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PERCEIVED EFFECTIVENESS OF THERAPY AS A FUNCTION OF PROFESSIONAL IDENTIFICATION

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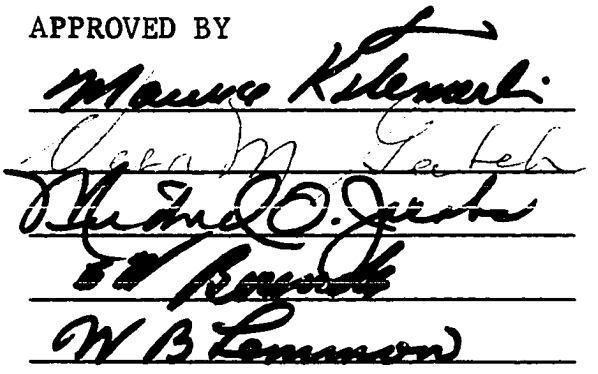

DISSERTATION COMMITTEE

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CHAPTER I

INTRODUCTION

In recent years the methods of psychotherapy have been criticized, particularly by behavior therapists. Behavior therapists have criticized both psychotherapy and psychotherapy research for a lack of objectivity. Bandura (1967) has deplored the traditional psychotherapeutic approach, maintaining that a client's "insights" and emergent "unconscious" may be predicted with more accuracy from his therapist's theoretical system than from the client's developmental history.

"It would seem from this finding and others that insight may primarily represent a conversion to the therapist's point of view rather than a process of self-discovery. It is therefore not surprising that insight can be achieved without any real effect on the difficulties for which the patient originally sought help." (p. 18).

Eysenck (1952) concluded that there was no evidence in the current literature to suggest that psychotherapy

resulted in improvement when working with neurotics. In fact, he purportedly obtained data suggesting a negative correlation between recovery and psychotherapy:

> In general, certain conclusions are possible from these data. They fail to prove that psychotherapy, Freudian or otherwise, facilitates the recovery of neurotic patients. They show that roughly two-thirds of a group of neurotic patients will recover or improve to a marked extent within about two years of the onset of their illness, whether they are treated by means of psychotherapy or not. This figure appears to be remarkably stable from one investigation to another, regardless of type of patient treated, standard of recovery employed, or method of therapy used. From the point of view of the neurotic, these figures are encouraging; from the point of view of the psychotherapist, they can hardly be called very favorable to his claims.
>
> The figures quoted do not necessarily disprove the possibility of therapeutic effectiveness. There are obvious shortcomings in any actuarial comparison and these shortcomings are particularly serious when there is so little agreement among psychiatrists relating even to the most fundamental concepts and definitions. Definite proof would require a special investigation, carefully planned and methodologically more adequate than these ad hoc comparisons. But even the much more modest conclusions that the figures fail to show any favorable effects of psychotherapy should give pause to those who would wish to give an important part in the training of clinical psychologists to a skill the existence and effectiveness of which is still unsupported by any scientifically acceptable evidence (pp 322-323.)

Since Eysenck's early attack on psychotherapy as an efficacious approach to neurosis, numerous studies have appeared in the same tradition, so much so that Astin (1966) could label his article the "Functional Autonomy of Psychotherapy." Indeed, Astin suggested psychotherapy was a myth which clinicians permitted to survive long after it has outlived its usefulness.

The most ambitious attempt to evaluate the success of various therapies has come from Wolpe (1960) who compared psychoanalytic and behavioral methods. Using removal of symptoms as a criterion of therapeutic success, Wolpe reported 44% "apparently cured", 46% "much improved", 7% "slightly or moderately improved" and 3% "umimproved" by behavioral techniques. In short, Wolpe (1960) claimed that 90% of patients treated by means of behavior therapy were "apparently cured or much improved" while only 10% were slightly improved or showed no improvement. By contrast, Wolpe found only 62% of the cases treated by psychoanalytic methods to be "apparently cured or much improved" and 38% to be slightly improved or to have shown no improvement. Wolpe attributed the greater success of the behavioral techniques to explicit and direct applications of principles of learning while the improvement using psychoanalytic method resulted from what accidental application of learning principles occurred during therapy. He justified the use of behavior therapy on the grounds that treatment is shorter in duration and concentrates on the practical removal of symptoms.

Taken at face value, the claims made by Wolpe and his associates are formidable. However, when viewed at closer range, several problems arise. Breger and Mc Gaugh (1965) have questioned whether the behavior therapy school is exempt from the very criticism which its advocates level

against psychotherapy, namely, the lack of objectivity in research. They cite sampling biases, experimenter biases and problems of experimenter control as factors which may distort experimental findings. Because behavior therapy has been identified with experimental psychology and with the so-called "well established laws of learning", it has often escaped the rigors of experimental controls. In this regard, Breger and McGaugh state: "Insofar as claims such as Wolpe's are based on uncontrolled case histories, they may reflect the enthusiasm of the practitioner as much as the effect of the method." (p. 47).

Although psychologists have been long aware that observations are subject to biases or distortions (Bruner & Postman, 1947; McGinnies, 1949; Howes & Solomon, 1950), there has been surprisingly little concern how such problems influence conclusions in research. Only within the past decade has observer bias itself become the focus of human research.

