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CRITERIA FOR EVALUATION OF RESULTS IN PSYCHOTHERAPY

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Before proceeding to the actual evaluation of results in psychotherapy, let us first observe how far we have advanced in our knowledge of the nature of neurosis.

As we have seen, neurosis is a condition of the mind characterized by various symptoms, such as anxiety, depression, and phobias, which are not due to any organic cause.

It is important to note that neurosis is not a disease, but a state of mind.

The following criteria can be used to evaluate the effectiveness of psychotherapy:

1. Improvement in symptoms
2. Increased self-esteem
3. Enhanced ability to cope with stress
4. Improved interpersonal relationships
5. Increased sense of control over life situations

In order to determine if psychotherapy has been effective, it is necessary to compare the patient's current state with their initial state. This comparison should be made on a regular basis, such as monthly or quarterly.

It is also important to consider the patient's overall progress, rather than focusing solely on specific symptoms.

In conclusion, the evaluation of results in psychotherapy requires a comprehensive approach, taking into account the patient's entire journey and progress towards recovery.
the behavior of the patient. If you assume that the reliability of psychiatrists' judgment is of the order of 0.57 and since they deal only with the sick who constitute only one per cent of the general population, then you may ask: How reliable would the judgment be if it were spread over the entire population, including both normals and abnormal? And the answer, statistically, is: It would jump to about 0.96. When the reliability of judging normality versus abnormality is 0.96, how often would one find a person who was really down at the bottom, in the lowest 1 per cent on the initial evaluation, shift by chance into the upper 99 per cent or well people. The answer is one-third of the time. In other words, you can regard this one-third, one-third, one-third division of outcome as nothing else but a reflection of the unreliability of the initial and final psychiatric judgment.

That is a harsh judgment to make, but although Winde's hypothesis is far from proven, there is no evidence to contradict it at the moment; these are the kinds of issues that we are faced with when we try to evaluate the outcome of therapy or the outcome of illness without having good criteria and good methods for making the initial judgment and the final judgment. What ways do we have for making the initial judgment? Dr. Stevenson has already pointed out ways of doing it, and so has Dr. Franz Alexander, and so has Dr. Wolberg. I would like to point out briefly the methods we have tried to develop in our own laboratory.

First of all, we try to find out, as far as possible, including the first nine months of life, all we can about the patient's early development, his adolescence, his early adulthood—all the data up to the point when he becomes a mental patient, that is, his premorbid characteristics.

Secondly, we obtain by means of a newly developed mental status examination schedule, which is objective in nature, the actual clinical status of the individual when he arrives for treatment. We no longer depend on the unsystematic history-taking methods of the psychiatric resident. Instead, we cover in a systematic fashion the possibly existing psychopathology through an objective, controlled interview. Then we have a whole series of psychologic tests, emerging in various laboratories, which tap the physiologic, sensory, perceptual, psychomotor, and conceptual areas. We go on into the sociologic milieu, family relations, family structure, and other sociologic and anthropologic aspects, in order to be able to get a picture of the entire individual from beginning to end, so that, with these data available, we can try to predict what the outcome will be. Finally, the course of the illness, after admission, is recorded in a specially developed Ward Behavior Inventory by the nursing staff.

Let me give you two examples of how variables, intuitive, clinical material, and numerous at particular goals, in order to be the whole literature, in which we found relevant to prognosis in schizophrenia, I am thinking through, these 150 traits have stood in some sign to have a sudden onset in the year end in our day. It was bad to have flatline today. About 80 per cent of the traits have gone in these last 70 years, but what it seems to be far more important than the kind of thing it is so important to find out the guiding for treatment and the kinds of assets are.

The first trait I have selected is flatness of tone, at least when you went through your hospital, had to assay the level of affect of the patient, you have to use many more clin there is one aspect of his behavior which is measurable, and recordable, but also seems to be recording in the usual interview into three parts, the first ten minutes, and the third ten minutes (1).

During the first ten minutes, the conversation is recorded, and for all you could tell, it is ancedotal. We have it so organized that if the patient says some reference to self-referred affect, like, "I'm embarrassed," "I was worried," "Uh-huh," "I see," "I understand." Finally, in the third period, we stop recording and carefully count the number of words, defined as being specifically related to affect.
Let me give you two examples of how we have taken the rather amorphous, intuitive, clinical material, and made it into sharpshooting rifles, shooting at particular goals, in order to be able to get objective facts. Out of the whole literature, in which we found approximately 150 traits that relate to prognosis in schizophrenia, I am picking two as an example. The way, these 150 traits have stood the test of time well. It was a sign to have a sudden onset in the year 1900, and it is still considered in our day. It was bad to have flatness of affect then, and it is still today. About 80 per cent of the traits have retained their prognostic power throughout recorded psychiatric history. Therapies have come and gone in these last 70 years, but what a patient brings to the therapy seems to be far more important than the kind of therapy he gets. That is why it is so important to find out the nature of the patient-material using for treatment and the kinds of assets and liabilities these patients are.

The first trait I have selected is flatness of affect. Many of you, I am sure, at least when you went through your training period in the mental hospital, had to assay the level of affect of which the patient is capable. Can’t mean to say that the measure replaces clinical intuition, because in the last analysis, when you really want to know what is the matter with a patient, you have to use many more clinical instruments to find out. There is one aspect of his behavior which seems to be not only objective, measurable, and recordable, but also seems to be related to outcome.

We conduct the interview in the usual fashion, asking the patient to bring him to the hospital and other general questions, and divide the interview into three parts, the first ten minutes, the second ten minutes, and the third ten minutes (1).

During the first ten minutes, the conversation goes on as I just indicated, and for all you could tell, it is an ordinary clinical conversation. I have it so organized that if the patient stops talking, we wait about 20 seconds and only then ask the next question or prod him along to go on talking.

During the next ten minutes, every time he makes an utterance which has some reference to self-referred affect, like the phrase “I love,” “I hate,” “I’m embarrassed,” “I was worried,” the interviewer says “yes,” “Uh-huh,” “I see,” “I understand.”

