___:___:___:___:___:	sociable
lenient	:___:___:___:___:___:___:___:	severe
excitable	:___:___:___:___:___:___:___:	calm
unsuccessful	:___:___:___:___:___:___:___:	successful
brave	:___:___:___:___:___:___:___:	cowardly
aimless	:___:___:___:___:___:___:___:	motivated
elevated	:___:___:___:___:___:___:___:	depressed
permissive	:___:___:___:___:___:___:___:	prohibitive
rational	:___:___:___:___:___:___:___:	intuitive
unimportant	:___:___:___:___:___:___:___:	important
serious	:___:___:___:___:___:___:___:	humorous
rash	:___:___:___:___:___:___:___:	cautious
sick	:___:___:___:___:___:___:___:	healthy
masculine	:___:___:___:___:___:___:___:	feminine
defensive	:___:___:___:___:___:___:___:	aggressive

HOW I THINK THE GROUP PERCEIVES ME AS AN INDIVIDUAL

optimistic   :___:___:___:___:___:___:___: pessimistic

weak   :___:___:___:___:___:___:___: strong

active   :___:___:___:___:___:___:___: passive

unsociable   :___:___:___:___:___:___:___: sociable

lenient   :___:___:___:___:___:___:___: severe

excitable   :___:___:___:___:___:___:___: calm

unsuccessful :___:___:___:___:___:___:___: successful

brave   :___:___:___:___:___:___:___: cowardly

aimless   :___:___:___:___:___:___:___: motivated

elevated   :___:___:___:___:___:___:___: depressed

permissive   :___:___:___:___:___:___:___: prohibitive

rational   :___:___:___:___:___:___:___: intuitive

unimportant   :___:___:___:___:___:___:___: important

serious   :___:___:___:___:___:___:___: humorous

rash   :___:___:___:___:___:___:___: cautious

sick   :___:___:___:___:___:___:___: healthy

masculine   :___:___:___:___:___:___:___: feminine

defensive   :___:___:___:___:___:___:___: aggressive

HOW   I   THINK   THE   GROUP   PERCEIVES   ME   AS   A   THERAPIST

optimistic	:___:___:___:___:___:___:___:	pessimistic
weak	:___:___:___:___:___:___:___:	strong
active	:___:___:___:___:___:___:___:	passive
unsociable	:___:___:___:___:___:___:___:	sociable
lenient	:___:___:___:___:___:___:___:	severe
excitable	:___:___:___:___:___:___:___:	calm
unsuccessful	:___:___:___:___:___:___:___:	successful
brave	:___:___:___:___:___:___:___:	cowardly
aimless	:___:___:___:___:___:___:___:	motivated
elevated	:___:___:___:___:___:___:___:	depressed
permissive	:___:___:___:___:___:___:___:	prohibitive
rational	:___:___:___:___:___:___:___:	intuitive
unimportant	:___:___:___:___:___:___:___:	important
serious	:___:___:___:___:___:___:___:	humorous
rash	:___:___:___:___:___:___:___:	cautious
sick	:___:___:___:___:___:___:___:	healthy
masculine	:___:___:___:___:___:___:___:	feminine
defensive	:___:___:___:___:___:___:___:	aggressive

HOW I THINK I WAS BEFORE I STARTED THE GROUP

optimistic	:___:___:___:___:___:___:___:	pessimistic
weak	:___:___:___:___:___:___:___:	strong
active	:___:___:___:___:___:___:___:	passive
unsociable	:___:___:___:___:___:___:___:	sociable
lenient	:___:___:___:___:___:___:___:	severe
excitable	:___:___:___:___:___:___:___:	calm
unsuccessful	:___:___:___:___:___:___:___:	successful
brave	:___:___:___:___:___:___:___:	cowardly
aimless	:___:___:___:___:___:___:___:	motivated
elevated	:___:___:___:___:___:___:___:	depressed
permissive	:___:___:___:___:___:___:___:	prohibitive
rational	:___:___:___:___:___:___:___:	intuitive
unimportant	:___:___:___:___:___:___:___:	important
serious	:___:___:___:___:___:___:___:	humorous
rash	:___:___:___:___:___:___:___:	cautious
sick	:___:___:___:___:___:___:___:	healthy
masculine	:___:___:___:___:___:___:___:	feminine
defensive	:___:___:___:___:___:___:___:	aggressive