The success of the experimental model as employed in physics, has prompted many researchers to follow its paradigm with humans. Orne (1962) has taken issue with viewing the human subject as a passive, inanimate object acted upon by external forces. Depending on the sophistication, intelligence or previous experience of the research subject, he is likely to form hypotheses as to the nature of the research. At some level the subject

views his task as being to ascertain the true purpose of the experiment and to behave in a manner which supports the hypothesis. The totality of those cues which convey an experimental hypothesis to the subject becomes a significant determinant of his behavior. Orne labels the sum total of these cues the "demand characteristics of the psychological situation." A subject's behavior in an experimental situation will be a dual function of (a) the experimental variables and (b) the perceived demand characteristics of the experimental situation. Orne and Scheibe (1964) suggested that demand characteristics may account partially for findings attributed to sensory deprivation. They arranged the experimental conditions so as to simulate a sensory deprivation experiment, namely, release forms and a "panic button." Subjects in the experimental group sat in a well-lit room, with comfortable chairs, water, a sandwich and an optional task of adding numbers. Control group subjects were told that they were controls for a sensory deprivation experiment. The "panic button" was eliminated for this group. The findings suggested that the overly cautious treatment of subjects, careful screening for psychological and physical disorders, awesome release forms and a "panic button" were more significantly related to producing the effects reported from sensory deprivation than the actual diminution of sensory input.

In a replication of a study conducted by Young,

Orne and Evans (1965), demonstrated that hypnotized subjects carried out "apparently antisocial acts" such as grasping a dangerous reptile, handling concentrated acid and throwing this acid into the face of an assistant. However, subjects asked to simulate hypnosis complied with the same requests. A post-experimental inquiry revealed that such subjects were convinced that the activities were safe because the research was conducted by responsible and competent scientists and were within the realm of legitimate requests made in an experimental context.

Orne (1962) concluded:

> In summary, we have suggested that the subject must be recognized as an active participant in any experiment, and it may be fruitful to view the psychological experiment as a very special form of social interaction. We have proposed that the subject's behavior in an experiment is a function of the totality of the situation, which includes the experimental variables being investigated and at least one other set of variables which we have subsumed under the heading, demand characteristics of the experimental situation. The study and control of demand characteristics are not simply matters of good experimental technique; rather, it is an empirical issue to determine under what circumstances demand characteristics significantly affect subjects' experimental behavior. Several empirical techniques have been proposed for this purpose. It has been suggested that control of these variables in particular may lead to greater reproducibility and ecological validity of psychological experiments. With an increasing understanding of these factors intrinsic to the experimental context, the experimental method in psychology may become a more effective tool in predicting behavior in non-experimental contexts (p. 783).

Like Orne, Riecken (1962) proposed a three-fold analysis of the subjects' expectations in psychological

research. The first concerns the expectation of his due reward for having agreed to participate in the experiment. His second aim is to discover the rationale behind the experiment, its "secret" purpose. The subject's final aim is to "put his best foot forward" in order to perform appropriately to the demands of the situation.

The research cited suggests that the subject is an active agent who makes implicit assumptions about the hypothesis being investigated which in turn may influence his behavior in the experimental context.

Thus far, mention has been made of the experimental behavior of the subjects. However, the experimenter is by no means exempt from the influence of his own hypothesis regarding research outcomes.

Rosenthal (1963) observed that the experimenter interacts in subtle, often non-conscious ways with his subjects, the result being to confirm his expected hypothesis. He termed this subtle interaction between Subject and Experimenter "self-fulfilling prophecy" (1966).

Rosenthal has identified a number of interactional effects which influence psychological research (1968). These are enumerated below:

(1) Bio-social effects: The sex, age and race of the experimenter affect research with human Ss.

(2) Psycho-social effects: Differences in E's level of anxiety, need for approval, personal hostility, tendency to smile and general warmth tend to differentially influence responses of Ss.

(3) Situational effects: Inexperienced experimenters

obtain different responses from those who are experienced, as do those who are acquainted with their Ss. Early data returns may cause E to behave in a manner which influences Ss to respond in a given fashion.

(4) Modelling effects: Expectencies or E's own implicit ratings may in turn influence the responses of his Ss.

A number of investigators (Vikan-Kline, 1962; Goranson, 1965; Raven and French, 1958; Wuster, Bass & Alcock, 1961) have noted an increase in expectency effects as a function of the experimenter's status. In general, these studies have suggested means by which experimenters of varying status tended to influence results. Those hoping to influence results in a positive direction tended to smile more frequently and were friendlier to their subjects while those trying to bias results negatively were cooler and less pleasant.

An examination of field research supports experimental laboratory findings that biases influence results, particularly when working with human subjects.

Rosenthal and Jacobson (1968) chose 20% of the children at random in the South San Francisco school group for their experimental group. Teachers were given the names of this group and told that these children scored high on a test for "intellectual blooming" and would show remarkable gains in intellectual development during the next eight months. In reality, no substantive difference existed between the groups labeled as "bloomers" and a control group composed of their classmates. At the end of

a period of one year, all children were given the same IQ test with the result that in total IQ, gain in the experimental group averaged four to seven points higher than control Ss. Furthermore, when asked to describe their children, teachers found "blooming" children to be more appealing, better adjusted and more affectionate. The results of these and other studies (Beez, 1968; Bunham and Hartsough, 1968) suggested that teachers expectations may cause dramatic alterations in teaching style which, in turn, influence rate and extent of learning.

In the context of psychotherapy, Heller & Goldstein, (1961) found partial support for the hypothesis that favorable therapist expectation of client improvement serves to enhance the therapeutic relationship.

Numerous studies have considered the effectiveness of therapeutic intervention as a function of social class. Magaro (1969) has expressed this relationship in terms of the following formulae: milieu therapy x middle class = positive treatment; milieu therapy x lower class = negative treatment effectiveness. Riessman et al (1965) have reported that the middle class clinic patient is more likely to be treated in interactive type therapy while the lower class patient will typically receive custodial or somatic forms of treatment. Furthermore, even in clinics in which the economic factor is eliminated, such discrimination occurs. Clinics have justified such routine practices on grounds

that lower class patients are relatively unsophisticated and hence are unable to benefit from traditional psychotherapies (Schaffer & Myers, 1954; Brill & Storrow, 1960). Granted that there is some justification for such policies, it is likely that the therapist's expectancy of failure with the lower socio-economic patient influences both his willingness to come into contact and the outcome of treatment with such a patient, ie, a "negative self-fulfilling prophecy."