Finally, in the third period, we stop reinforcing, and then we take the recording and carefully count the number of utterances which we are defined as being specifically related to affect. We count the number of the first ten minutes, in the second ten minutes and in the third ten.
minute interval. Here’s what happens: He gives little affect to begin with, and then, when you start reinforcing, he emits more affect. When you stop reinforcing, he declines in affective utterances.

What happens to normals is the first question you might ask (2). The normal’s curve to begin with is very much like the patient’s. Normals do not differ significantly from schizophrenics in the first period (operant). The second period (conditioning) also shows no significant difference. The difference here lies in the third period (extinction). While both normals and schizophrenics slow down in their rate of making affect statements, the schizophrenics slow down much more. This may be the reason why Freud said that it’s no use trying to analyze a schizophrenic. You have to keep on doing it the rest of his life, because when you leave him, he'll drop back, he won’t show much of the effects of learning. And in the conditioning curve is the area where we have our diagnostic differential (3). The patients who do not become conditioned are by and large the ones who remain in the hospital at the end of six months. Those who show an increase in affect statements are out at the end of six months. Whether the differentiation into Ins and Outs is due to differences in affect or to differences in conditionability per se remains for further research to clarify.

Just as an aside, it may very well be that this increase in affect statements under reinforcement may be the reason why Freudians get freudian dreams, Jungians get jungian dreams, Rogerians get no dreams at all! It may very well be that a freudian dream starts looming up, the freudian therapist knowingly or unknowingly becomes more reinforcing in his manner. Thus the process of reinforcement that takes place may be one of the most essential elements in the interaction between the therapist and patient. In fact, we have turned this thing around a bit, asking ourselves, “Can we use this technique to find out what goes on in people’s minds—what concepts they have?” (4), just as Piaget, for example, goes about trying to discover concepts in the minds of children at various ages. This is a technique which may be useful for our purposes.

For example, we tried the following experiment (5). We asked the subject to say three digit numbers. Every time he gave an odd number, we would say, “good”; we wanted to see whether or not he would give more odd numbers, that is, did he have the concept of odd numbers? And the same thing can be done in other areas. Children, for example, are very difficult to deal with in these situations. We like to know their concepts of mother and father and of their family relations so we made a little papier-mâché clown with a red bulb for a nose (6). We have a little song, ostensibly sung by the clown. The happy only when children speak to him up. You can see what sort of a tool we talk toward “mother” or “father” or the light reinforcement and in this mental content they have.

As a second example I want to describe the question of sudden versus insidious. Here, we searched over the entire lifespan development which would tell us whether or not was already sick or not. We concentrated pattern and discovered, to our great amazement, important for detecting insidious onset normative studies on adolescent friends and poems have been written about it but friendships in the normal—we had to go further, we discovered, was that a chronic schizophrenic has, in contrast to distribution is quite unusual. Is it the U's! his own age, the rest are mostly younger the normal, his friends are mostly around a few older.

Secondly, this chronic schizophrenic always the one brought into the friendship. It’s the others who break it off. The variety of other interesting features which studying the adolescent friendship patte whether or not he was already showing signs of a psychosis.

I would like to go on to the next topic issue with Dr. Alexander. I regard his st... you cannot go on to evaluate outcome at turn to an analysis of the process of the problem—a flight into process if you will solving the problem. You will never get the problem. It seems to me that the histories where, instead of facing up to th... to evaluate,” we turn away from it at technique whose effect we do not know. Recently as a hundred years ago there was
song, ostensibly sung by the clown. The little clown explains that he is happy only when children speak to him. On these occasions his nose lights up. You can see what sort of a tool we have here. We can direct their talk toward “mother” or “father” or “school” by appropriate delivery of the light reinforcement and in this way we can study what sort of mental content they have.

As a second example I want to describe how we went about answering the question of sudden versus insidious onset by an objective approach. Here, we searched over the entire lifespan trying to find an area of early life development which would tell us whether at that time the person was already sick or not. We concentrated on the adolescent friendship pattern and discovered, to our great amazement, that this period was most important for detecting insidious onset. However, we found that no normative studies on adolescent friendship existed. Novels, romances, and poems have been written about it but there are no data on adolescent friendships in the normal—we had to get our own. One distinguishing feature, we discovered, was that the adolescent who later becomes a chronic schizophrenic has, in contrast to the normal, friends whose age distribution is quite unusual. It is U-shaped; he has very few friends his own age, the rest are mostly younger or mostly older. In the case of the normal, his friends are mostly around his own age, a few younger and a few older.

Secondly, this chronic schizophrenic never forms a friendship. He is always the one brought into the friendship. He never breaks a friendship. It’s the others who break it off. The kind of friendship he forms has a variety of other interesting features which makes us feel that perhaps, by studying the adolescent friendship pattern, we may get an insight into whether or not he was already showing insidious signs of later development of a psychosis.

I would like to go on to the next topic about which I want to raise an issue with Dr. Alexander. I regard his statement that at the present time you cannot go on to evaluate outcome statistically, and therefore must turn to an analysis of the process of therapy, as a flight away from the problem—a flight into process if you will, rather than as an approach to solving the problem. You will never get anywhere running away from the problem. It seems to me that the history of medicine is full of instances where, instead of facing up to the issue and saying “We’ve got to evaluate,” we turn away from it and try instead to describe the technique whose effect we do not know. Let me remind you that as recently as a hundred years ago there was a procedure called phlebotomy.
In the seventeenth century, book after book was written devoted wholly to process in phlebotomy, illustrating and discussing the various methods and locations for cutting into different veins for different symptoms of disease. The whole history of medicine seems to be replete with zealous movements in which the zealots redoubled their effort when the goal was lost!

There are ways of attacking the problem more directly, but I can only intimate this. We can build a scientific model, a structure, for encompassing the known facts about psychotherapy, of such a nature that we can elicit from it certain hypotheses for testing and for evaluating which perhaps will bring us out of the darkness so that we do not simply take refuge in studying the process, regardless of outcome. The process may be irrelevant to the outcome.

REFERENCES


CRITERIA FOR EVALUATION OF RESULTS

Franz Alexander, M.D.

I feel I didn’t make my point, because I should be very brief, and certainly briefly as the chairman would like it. I think, after I heard certain misunderstandings why I didn’t make my point.

To study outcome without studying the process has been achieved doesn’t answer the question of why Dr. Zubin’s objection. To take the problem. If we only study what and after, a host of questions are not answered procedures at all.

The best argument was given by Dr. Alexander in which I thoroughly believe. I am about the Hippocratic principle that if you begin healing—then one. Is there such a thing as beginning state and the other without paying attention to the other, without paying attention to one won’t know anything. The patient was healed because of your therapeutic effect, primarily through your therapeutic effect. He might have recovered. Psychotherapy. He might have recovered, and other phases might have come to think often happens in very prolonged recovery.

If you don’t know what happened in effect of what you did. Of course you have the beginning and at the end, each patient different, however. One must study each thing to the end. I am against a general therapeutic procedure by comparing these end states. In order to evaluate psychological, and what we are doing, and how what we’re doing. Without this, we are simply not knowing what they mean.

Psychotherapy comprehends a most diverse range from magic, suggestion, persuasion, and also systematic rational procedures of the same knowledge. One cannot even meani
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DISCUSSION

FRANZ ALEXANDER, M.D.

I feel I didn't make my point, because the chairman admonished me that I should be very brief, and certain things cannot be said quite as briefly as the chairman would like it. But to make my point is easier now, after I heard certain misunderstandings which show me where and why I didn't make my point.

To study outcome without studying the process by which this outcome has been achieved doesn't answer the question. And here I can right away answer Dr. Zubin's objection. This is far from running away from the problem. If we only study what happens to the patient before and after, a host of questions are not answered, and we don't evaluate our procedures at all.

The best argument was given by Dr. Stevenson, who took up something in which I thoroughly believe. I am very much in agreement with him about the Hippocratic principle that the doctor helps nature to heal—he doesn't heal. There is such a thing as spontaneous recovery. If you take the beginning state and the outcome state and compare them with each other, without paying attention to what happened in between, you won't know anything. The patient might have achieved what was achieved because of therapeutic efforts. He might have achieved primarily through your therapeutic effort, partially by his own self-healing powers. He might have recovered not because but in spite of psychotherapy. He might have recovered in some phases of the therapy and other phases might have counteracted his recovery, which think often happens in very prolonged treatments. There are many possibilities.

If you don't know what happened in between, you can't evaluate the effect of what you did. Of course you must compare the patient at the beginning and at the end, each patient on his own. This is not efficient, however. One must study each case precisely from the beginning to the end. I am against a general statistical evaluation of the therapeutic procedure by comparing these two points, the beginning and the end state. In order to evaluate psychotherapy, we must understand what we are doing, and how what we are doing affects the process recovery. Without this, we are simply setting up figures blindly without knowing what they mean.

Psychotherapy comprehends a most diversified array of procedures, ranging from magic, suggestion, persuasion, consolation, reassurance, and also systematic rational procedures, based on advanced psychodynamic knowledge. One cannot even meaningfully differentiate the thera-
pies according to these therapeutic measures, because most therapies contain all these factors. Equally heterogeneous is the total set of the conditions we treat, including psychopathologic symptoms and reactions to extreme traumatic events, chronic personality dysfunctions, behavior disturbances, chronic and transient forms of psychosis. And to increase the complexity of the problem, the instruments of psychotherapy include not only the technical procedure enumerated above but also a most important factor, the unique personality of the therapist.

According to our present studies, which we are carrying out by observing the process, this may turn out to be one of the most significant therapeutic factors. There is strong indication that the outcome of the procedure, be it magic incantation or standard psychoanalysis, to a large degree depends on the idiosyncratic qualities of the therapist or of the magician. There is good historic corroboration of this statement, since magicians and medicine men become medicine men because of certain idiosyncratic qualities which make them effective. This factor is even more elusive because the effectiveness of the psychotherapy seems to depend largely upon a lucky combination of the therapist's and the patient's idiosyncratic qualities. It requires a methodologic naiveté of the first order to expect meaningful answers in this field to come from statistical figures. The number of the independent pertinent variables determines the number of categories into which the whole sample has to be broken down, in order to compare similar things. The greater the number of these categories, the greater is the required size of the total sample. In the case of psychotherapy, this may reach astronomic dimensions. Well, today that shouldn't be an obstacle. The correlations between this multiplicity of variables could be statistically handled by computers. We heard a very interesting paper about the use of computers a while back in the Academy. Dr. Jaffe, who uses computers, does remarkable things with them. But a meaningful coding of these variables can be hardly visualized today. Jaffe's very interesting procedure does not seem to have a meaningful coding system. Why? Because in every coding you must overlook certain differences. In the psychotherapeutic experiments, no two cases are similar, so it would be extremely difficult to code them meaningfully. One cannot help but overlook certain differences. And, not knowing the significance of the differences, one can't do meaningful coding.

Now, for example, if you put into the machine such variables as the theoretical persuasion of the therapist, the procedures that he actually uses, the nature of the case, the nature of the neurosis, its duration, and I don't know what else, but forget to put in the "lucky combination" between the therapist and the patient, comes meaningless. Fiedler maintains that adlerian, rogerian or freudian, has about one-third statistical results among different individuals by the parallel distribution of personality, one should not try to evaluate the end today it can only be done meaningfully in an individual case, and by observing what happens or happens when it happened and why it happened, even with another psychoanalysis: say, one jungian analysis with another jנת personality factors may be different freudian analyses.