Hollingshead and Redlich (1958) found a systematic relationship between the prevalence of mental illness and social class. The lower the social class, the greater the incidence of psychosis and the higher the social class the greater the incidence of neurosis. However, the lower class patient typically has only the state hospital at his disposal while the more privileged patient has recourse to private hospitals, clinics and private practice which are more loathe to give psychiatric diagnosis and if they do are prone to assign a diagnosis of neurosis.

Using socio-economic status as the independent variable, Haase (1965) found that similar Rorschach protocols were given different interpretations by clinical psychologists contingent upon the designated social class of the patient. Haase suggested that the clinical psychologist is likely to assume a biase favorable to his own social class.

Lee and Temerlin (1968) demonstrated that psychiatric residents typically diagnosed mental illness when

the socio-economic history of the individual suggested that they were from the lower classes. Conversely, the higher the socio-economic status, the greater the probability of a diagnosis of mental health. Moreover, the suggestion of lower socio-economic status was directly related to poor prognosis while the reverse was true with the suggestion of a higher socio-economic status.

Temerlin and Trousdale (1969) examined the susceptibility of psychiatric diagnoses to prestige suggestion. A professional actor enacted a script in which he was instructed to portray a "relaxed, confident & productive man who was enjoying life, free from psychological problems, but who was intellectually curious about psychotherapy" (p. 24). The session was taped and diagnosed by a group of undergraduate students, advanced law students, graduate students in clinical psychology, practicing clinical psychologists and psychiatrists. For each group, a prestige figure provided the suggestion that the individual interviewed "looked neurotic, but actually was quite psychotic." Results indicated that diagnosis of "mental illness" (neuroses, psychoses and character disorders considered together) ranged from 84% among the undergraduates to 100% among the psychiatrists while diagnosis of normality ranged from 9 to 16%. The authors concluded that the differentiation of normality

from neurosis and psychosis may be subject to distortion when made (a) in a clinical setting, (b) under the influence of a prestige suggestion, and (c) in the absence of a generally accepted definition of mental health and mental illness. Unfortunately, diagnostic evaluations are typically made under such conditions and hence, their value is subject to question.

The conclusions of these and other studies attest that the expectancy or biasing effect is a factor to be reckoned with in laboratory and educational settings. Furthermore, its relevance to social class distinctions and psychiatric diagnosis is crucial to the understanding and the development of effective treatment programs.

CHAPTER II

STATEMENT OF THE PROBLEM

Considerable effort has been put forth to examine the relationship between expectancy effects and research outcomes in an experimental laboratory setting. Much energy has also been expended to apply these experimental findings to field situations, notably in the areas of psychiatric diagnosis, education and social class.

Thus far, relatively few attempts have been made to relate perceived outcome of a given form of therapy to the many biasing suggestions to which an individual practitioner is exposed. It has already been reported that biases in research with human subjects may arise as a function of prestige suggestion, professional identification or limited exposure to a given orientation.

In order to fully appreciate the value of a given form of therapy from the standpoint of utility and economy, it is crucial that we distinguish methodologically sound research from research riddled with biases. Without such a frame of reference, there is no means by which to judge the effectiveness of treatment, nor is there a basis on which to evaluate the efficacy of past research.

Comparisons in the literature between traditional psychotherapeutic methods and behavioral techniques are often saturated with an underlying conspicuously present attitude of "We are right, they are wrong." This attitude obscures the true purpose of research in the helping professions, ie, the dedication to advance and increase our knowledge of appropriate therapeutic measures, and substitutes in its place a less useful purpose, the dedication to vindicating what one already holds to be true. One approach to the problem of how bias influences the perceived effectiveness of therapy would be to present adherents of traditional dynamic and behavior therapy schools with identical taped sessions varying only in the biasing suggestion of what type of therapy was being conducted and to ask them to judge the effectiveness of the therapy along several dimensions. The present investigation was undertaken with this problem in mind.

It was hypothesized that an individual's perception of the effectiveness of a given form of treatment will be a function of his particular orientation or bias (ie, professional identification) which exists independently of the sessions, per se. More specifically:

A - Those oriented toward traditional analytic psychotherapy who are given the suggestion that the sessions were conducted by a psychotherapist of their own persuasion will be more inclined

to view treatment as effective than when told the sessions were conducted by a behavior therapist.

B - Those oriented toward behavior therapy who are given the suggestion that the sessions were conducted by a behavior therapist will be more inclined to view treatment as effective than when told the sessions were conducted by a psychotherapist who was oriented in the analytic approach.

C - Control subjects composed of equal representations of both orientations will view no change in treatment sessions when no suggestion is provided.

CHAPTER III

METHOD

Subjects

Preliminary Investigation: Twenty-nine subjects participated in this phase of the research. All but one subject (a psychiatrist) received his clinical training from an American Psychological Association approved program in psychology. Subjects were divided into two groups according to their therapeutic orientation. Sixteen of the subjects were advanced students in clinical psychology at the University of Oklahoma. All were either in the process of serving their clinical internships or had completed the internship requirement. All subjects had from two to five years experience in the practice of psychotherapy. Thirteen of the subjects were affiliated with the University of Oklahoma Medical School. Three of these were students in the process of completing their clinical internship requirement and had approximately one year of experience doing behavior therapy. Five were practitioners (4 Ph.Ds, 1 M. D. psychiatrist) with extensive experience in the practice of behavior therapy. The remaining five were theoreticians or college professors. Ten of these

thirteen subjects had direct experience with behavioral techniques and three had extensive theoretical backgrounds (although no direct therapeutic experience) which justified their inclusion as subjects for the preliminary investigation.