This is only one example to show match similar cases in sufficient number effectiveness of one form of psychotherapy to another form of psychotherapy. What we can do is to achieve a certain amount of meaningfulness, maybe nonmeaningful, by such and such factors. The chance factor has been undervalued to a very great extent, meeting the right person might not be necessary, and another chance event, but which may prolongation of treatment or a failure of long, and an unfortunate event which may not be simply neglected.

The complexity of all the many factors turns out the way it does, is so great that, try to understand how we achieve those of the therapy did it, how much fort and these other fortuitous events, such as the
between the therapist and the patient, then your statistical result becomes meaningless. Fiedler maintains that any psychotherapy, jungian, Adlerian, Rogerian or freudian, has about the same results. Let us assume—I don't state that it is so, but let us assume—that the lucky combination of the therapist's and the patient's idiosyncratic qualities is one of the powerful therapeutic factors. It is very probable—there is no reason not to assume it—that the distribution of such lucky combinations is the same among all types of psychotherapies.

There is no good reason to assume that among Jungians the personality of the therapist can be matched less often with the patient's qualities in a therapeutically useful combination than among Freudsians. The parallel statistical results among different disciplines could be accounted for by the parallel distribution of personality factors. My point is not that one should not try to evaluate the end result of therapy. I say that today it can only be done meaningfully by treating every patient as an individual case, and by observing what happened to the patient and evaluating how it happened and why it happened. But you can't compare it, even with another psychoanalysis, or you can't compare, let us say, one jungian analysis with another jungian analysis, because important personality factors may be different between two jungian and two freudian analyses.

This is only one example to show that we are not able yet to match similar cases in sufficient number to compare statistically the effectiveness of one form of psychotherapy as compared with another form of psychotherapy. What we can say is merely that this physician with this patient achieved a certain change in the patient, maybe beneficial, maybe nonbeneficial, and that it was achieved by such and such factors. The chance factors, for example, must be put also into the calculating machine. Chance factors are terrifically important. More and more I've come to the conclusion that the chance factor has been undervalued to a very high degree. In the right moment, meeting the right person might be the difference between recovery, and another chance event, but which is not favorable, might mean prolongation of treatment or a failure of the treatment. Life is not so long, and an unfortunate event which retards recovery for a few years, cannot be simply neglected.

The complexity of all the many factors which determine why a case turns out the way it does, is so great that, at least at present, we should try to understand how we achieve those changes which came about, how much the therapy did it, how much fortuitous events did it, how much these other fortuitous events, such as the matching of the two personal-
itics, play a role in it. And there are still other variables and combinations of variables, of which we cannot even think now. We will learn them only by careful, systematic observation of what is going on.

Now one more word about some of these criteria. I mentioned briefly that I think it may be possible, by using modern experimental methods, which psychologists are perfecting—for example those which I was talking about and which measure definite, concrete personality functions—that we may be able to substitute for the global evaluation, what the patient says, what he feels, what the relatives say, or general life-performances; maybe we can replace these global criteria by more precise ones. And I think there are more and more intelligent methods. But Dr. Wolberg mentioned a very interesting criterion, the dreams of the patient. I agree with him that they are extremely valuable for the understanding of certain dynamic changes which have taken place in the personality, but again, without understanding very precisely the dynamics of dreaming, one cannot glibly draw conclusions.

Here is one example. I know of a group of patients, whom I observed during 30 years or more of practice. I was often very much impressed by the fact that these patients, when their behavior in life definitely improved—when they functioned better, had less symptoms—had weirder and weirder, more and more regressive dreams. It almost looked, on superficial inspection, as if they were schizophrenic. Now, why is that? The patient improves in life and behavior, and his dreams become more and more regrettively primitive. The solution, I think, is rather simple. What takes place is that this patient has succeeded in excluding certain regressive trends from his behavior, but there are still these residues, which now have no other outlet. They could not influence the patient's behavior, because, in that system which we call the conscious personality, which is a harmoniously integrated entity, they have no place anymore, and they have no other outlet but in dream life. Let us not forget that this is partially the natural function of the dream. The dream is the psychosis of the normal person. He gets rid of those things which he cannot get rid of in his interpersonal relationships in actual life. And this discrepancy between behavior and dreams indicates improvement. One should not generalize, however.

What is a desirable change? That is indeed a difficult question. I treated a middle-aged woman with arterial hypertension. That was why she came for treatment. Later, I met the husband. He turned to me and said, "You may have helped my wife's blood pressure, but she became a much more difficult person to live with." Was this an improvement or not? For the harmonious marriage she paid a pretty great price, increased arterial hypertension. But he didn't become much more complicated. Now he died very soon after that. I ask, what would a man do? Probably there would have been a suicide in the woman, maybe a suicide. Use your own judgment or the consequences of this cure. What is improvement? This is the first...

IAN STEVENSON, M.D.

On the second round I found myself much in the absence of Dr. Alexander, and this shows the evils of brevity. I have no opportunity to expound his fundamental ideas. I do still agree with Dr. Zubin, that studies of a full or even partial understanding of the present condition of the patient, will all agree in thinking that these two are our incompatibilities and in fact cannot go on simultaneously.

In our studies we are trying to separate the two factors and to learn a good deal about process, if our study has been full or even partial understanding of the process in which he is involved. We hope to learn about process from having the same session what he thinks he is doing in the process, and we may miss those very important intangible features, and Dr. Wolberg mentioned. But still we will have to remember that these therapists say they are doing, and are undoubtedly doing. And then if we find can be the outcomes of the patients, belonging to different therapists when he is using different techniques, something about process, at least to the extent that a particular technique (as reported by the therapist) is a common denominator of the results we are concerned about. I think we need to have any feeling of profound interest in the studies of outcome and of process.

LEWIS R. WOLBERG, M.D.

I find myself in agreement with both of my colleagues. It seems evident that you cannot isolate process from one of the same continuums. After all, we are attempting to describe therapy, and if we are unable to describe the process, we are attempting a certain outcome, we many miss our target. Here a number of value judgments are involved.
price, increased arterial hypertension. But her marriage after treatment became much more complicated. Now for the husband’s luck. He died very soon after that. I ask, what would have happened if he hadn’t died? Probably there would have been a divorce, a deep depression in the woman, maybe a suicide. Use your poetic fantasy to figure out what could have been the consequence of this beautiful symptomatic cure. What is improvement? This is the first thing we should know.

IAN STEVENSON, M.D.

On the second round I found myself much more in agreement with Dr. Alexander, and this shows the evils of brevity, because earlier he did not have enough opportunity to expound his full views. On the other hand, I do still agree with Dr. Zubin, that studies of outcome should await a full or even partial understanding of process. And I think we would all agree in thinking that these two kinds of studies are not incompatible and in fact can go on simultaneously.

In our studies we are trying to separate them but I think that we may learn a good deal about process, if our study works out satisfactorily. We hope to learn about process from having the therapist check after each session what he thinks he was doing in the session. Now he may have been doing many things besides those he checks, and undoubtedly we may miss those very important intangible features that Dr. Alexander and Dr. Wolberg mentioned. But still we will have a list of some things that these therapists say they are doing, and assuming their candor, as undoubtedly doing. And then if we find considerable differences in the outcomes of the patients belonging to different therapists, or to the same therapist when he is using different techniques, I think we will have something about process, at least to the extent of being able to say that a particular technique (as reported by the therapists) was or was not a common denominator of the results we are observing. So I do not think we need to have any feeling of profound incompatibility between the studies of outcome and of process.

LEWIS R. WOLBERG, M.D.

I find myself in agreement with both of my previous discussants, to the extent that you cannot isolate process from outcome. They are part of the same continuum. After all, we are attempting to evaluate psychotherapy, and if we are unable to describe the process through which we attempt a certain outcome, we may miss our goal.

Here a number of value judgments are involved, because what con-
stitutes psychotherapy has not yet been dogmatized. We have certain notions as to what constitutes good psychotherapeutic process, but frequently we find ourselves in the position, in examining why a certain patient has improved, of concluding that the contact between the therapist and the patient was purely coincidental. I remember a patient who came to see me because he wanted me to stop him from smoking.

When I asked him about other problems, he denied having any. In the past he had, he revealed, been a schizophrenic; however, he had been cured by a psychiatrist. "How were you cured?" I inquired. He replied: "I had been to a number of doctors before, but they couldn't help me with talk. All this talk did no good. But this psychiatrist really did things that helped me." The doctor, he continued, asked him to strip off all his clothes at each interview, and to lie nude on the couch. He would then open the window, to cool off the room. The patient was forced to lie on the couch, enduring the cold without being permitted to utter a single word. The idea was that if he learned to tolerate suffering, this would produce a psychic callus and enable him to handle his inner conflicts and tensions. When I asked the patient: "What did the therapist do during this time?" he countered, "Well, he just sat there covered by a blanket."

When we attempt to evaluate what happened, we have to admit that this was no psychotherapy by any traditional standard. I do not doubt that certain things did happen to the patient. The significance to him of this situation probably had certain beneficial effects.

We know enough about psychotherapeutic process to realize that what goes on in psychotherapy requires the development of a relationship between the patient and therapist. The relationship is employed to understand some of the forces that are operating within the individual, to delineate the conflicts that are burdening the patient, to connect these with their genetic determinants, to understand and handle resistance and transference. We know that we can designate certain things that occur in good therapy.

When we try to assess any psychotherapy, we assume that the psychotherapist is sophisticated enough to understand how to utilize his techniques with a certain degree of expertness. If the therapist hasn't had a good deal of training and supervision, we are unable to evaluate the techniques he employs.

In evaluation we are dealing with tremendously complex problems. It is dangerous to oversimplify by adopting a limited criterion and generalizing from this. Take dreams for instance. We have to utilize and interpret dreams within the context of the total life adjustment of the dreamer. His dreams may be disturbed, his relationships with people may be inadequate. Not from his dreams is not entirely apparent.

To say his treatment is a failure because he didn't find that, willy-nilly, the patient, while not getting well, made better life adaptation. He is able to live with people. He is a much happier person under these circumstances, that perhaps he pays for his better adaptation, there are none of the problems are irremediable, the best that can be expected. In another case retention of symptoms is a manifest; he has not accomplished. This situation is one which is bountiful.

Another problem is the matter of con susceptibility to set up controls as in other kin cases, two patients are alike. Any attempt to control may try to match patients according to age or milieu, but the errors of selection. I believe that every individual patient that we need to do is match the patient at the beginning of therapy.

SEPH ZUBIN, PH.D.

I think Dr. Alexander's compromise, the more I think, however, that it will leave the audience of this area. Let me raise one issue which is the matter of overgeneralization of the process altogether. One might point to situations where we do not, the outcome might be so obvious.

One situation which I think might be worth noting is the spontaneous improvement. Suppose we do with the patients, some types of patients, certain factors, certain premorbid characteristics, the onset of onset, and so on, get well, no matter...
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do no good. But this psychiatrist

The doctor, he continued, asked him

interview, and to lie nude on the couch,

cool off the room. The patient was

g the cold without being permitted to

that if he learned to tolerate suffering,

and enable him to handle his inner

patient: "What did the ther-
counterparted, "Well, he just sat there

That happened, we have to admit that

traditional standard. I do not doubt

the patient. The significance to him

in beneficial effects.

therapeutic process to realize that

requires the development of a relationship

T relationship is employed to

are operating within the individual,

hardening the patient, to connect them.

understand and handle resistance and

in designate certain things that occur

As therapy, we assume that the psycho-

understand how to utilize his tech-

nertness. If the therapist hasn't had

vision, we are unable to evaluate the

with tremendously complex problems.

adapting a limited criterion and gen-

for instance. We have to utilize and

of the total life adjustment of the

 dreamer. His dreams may be disturbed, but his waking behavior and

relationships with people may be adequate. To say he is disturbed

ly from his dreams is not entirely appropriate. Or we may take

symptoms. A patient may complete therapy and still suffer from cer-

symptoms.