Subjects in the preliminary investigation were asked directly by the experimenter to participate in his dissertation research. In each of the two groups, only a small portion of the subjects did not participate, primarily because of their unavailability on the date the data were collected. For the most part, subjects were run in groups of four to eight. Occasionally, however, it became necessary to run subjects individually owing to difficulties in scheduling.

Two universities in the eastern region of the United States and one in the southwestern region cooperated in the study. All three institutions were accredited by the A.P.A. and were selected because their clinical psychology programs were eminently linked to either a behavioral or traditional psychodynamic orientation.

A total of forty-eight subjects participated in the research. Subjects were thirty-seven psychological interns and eleven Ph.Ds in clinical psychology who had received their degrees within the year. Eighteen of the subjects were affiliated with the clinical psychology program at Adelphi University, whose emphasis is on traditional analytically oriented clinical service. Six

subjects were affiliated with the clinical psychology program at the University of Oklahoma, whose emphasis is nearly identical to that of the program at Adelphi. Ten subjects were affiliated with the clinical psychology program at the State University of New York at Stonybrook, whose focus is on behavior therapy. The remaining fourteen subjects were affiliated with a number of different clinical psychology programs, but all were screened before inclusion as subjects in order to ensure that their orientation was broadly behavioral. (See Procedure).

Recruitment of subjects was difficult for a variety of practical considerations; (1) subjects were run during the summer months; consequently, a large number were unavailable for participation since neither Adelphi nor Stonybrook Universities conducted graduate summer school sessions in psychology. (2) Those subjects who were available were widely dispersed around the New York metropolitan area; therefore, individual appointments had to be arranged at the convenience of the subject (often in his own home). (3) Finally, many subjects who had originally agreed to participate in the research, were unable to do so because their summer employment schedule conflicted with the availability of the experimenter.

An additional procedural difficulty arose with regard to the contacting of subjects of different orientations after obtaining clearance by the clinical director. Prospective subjects from Adelphi University were sent

letters by the experimenter enlisting their cooperation and were requested to remit self-addressed post cards stating whether or not they would participate. Subjects from the State University of New York at Stonybrook were contacted informally by a graduate student of the clinical director. The informal means of contact of the behavioral therapy subjects, as contrasted with the relatively formal method of contact of the dynamic psychotherapy subjects, may have resulted in the lower number of participating subjects in the former cases and the need to recruit subjects from other programs broadly oriented toward behavior therapy. Further mention of this difficulty will be made in the discussion section. Although all subjects (irrespective of orientation) came from A.P.A. accredited schools, it is questionable whether sample homogeneity with respect to orientation can be assumed for the behavior therapy subjects.

Materials

Taped Interviews: Two seven minute interview segments, interchangeably labelled "early" and "late" were written in which the patient was portrayed as sexually inadequate, fearful of sexual intercourse and afraid to approach women in social situations. The instructions preceding the taped sessions described the patient as a 28 year old male interior designer who was concerned about his impotence. The instructions further stated that the

patient had never been overtly homosexual but was profoundly fearful of heterosexual relationships.

In construction of the taped interviews, it was crucial to set up a situation which would capture the interest of practicing behavior therapists and analytically-oriented clinicians. The presenting symptoms of impotence and suggested latent homosexuality (as given in the instructions) respectively provided a framework in which adherents of both orientations could function comfortably.

The content of the interviews was constructed to be ambiguous, that is, identifiable as either behavior therapy or psychotherapy, 50% of the time. To achieve these conditions the dialogue was interspersed with identifiable elements of both traditional dynamic psychotherapy and behavior therapy. (Namely, (1) interpretation; (2) reflection of feeling; (3) focus on understanding, awareness and attitudes, on the one hand and (1) preparatory construction of hierarchies of anxiety, (2) concentration on the alternatives to present maladaptive behavior and (3) the therapist's active orientation, on the other hand.)

Both excerpts were modelled after a rational therapy session of Albert Ellis (Patterson, 1966) and were modified to satisfy the conditions enumerated above (Appendix A).

The tone of the script was designed to be

emotionally bland and unreflective of positive or negative change.

Two advanced graduate students in clinical psychology at the University of Oklahoma enacted the roles of patient and therapist. Each had considerable experience in both situations and one had participated non-professionally in several dramatic productions.

Rating Scales: The 3 point rating scale by which the subjects judged the extent and direction of change over sessions was devised by a comprehensive search of the behavior modification and dynamically oriented literature on criteria for improvement in therapy (Jahoda, 1958; Wolman, 1965; Wolpe, 1958; Wolpe et al, 1964; Ullman and Krasner, 1964). A total of fifteen items were included in the scale, each consisting of three choices; increase, no change, and decrease. Five items were chosen to represent behaviorally oriented standards for improvement, five items to typify analytic criteria for improvement and five items to represent criteria for improvement which overlapped orientations. The fifteen items along with the therapeutic orientations which utilize them as criteria for positive change are presented in Table 1.

Questionnaire: A series of questions was formulated, in order to definitively establish that a subject was placed in the appropriate orientation category. Questions

TABLE 1

RATING SCALE ITEMS SUBDIVIDED ACCORDING TO THE ORIENTATIONS WHICH UTILIZE THEM AS CRITERIA FOR IMPROVEMENT IN THERAPY

Items Utilized by Behavior Therapy	Items Utilized by Traditional psychotherapy	Items Utilized by Both Groups
Symptomatic relief (item 1)	Adequacy of interpersonal relations (item 4)	Level of productivity (item 2)
Appearance of substitute symptoms (item 6)	Self acceptance item (item 7)	Sexual adjustment (item 3)
Capacity to rely on internal as opposed to external reinforcement with respect to behavior (item 10)	Freedom to experience feelings (item 8)	Capacity to cope with stress (item 5)
Development of adaptive new behavior patterns (item 11)	Capacity to enter into satisfying relations with others (item 9)	Effectiveness of treatment (item 14)
Degree of relaxational responses (item 12)	Capacity to love (item 13)	Effectiveness of therapist (item 15)

were concerned with the following six areas:

(1) Primary therapeutic orientation.