To say his treatment is a failure because of this is inaccurate. We

any find that, willy-nilly, the patient, while not symptom-free, makes a

much better life adaptation. He is able to develop better relationships

with people. He is a much happier person all around. We might con-

ider, under these circumstances, that perhaps his symptoms are the

reality he pays for his better adaptation, that under his present circum-

ances, many of the problems are irremediable. For him this outcome

the best that can be expected. In another patient we may feel that

reduction of symptoms is a manifestation of a poor outcome. The

ast he should have accomplished is a relief of symptoms since his life

uation is one which is bountiful.

Another problem is the matter of controls. I believe that it is

possible to set up controls as in other kinds of scientific experiments.

o two patients are alike. Any attempt to match patients is fallacious.

e may try to match patients according to so-called diagnostic cate-

ries, or to age or milieu, but the errors in this procedure are over-

hanging. I believe that every individual has to be his own control.

hat we need to do is match the patient at the end of therapy against

hat he was at the beginning of therapy.

ZUBIN, PH.D.

I think Dr. Alexander's compromise, that he will look at the outcome

agree to look at the process, may satisfy the questions for the moment.

thinks, however, that it will leave the audience a little bit disgruntled,

cause after all, they don't want us to be in full agreement when the

uation really isn't as agreeable as it might be. There are problems

this area. Let me raise one issue which perhaps might make it un-

necessary to look into the process altogether, just as perhaps Dr. Alex-

nder might point to situations where we don't have to examine the out-

ome, the outcome might be so obvious.

One situation which I think might be worthwhile considering at least,

spontaneous improvement. Suppose we find that regardless of what

do with the patients, some types of patients with certain character-

certain premorbid characteristics, certain characteristics at the

e of onset, and so on, get well, no matter what happens. Wouldn't
it be nice to know that there are such people! And wouldn’t it be nice to say—when you get a patient of that type who doesn’t get well—“what’s the matter with your technique?” Apparently, you interfered with the natural healing processes.” In this case, knowledge of the process would be important, but I don’t think we need in every instance to know the full process. Ideally, science would like to know all there is to know about all the behavior that goes on, but I would say, from the point of view of the strategy of the moment, it may be that concentrating on outcome perhaps might be equally fruitful.

I’d like to raise another point—as a matter of fact, I didn’t have Dr. Alexander and Dr. Stevenson and Dr. Wolberg in mind when I was talking about this matter. I had in mind the tremendous number of studies throughout the country, for which reel after reel of taped recordings and moving pictures are being collected without any rhyme or reason or focus as to what will be done with them. I suspect that a million years from now, when they dig up the ruins of our civilization, that will be the thing to remain, those untold tapes we’ve collected throughout our era. As a matter of fact, I have been to places where people had to move out of offices which became filled with tapes, and had to move into new offices because there was no more room. It seems to me that there should be more planning, more focusing, in the collection of data.

I would say that focusing in your interviews on specific points, specific areas, is superior to having a free-floating interview in which you simply collect data for the future, because the amount of data collected gets to be ponderous as the years go by. Having a goal that you are aiming at at the moment when you are collecting data, and analyzing it out to see whether you hit the target, and how much you got of this particular content, may perhaps make it easier to get information, and may make the work of discovering what process means in therapy a little easier and a little quicker.

GEORGE M. LOTT, M.D., State College, Pa.

I want to ask questions concerning a method and a technique of teaching psychotherapy. Student therapists have to have some orienting impetus to carry them along so they will not become too confused.

Let us consider the therapy of a real obsessive-compulsive neurosis. Isn’t it best to require the student to keep a verbatim record of the spontaneous associative material of his patient? This material is of great value, especially if key remarks are listed in sequence on the blackboard. Marginal notations can be made of the expressions of resentment, hostility, and guilt. In a series of interviews it usually is evident that hostility releases will be soon frozen of self-punishment, this process goes on calming down with the expectation of the student to see that the occurrence of this clients hope we have not picked a patient for psychotic, abreact violent, or antisocially "sick" during the therapeutic process. We techniques to pace the process so the patient A realization of this cyclic flow of events especially where prolonged therapy is required along with more confidence. His presence of faith which holds the patient in therapy. A corollary of this method is, in the first iterations of the spontaneously produced topic and cue of what the patient is trying to explain reveals the subject’s "unconscious" like current of a fight with a boy, then of mention of his father, of a severe professor, his father again. From this the therapist can assume sibling rivalry, or oedipal conflicts, or become to consciousness.

Have the members of the panel found t teaching and orienting tools? I have found seminar teaching, but I do not have objective feelings.

FRANK ALEXANDER, M.D.

My answer is a categorical yes. It is a would go so far as to say that at the moment will substantially increase our knowledge of how it will demonstrate what we know about students. I am effectively using our records I listen to the record and then discuss the difference, for example, let us see what the effect of the next interview. We make predictions on the reasoning. For example, we expect now that there is more anger, more guilt, more retreating, or turning feelings to the therapist, and will speak at type of predictions can be checked by studying excellent exercise in psychodynamic reasoni
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people. And wouldn't it be nice to type "I can't get well—what's the matter?" you interfered with the case, knowledge of the process would need in every instance to know there was no way to know all there is to know. I would say, from the point of it may be that concentrating on it is helpful.

A matter of fact, I didn't have Dr. Wolberg in mind when I was remembering the tremendous number of photographs which we used to collect without any rhyme or reason. I suspect that a million years of our civilization, that will be the collection we have collected throughout our era. Where people had to move out of their homes, and had to move into new offices, it seems to me that there should be a collection of data.

Interviews on specific points, specifying interview in which you simply have a goal that you are aiming at getting information, and analyzing it out to know what you got of this particular information, and may make things in therapy a little easier.

A. Alexander, M.D.

My answer is a categorical yes. It is an excellent teaching tool. We could go so far as to say that at the moment I don't know whether it will substantially increase our knowledge of psychotherapy, but I am sure it will demonstrate what we know about psychotherapy to our students. I am effectively using our records in teaching my residents. I listen to the record and then discuss the different problems of therapy. For example, let us see what the effect of an interpretation was in the next interview. We make predictions on the basis of psychodynamic reasoning. For example, we expect now that the patient will show more anger, more guilt, more retreating, or turn away from expressing feelings to the therapist, and will speak about other persons. This type of predictions can be checked by studying subsequent records. It is excellent exercise in psychodynamic reasoning for the students.
answer is: Yes, these records constitute an excellent teaching device. Whether it is a good research device must still be seen.

THOMAS FRENCH, M.D., Chicago, Ill.

I must state an emotional bias in the beginning: I am interested in studying process, and I am not very much interested in studying evaluation. But perhaps it would be worthwhile if I state some of the reasons for my prejudice.

I think that evaluation, in so far as it can be effectively done, has obvious practical value. But it is essentially, almost by definition, a nonscientific procedure. You use the word evaluation; that means you are making a value judgment, and I don't see how a value judgment can have the objective precision that we would like to have for a real attempt to understand even the question whether one therapy is better than another.

I would like to indicate what seems to be involved if you try to understand what happens in therapy. Let's take a rather intensive case of therapy. Let's say the doctor has seen the patient for an hour or even two hours a day over a period of a year. Now you measure what has happened, that is, you compare his state of mind or his situation at the beginning and at the end. You try to obtain objective criteria for your value judgment (but still it is essentially a value judgment) that at the end of therapy there has been a considerable improvement. This is a value judgment, but still it can have a relative degree of objectivity. How was that improvement brought about? Thousands of things happened in those six months or that year of treatment. What did it?

If you really want to find out, you have to divide the therapy up into much shorter periods. Actually I have been very much interested in doing this for quite a while. However, you don't make divisions into fixed time periods. You will discover that, whatever change happened, happened in chapters. Something decisive may have happened, let's say, in the first three weeks. Something even more decisive may have occurred during the next chapter, lasting perhaps only one week, or it may take a few months before something else happens. But if you study these definite periods, you are going to learn a lot more about what your therapeutic method achieved. It may be, as Dr. Alexander indicated, that in some cases what happened was detrimental, but that is a value judgment.

The next statement that I would like to make is that, if you really want to understand what happens, you had better try to get rid of value judgments altogether. You won't say that the patient is better or worse, but precisely what the difference is. Today and two weeks from today, or today a year from today, you will find that the changes in the patient are due to many more variables than you could have a few weeks ago. The scientist introduces his own bias; he has his own way of evaluating. The change that occurs in the patient is a different aspect of behavior than the one you are trying to judge what happened thinks of.

I also get another impression from this that may possibly take place in a patient's mental life, but, in a properly conducted therapy of mental changes concern one conflict at a time.

Let us assume that you try to find out the period and let us assume further that it was chosen as a real chapter in the therapy. If the therapy was done correctly, you will find that there has been only one focal area, not a complex process. The next chapter may be a change in an area of study of therapy I think it is objective. You can actually tell what has happened, but you can't determine just what has done it, whether it is due to something that occurred outside the patient or the result of the therapist's attitude or in response to the therapist did. That kind of question can be answered with less degree of objectivity.

But I don't see any possibility of evaluating at all, except for practical purposes. What you want to know is what happened, to what extent. And that is something which can be done for small sections, and then studied further. I might add also—and this is a point or not to agree entirely—that I do not believe in sound of sound record and so on and multiple papers, as the kind of an understanding. The difficulty in trying to understand a patient is not lack of data, but rather lack of the data we have. By careful scrutiny of a record and a great deal toward discovering exactly
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Like to make is that, if you really
be an excellent teaching device,
not see how a value judgment can
be involved if you try to under-
the patient for an hour or even
of mind or his situation at the
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do this kind of study I think it is possible to become really
youselves; you don’t make divisions
over that, whatever change hap-
ning decisive may have happened,
thing else happens. But if you
of Dr. Alexander and I
may not agree entirely—that I do not believe all the complicated apar-
sonic gestures, tone of voice, and the like, the patient may have
the difficulty in trying to understand the therapeutic process is
lack of data, but rather lack of careful enough study of the
data we have. By careful scrutiny of a relatively brief record, you can

two-week or one-week chapter of psychotherapy, and then you can follow it through, step by step, for all the different chapters in a long treatment.

IAN STEVENSON, M.D.

I just want to say that Dr. French’s comments illustrate well the difficulty in separating outcome studies and process studies, because, as I see it, a total improvement in outcome must be composed of one hundred or some other number of individual units of improvement. And what Dr. French is proposing we study is surely these smaller units. This is a kind of micro-outcome study, as I see it. He is observing some kind of changes that go on in one day or two weeks, and the smaller your unit of observation of the outcome, the closer you get to process. But I would still think this is one kind of outcome study. We are, in fact, also outlining a program of this sort in which we study changes in a patient within 24 hours of an interview. This is a kind of outcome study and also a process study.

LEWIS R. WOLBERG, M.D.

The comment I want to make relates to values. The complexities of social living are bound up with value judgments. A “good” marriage is a value judgment. “Happiness” is a value judgment. “Getting better”—the word better itself involves value judgments. We operate on the basis of values constantly, and there is no reason why we should try to avoid values in judging the results of psychotherapy. The important thing is the validity of the values we use. And that is the reason, I assume, for the organization of this panel. I believe that we are able now to define reasonable values we can use in appraising outcome. These are not as immutable as the law of gravity, but in the present time-space continuum, are reality oriented.

JOSEPH ZUBIN, PH.D.