(2) Percentage of time devoted to research, practice of therapy or other activities.

(3) Preferred areas of research.

(4) An assessment as to which form of treatment, behavior therapy or traditional psychotherapy might be most effective in the treatment of an individual with clear cut symptoms.

(5) A projection of the specific type of work a subject would like to be engaged in five years from now.

(6) Comments on the nature of the present investigation.

An additional rationale for inclusion of the questionnaire was to provide a means by which attitude difference between orientation groups could be evaluated.

Procedure

Prior to the running of subjects in the experimental design, a preliminary investigation was conducted in order to obtain an operational definition of ambiguity of the taped excerpts. Subjects run in groups of four to eight were asked to listen to one of two taped excerpts and to render a judgement regarding whether the segment came closer to being a behavior therapy session or a psychotherapy session. An operational definition of ambiguity was secured when 50% of the subjects in each group judged the tape in one direction while the remaining 50% judged the tape in other direction. Judgments rendered and a sampling of reasons accounting for these judgments are presented in Table 2.

TABLE 2

PRELIMINARY DATA TO ASSESS THE AMBIGUITY OF TAPE SEGMENTS

Orientation	Judgments Based on Tape Segment Heard	Sampling of Reasons Accounting for Judgments
Psychotherapists N = 16	Tape 1 N = 8 4 behavior therapy 4 psychotherapy	Judgments of Psychotherapy (Tapes 1 and 2) Interpretation and reflection of feeling Focus on feeling and underlying attitudes Emphasis on thought processes which underlie symptoms Focus on clients' understanding and awareness Emphasis of responsibility
	Tape 2 N = 8 4 behavior therapy 4 psychotherapy	Judgments of Behavior Therapy (Tapes 1 and 2) Reference of therapist to overt actions The directiveness of therapist Reference to recall of anxiety-provoking situations Focus on symptom and desensitization Suggestions regarding changing patient's behavior given by the therapist; consideration of alternative modes of behavior

TABLE 2 (Continued)

Orientation	Judgments Based on Tape Segment Heard	Sampling of Reasons Accounting for Judgments
Behavior Therapists N = 13	Tape 1 N = 8 4 behavior therapy 4 psychotherapy	Judgments of Psychotherapy (Tapes 1 and 2) Reflection feeling Interpretations irrelevant to behavior therapist Confrontation Similarity to Ellis' rational therapy
	Tape 2 N = 5 2 behavior therapy 3 psychotherapy	Judgments of Behavior Therapy (Tapes 1 and 2) Construction of hierarchy of anxiety (imagination of a scene) Concentration on source of fear Therapist demand that patient consider alternatives to present behavior Action orientation of therapist

Once ambiguity of the taped excerpts was operationally established, this enabled the experimental portion of the investigation to proceed. Subjects with orientations which favored psychotherapy or behavior therapy were instructed to listen to taped excerpts of sessions labelled "early" and "late" and to rate on a number of dimensions the extent and direction of the change which occurred over the sessions. The outline of the experimental procedure is presented in Table 3 and the procedures are described in some detail on the following pages.

Subjects from each orientation were randomly assigned one of two experimental conditions. Prior to making the ratings, half the subjects from each orientation were read instruction P while half were read instruction B in order to establish different biasing suggestions. The specific instructions for each biasing suggestion appear below:

Biasing suggestion for orientations whose subjects were told a traditional analytic psychotherapist conducted the sessions.

(Instruction P):

> Thank you very much for agreeing to participate in this research project. This is a study of the effects of psychotherapy which takes into account the actual nature of the therapeutic situation. We are studying the effects of a new variation of traditional analytic psychotherapy with a particular kind of patient. We want you to listen to random excerpts of actual psychotherapy interviews separated in time. The first excerpt is taken from an early interview and the last excerpt is from a late session. After listening to these two excerpts, indicate on the scales presented

TABLE 3

OUTLINE OF EXPERIMENTAL PROCEDURE

Orientation	Suggestion	Order of Presentation of Tapes
Psychotherapists N = 20	Told sessions were conducted by a Behavior Therapist (P_B) N = 10	Heard Tape 1, then Tape 2 sequence, then filled out ratings N = 5
		Heard Tape 2, then Tape 1 sequence, then filled out ratings N = 5
	Told sessions were conducted by a Psychotherapist (P_P) N = 10	Heard Tape 1, then Tape 2 sequence, then filled out ratings N = 5
		Heard Tape 2, then Tape 1 sequence, then filled out ratings N = 5

TABLE 3 (Continued)

Orientation	Suggestion	Order of Presentation of Tapes
	Told sessions were conducted by a Behavior Therapist (B_B) N = 10	Heard Tape 1, then Tape 2 sequence, then filled out ratings N = 5
		Heard Tape 2, then Tape 1 sequence, then filled out ratings N = 5
Behavior Therapists N = 20	Told sessions were conducted by a Psychotherapist (B_P) N = 10	Heard Tape 1, then Tape 2 sequence, then filled out ratings N = 5
		Heard Tape 2, then Tape 1 sequence, then filled out ratings N = 5
Modified Control 1/2 Psychotherapists 1/2 Behavior Therapists N = 8	NONE	Half the subjects in each orientation heard the tapes sequence in different orders and were asked to judge which was the earlier and which was the later session.

below whether or not the patient has changed, in what way has he changed, if any, and what has been the direction of the change.

The interviews are with a 28 year old male interior designer who was treated by means of a variation of traditional analytic psychotherapy because of sexual difficulties. He has never been overtly homosexual but he is profoundly fearful of heterosexual relationships. Specifically, he is afraid of women; particularly of sexual intercourse. He reports that he experiences heterosexual urges but that he is afraid to approach women socially. On the few occasions where he has overcome this fear sufficiently and actually attempted sexual relations, he has been impotent. The erection usually subsides at the moment of anticipated penetration. These are basically the symptoms for which he sought treatment.