I wonder whether the attack on the notion of values in the evaluation of outcome is entirely justified, because all science depends on value judgments. You look at an indicator, and you want to know, is it 0.95 or 0.96. That’s a value judgment too. We get around the subjectivity involved by having a consensus. I see no difficulty in evaluation if you provide the objective criteria for evaluation and measure up your patient’s performance against these criteria: for example, the kind of success he has on the job, or the kind of success he has in the family, or in the community. And, like Dr. Wolberg, I have no fear of being incriminated by being subjective, because there is no basic difference between

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the subjective and the objective approach to difference is that the subjectivist doesn’t know he’s got the real thing. The objectivist knows allowances for it!

One should realize, however, that the or Dr. French’s view and mine is that he is interested in outcome. I interest in outcome. I interests and Dr. French and I may some day to our interests without losing an iota of scien

FRANZ ALEXANDER, M.D.

I am in complete agreement with Dr. French. I really compare this type of approach to the physical sciences, where natural events units. That is the basis of calculus. The valued integral of these little units. You can understanding what happens in these small more about this, which is a very interesting operating with values. If you build a brick by the theory of elasticity, you want to build a that is very true. But the same physics can bridge collapsed and not only why the bridge of the laws of elasticity helps you to avoid a bridge. First comes a nonevaluative study but you can use that knowledge for good or bad. Physics can be used for advancement of human and I don’t know what—utilization of power can be used also for destruction. So i psychodynamics can be used for brainwashing as a very legitimate point of view. The one i applied science.

Dr. French is interested in the basic science of the therapeutic process, and my inclination is therefore it can be used for benefit in a really con and today—I am sorry to say—is a hit-or-miss for therapy which look very easy, but after either better nor worse. Initially, these see relatively minor problems. Conversely, you stood in a few months the patient recovers. The one case I had luck. In the other I didn’t extremely unsatisfactory feeling not to know
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In psychotherapy and then you can follow the changes in a long treatment.

Dr. French's comments illustrate well the difficulties of process studies, because, as I see it, the process should be composed of one hundred or more smaller units. And what Dr. French says about some kind of changes in the smaller your unit of observation made in a patient within 24 hours is an excellent study and also a process study.

... to values. The complexities of values. A "good" marriage is a matter of judgment. "Getting better" is another judgment. We operate on the basis of a very simple reason why we should try to improve our psychotherapy. The important reason is that it works. And that is the reason, I believe, that we are able now to appraise outcome. These are the present time-space values.

... notion of values in the evaluation of all science depends on value judgments. If you want to know, is it 0.95 or 0.90? We get around the subjectivity of evaluation and measure up your experience: for example, the kind of orthopedic process he has in the family, or in the community. I have no fear of being incriminated. There is no basic difference between the subjective and the objective approach to human behavior. The only difference is that the subjectivist does not know he's subjective—he thinks he's got the real thing. The objectivist knows he's subjective—and makes allowances for it.

One should realize, however, that the only basic difference between Dr. French's view and mine is that he is interested in process and I, for the time being, am interested in outcome. Both of these are legitimate viewpoints and Dr. French and I may some day change places with regard to our interests without losing an iota of scientific respectability.

FRANZ ALEXANDER, M.D.

... I am in complete agreement with Dr. French about the small section study. I really compare this type of approach to a great advancement in the physical sciences, where natural events are studied in infinitesimal units. That is the basis of calculus. The whole treatment is a complicated integral of these little units. You can understand the process only by understanding what happens in these small sections. I don't want to say more about this, which is a very interesting methodologic issue. We are operating with values. If you build a bridge, with the help of physics, the theory of elasticity, you want to build a bridge which will be stable. That is very true. But the same physics can be used to explain why the bridge collapsed and not only why the bridge is good. So the knowledge of the laws of elasticity helps you to avoid a bad bridge and build a good bridge. First comes a nonevaluative study of what is taking place, then you can use that knowledge for good or bad. We know that atomic physics can be used for advancement of human comforts, saving labor, and I don't know what—utilization of power for constructive purposes—can be used also for destruction. So it is with psychodynamics. Psychodynamics can be used for brainwashing and psychotherapy. This is a very legitimate point of view. The one is a basic science; the other is applied science.

Dr. French is interested in the basic science of the psychodynamics of the therapeutic process, and my inclination is also that this comes first before it can be used for benefit in a really controlled way. What we are doing today—I am sorry to say—is a hit-or-miss procedure. We accept the patients for therapy which look very easy, but after six years the patients are either better nor worse. Initially, these seemed to be easy cases with relatively minor problems. Conversely, you may get a desperate case, and in a few months the patient recovers. The therapist may say, "Well, one case I had luck. In the other I didn't have luck." But it is an extremely unsatisfactory feeling not to know why you fail or succeed.
You don’t control the phenomenon with which you are dealing. And maybe it is because we felt so helpless, that French and I have spent years and years to figure out the dynamics of treatment, to make it more than a haphazard procedure where the independent variables defeat us. We wanted to know more, so that we can control these variables, and cure, not only by intuition and luck, but also by calculated and methodical procedure. For this we must know what is going on, what are the basic principles in this complex human interaction between two persons which we call psychotherapy.

GEORGE HUTHSTEINER, M.D., Los Angeles, Calif.

I think we might start with the here and now, to evaluate therapy on the basis of how we can learn to evaluate a conference, even one like this, a discussion, or a panel. I think that most of us, if you are like me, have a lot of stimuli that are not tape recorded, and they are really at the bottom of things. And that is one of the big problems in psychotherapy. There are a lot of stimuli that are never observed, even through a one-way mirror, that cannot be picked up even by the best video tape recorder. But, as I think everybody can vouch for right here, these stimuli are most important in determining how you feel.

If we can find a way to detect not only nonverbal, nonsemantic communication—and I don’t mean just tactile communication, because there is a wide range of types of communication—if we can learn to study this problem more accurately, not only in the patient, but in the therapist as well, then I think we will start to make real headway. And I would like to ask Dr. Zubin what he means by “normal.” I would say that one of the first things I realize is that I am not “normal.” And I don’t believe he thinks he is either.

JOSEPH ZUBIN, PH.D.

Well, the 16 per cent of New Yorkers which Midtown declared normal are normal.