Here is an excerpt from an early interview. Listen to it carefully and afterwards we will play an excerpt from a later treatment interview with this same man.

Biasing suggestion for orientations whose subjects were told a behavior therapist conducted the sessions.

(Instruction B):

Thank you very much for agreeing to participate in this research project. This is a study of the effects of behavior therapy which takes into account the actual nature of the therapeutic situation. We are studying the effects of a new variation of behavior therapy with a particular kind of patient. We want you to listen to random excerpts of actual behavior therapy interviews separated in time. The first excerpt is taken from an early interview and the last excerpt is from a late session. After listening to these two excerpts indicate on the scales presented below whether or not the patient has changed, in what way has he changed, if any, and what has been the direction of change.

The interviews are with a 28 year old male interior designer who was treated by means of a variation of behavior therapy because of sexual difficulties. He has never been overtly homosexual but is profoundly fearful of heterosexual relationships. Specifically, he is afraid of women, particularly of sexual intercourse. He reports that he experiences heterosexual urges but that he is afraid to approach women socially.

On the few occasions where he has overcome this fear sufficiently and actually attempted sexual relations, he has been impotent. The erection usually subsides at the moment of anticipated penetration. These are basically the symptoms for which he sought treatment.

Here is an excerpt taken from an early interview. Listen to it carefully and afterwards we will play an excerpt from a later treatment interview with the same man.

Modified Control Group: Originally, the experimental design called for inclusion of a standard control group composed of an equal number of behavior therapists and traditional dynamic psychotherapists. This group would be instructed to listen to the excerpts and rate the extent and direction of change over sessions in the manner described above. Unlike the experimental group, however, they would receive no biasing suggestion. The need for a formal control group was obviated by the following more simple procedure. A group of eight subjects, four from each orientation, were asked to listen to the two excerpts and to judge which was the earlier session and which was the late session. For half the subjects in each orientation, Tape 1 was arbitrarily played first, followed by Tape 2, while the other half heard Tape 2 first, followed by Tape 1. Instructions administered to the quasi control group are given below:

(Instruction C):

Thank you very much for agreeing to participate in this research project. You are going to hear two excerpts of treatment interviews with the same individual. One of these is an earlier session while the other takes place later in treatment, although the

order in which the tapes are presented do not necessarily reflect the order in which they occurred. After listening to the tapes, we want you to judge which was the earlier interview and which was the later one.

The interviews are with a 28 year old male interior designer. He has never been overtly homosexual but he is profoundly fearful of heterosexual relationships. Specifically, he is afraid of women, particularly of sexual intercourse. He reports that he experiences heterosexual urges but that he is afraid to approach women socially. On the few occasions where he has overcome this fear sufficiently and actually attempted sexual relations, he has been impotent. The erection usually subsides at the moment of anticipated penetration. These are basically the symptoms for which he sought treatment.

CHAPTER IV

RESULTS

Table 4 shows the percentage of Therapeutic Effectiveness Ratings (TERs) for both orientations irrespective of suggestion.

Table 4

Percentage of TERs Falling into Each Category for Both Orientations Irrespective of Suggestion

Orientation	Increase	Decrease	No Change
Behavior Therapists N = 20	8.3	7.3	84.4
Analytic Psycho-therapists N = 20	19.3	21.7	59.0

Table 4 reveals that both groups used the "no change" category more frequently than the "increase" or "decrease" categories. The behavior therapists, however, used "no change" 84.4 percent of the time while the anlaytic psycho-therapists used the category only 59 percent of the time. Moreover, thirteen out of the twenty behavior therapists exhibited a set to respond "no change" (13 of 15 items) in

the questionnaire as compared with only six out of twenty analytic psychotherapists. A chi square value of 4.91 was obtained for 2 degrees of freedom which was significant at the .05 level. These results, taken together, suggested that analytic psychotherapists tended to see change (be it in a positive or negative direction) significantly more frequently than did behavior therapists.

Analysis for Hypothesis A: Hypothesis A predicted that those subjects with an analytic psychotherapy orientation who are given the suggestion that the sessions were conducted by a psychotherapist of their own persuasion (Suggestion P) would be more inclined to view treatment as effective than when told the sessions were conducted by a behavior therapist (Suggestion B). Table 5 shows the frequency breakdown of TERs for analytic psychotherapists under suggestions B and P.

Table 5

Frequency of TERs for Analytic Psychotherapists Under Suggestions P and B

	Increase	Decrease	No Change	Totals
Psychotherapists given Suggestion P; N = 10	37	25	88	150
Psychotherapists given Suggestion B; N = 10	21	40	89	150
Totals	58	65	117	300

Results indicated that the dynamic psychotherapists gave significantly different TERs under different suggestions.

Chi square = 6.14, for 2 degrees of freedom, $p < .05$.

A percentage analysis further revealed that analytic psychotherapists who were given suggestion P tended to see a greater percentage of increases and fewer decreases in the effectiveness of the treatment than when given Suggestion B. Of the analytic psychotherapists marking increases, 63.8% so marked under Suggestion P as compared with 36.2% under Suggestion B. Similarly, of the analytic pscho-therapists marking decreases, only 38.5% so marked under Suggestion P as compared with 61.5% under Suggestion B. The results clearly supported Hypothesis A.

Analysis for Hypothesis B: Hypothesis B prediced that those subjects with a behavior therapy orientation who are given the suggestion that the sessions were conducted by a behavior therapists (Suggestion B) would be more inclined to view treatment as effective than when told the sessions were conducted by a analytic psycho-therapist (Suggestion P). The frequency breakdown of TERs for behavior therapists under suggestions B and P are given in Table 6.

Results indicated that behavior therapists who received Suggestion B tended to give significantly different ratings than those who received Suggestion P. Chi-square = 10.40, for 2 degrees of freedom, $p < .01$. Owing to the

TABLE 6

Frequency of TERs for Behavior Therapists under Suggestions P and B

	Increase	Decrease	No Change	Totals
Behavior Therapists given Suggestion P N = 10	11	4	135	150
Behavior Therapists given Suggestion B N = 10	14	18	118	150
Totals	25	22	253	300

small frequency of one of the entries in Table 6, a Yates correction for continuity was performed but no change in the level of significance was found (Chi-square = 9.87, $p < .01$). The direction of the obtained ratings, however, was not consistent with that formulated in Hypothesis B. Under Suggestion B, behavior therapists rated a slightly greater percentage of increases than under Suggestion P (56% vs. 44%, respectively.). This finding was in the direction of Hypothesis B. However, of the behavior therapists marking decreases, 82% so marked under Suggestion B as compared with only 18% under Suggestion P. The latter results are contradictory to the prediction of Hypothesis B.

A percentage analysis was tabulated for each group, to evaluate item meaningfulness from the standpoint of assessment of therapeutic effectiveness. Each item was

compared with the overall categorical percentages for each orientation. A summary of the findings is presented in Table 7.

Initially, it was thought that idiosyncratic interpretations of the items geared toward behavior therapy might have contributed to the disproportionately large frequency of "decrease" ratings for behavior therapists under Suggestion B. To test whether items geared toward behavior therapy differed significantly from the total remaining item pool, a chi-square analysis was performed. A chi-square value of 2.68 was obtained, which was not significant ($p > .50$, with 2 degrees of freedom.) Thus, it appeared that the obtained reversal of results with respect to Hypothesis B, could not be adequately explained on the basis of differences in the nature of the items. An attempt to explain the discrepant findings will be presented in the discussion section.

Analysis for Hypothesis C: Hypothesis C predicted that control subjects composed of equal representations of both orientations would view the taped sessions as interchangeable when no suggestion was offered. Using the modified control procedure enumerated in the procedure section, it was found that 50% of the subjects selected Tape 1 as the earlier interview segment, while 50% selected Tape 2 as the earlier. It would appear that the tapes were

TABLE 7

PERCENTAGE ITEM ANALYSIS COMPARING EACH ITEM WITH OVERALL CATEGORICAL PERCENTAGES FOR EACH ORIENTATION

	Analytic Psychotherapists		
	Increase (19.3)	Decrease (21.7)	No Change (59.0)
Rarely represented items compared to categorical percentages	symptomatic relief sexual adjustment satisfying relations with others development of adaptive behavior capacity to love	development of adaptive behavior level of productivity	effect of therapist effect of treatment
Frequently represented items compared to categorical percentages	freedom to experience feelings	symptomatic relief relaxational responses effect of treatment effect of therapist	sexual adjustment development of adaptive behavior capacity to love

TABLE 7--Continued

Behavior Therapists		
Increase (8.3)	Decrease (7.3)	No Change (84.4)
symptomatic relief	sexual adjustment	self-acceptance
sexual adjustment	satisfying relations with others	relaxational responses
substitute symptoms	relaxational responses	effect of therapist
satisfying relations with others	capacity to love	
capacity to love		
effect of therapist		
effect of treatment		
relaxational responses	effect of therapist	symptomatic relief
freedom to experience feelings	effect of treatment	sexual adjustment
self- acceptance		substitute symptoms
		satisfying relations with others
		capacity to love

indeed unreflective of change and were assumed to be interchangeable without the introduction of the biasing suggestion. Hypothesis C was therefore supported.

The next step in the analysis of results was to determine whether TERs varied between orientations under the same suggestion.

Table 8 shows the comparison TER frequencies for Behavior Therapists and Analytic Psychotherapists under Suggestion P.

Table 8

Comparison of TERs for Behavior Therapists and Analytic Psychotherapists under Suggestion P

	Increase	Decrease	No Change	Totals
Behavior Therapists given Suggestion P N = 10	11	4	135	150
Psychotherapists given Suggestion P N = 10	37	25	88	150
Totals	48	29	223	300

Results indicated that analytic psychotherapists gave significantly different TERs under Suggestion P than did behavior therapists. Chi-square = 39.18 for 2 degrees of freedom, $p < .001$. A percentage analysis of the above data revealed that under Suggestion P (1) of the ratings marked "increases", 77.1% were from analytic psychotherapists

while 22.9% were from behavior therapists; (2) of the ratings marked "decreases", 86.2% were from analytic psychotherapists while 13.8% were from behavior therapists; (3) of the ratings marked "no change", 39.5% were from analytic psychotherapists while 60.5% were from behavior therapists.

It is clear that under Suggestion P, analytic psychotherapists viewed considerably more change, irrespective of direction, than did their behavior therapist counterparts.

Table 9 shows the comparison TER frequencies for behavior therapists and analytic psychotherapists under Suggestion B.

Table 9

Comparison of TERs for Behavior Therapists and Analytic Psychotherapists under Suggestion B

	Increase	Decrease	No Change	Totals
Behavior Therapists under Suggestion B N = 10	14	18	118	150
Psychotherapists under Suggestion B N = 10	21	40	89	150
Totals	35	58	207	300

The groups differed significantly in their TERs under Suggestion B. Chi-square = 13.8, for 2 degrees of

freedom, $p < .001$. Results of the percentage analysis indicated similar findings to those reported under Suggestion P. Of the ratings marked increases and decreases, analytic psychotherapists gave greater percentages than behavior therapists for both categories (60% vs. 40% and 68.7% vs. 31.3%, respectively.) Of the ratings marked no change, 43% were from analytic psychotherapists while 57% were from behavior therapists.

The final series of analyses involved a comparison of TERs among orientations under the suggestions that (1) a member of their own persuasion was conducting the sessions, (2) a member of the other persuasion was conducting the sessions.

Table 10 shows TER comparisons according to condition #1 as given above.

The analysis suggested that the groups differed significantly in TERs when told that a member of their own persuasion was conducting the sessions. Chi-square = 15.78, for 2 degrees of freedom, $p < .001$. A percentage analysis yielded results which were similar to those cited under suggestions P and B. Ratings from analytic psychotherapists showed greater percentages of increases and decreases and lesser percentages of no change than ratings from behavior therapists.

TER comparisons under condition # 2 are shown in Table 11.

Table 10

Comparison of TERs for Behavior Therapists and Analytic psychotherapists when given the suggestion that a member of their own persuasion was conducting the sessions.

	Increase	Decrease	No Change	Totals
Behavior Therapists given Suggestion B N = 10	14	18	118	150
Psychotherapists given Suggestion P N = 10	37	25	88	150
Totals	51	43	206	300

Table 11

Comparison of TERs for Behavior Therapists and Analytic Psychotherapists when given the suggestion that a member of the other persuasion was conducting the sessions.

	Increase	Decrease	No Change	Totals
Behavior Therapists given Suggestion P N = 10	11	4	135	150
Psychotherapists given Suggestion B N = 10	21	40	89	150
Totals	32	44	224	300

The results suggested that the groups differed significantly in TERs when told that a member of the other persuasion was conducting the sessions. Chi-square = 41.50,

for 2 degrees of freedom, $p < .001$.

As in all other analyses, analytic therapists typically rated a greater percentage of change than their behavior therapy counterparts.

CHAPTER V

DISCUSSION

A basic procedural question must be raised with regard to the differential recruitment of subjects and its possible contribution to the divergence from Hypothesis B for behavior therapists. The preponderance of behavior therapy interns and post-interns were contacted informally while most of the analytic subjects were contacted by letter. This course of action was taken as a matter of practical necessity and done in compliance with the wishes of the clinical directors. It might well be that differential means of recruitment might have influenced attitudes toward the experiment or the experimenter and consequently affected the results in an unsystematic manner. One might speculate that the informally contacted group of behavior therapists considered the investigation to be less important and hence were more likely to respond "no change" simply because such a rating required less time and effort to make. This explanation was consistent with the finding that thirteen out of twenty behavior therapists rated "no change" for thirteen of the fifteen items as compared with only six

out of twenty analytic subjects. Furthermore, this would also explain why it was considerably more difficult to find behavior therapy subjects who were willing to participate in the research.

The relative dearth of participating subjects from the Stonybrook program necessitated further recruitment from a variety of other programs broadly oriented toward behavior therapy but not expressly similar to the orientation at Stonybrook. While complete unanimity of approach is not to be found in any orientation, it is even less likely that the behavior therapists in this study approach homogeneity with respect to orientation.

On the post-evaluation questionnaire, for example, several behavior therapists from the Stonybrook orientation said it was a false dichotomy to distinguish between behavior therapy and psychotherapy. A typical attitude was verbalized by one of these subjects, "I don't know how you draw the line between behavior therapy and psychotherapy. To me, behavior therapy <u>is</u> psychotherapy."

Another commented, "I find it difficult to distinguish between behavior therapy and psychotherapy. My ratings were no doubt influenced by my philosophy on therapy." Nearly one-third of the behavior therapists, commenting on the nature of the investigation, noted an absence of clear-cut differentiation between "behavior therapy" and "psychotherapy." To many behavior therapists,

there was no psychotherapy which was not behavior therapy. It is plausible that this attitude obscured the effects of demand variables in the "decrease" column. On the other hand, none of the psychotherapists felt behavior therapy and psychotherapy were equivalent. Table 12 presents the verbatum comments of both groups on the nature of the investigation.

A further empirical question concerns the simulation of the treatment sessions as a possible source of variance. Based on responses to the post-experimental questionnaire and spontaneous comments during the investigation, there is no reason to believe that any subject questioned the authenticity of the sessions. On the contrary, many subjects vehemently criticized the qualities of the therapist and one subject inquired as to the eventual therapeutic outcome.

Research on the effects of psychotherapy would seem to have its own demand characteristics--at least in the case of behavior therapy and analytically oriented psychotherapy. Evaluating the same stimulus material, behavior therapists found more personality change when they thought it was behavioral than when they believed it was psychotherapy, and analytically oriented therapists illustrated a converse bias by "finding" more change when psychotherapy was used. In a sense, both groups "found" what they expected about the effectiveness of these two

TABLE 12

VERBATUM COMMENTS OF BEHAVIOR THERAPISTS AND ANALYTIC THERAPISTS ON NATURE OF INVESTIGATION

Analytic Therapists	Behavior Therapists
The therapist's cognitive approach was oblivious to inner feelings made readily apparent by patient and thus will not ever affect his essential being.	The tape did not make much sense to me. The 2nd excerpt was supposed to be later in therapy but it seemed more like a 2nd session. From a behavioral viewpoint there was no homework assignment or desensitization. If it was traditional therapy, then why was the therapist speaking on such a concrete level?
Most of the questions asked about the two segments could not be answered with any degree of confidence on the basis of the information provided. My own negative response to therapist was probably the decisive factor in most of my evaluations.	Only that my background is not suitable for this study.
Just on the abrasiveness of the therapist.	I don't know what's being investigated.
Just fine!	I find it difficult to distinguish between "behavior therapy" and "psychotherapy". The ratings were no doubt influenced by my philosophy on therapy.
I dislike behavior therapy!	It was difficult for me to imagine that the excerpts were at all separated in time since little seemed to have occurred in the therapeutic relationship. Also in questionnaire, alternative didn't always allow me to express my actual opinion (This was not severe, however.)
I'm curious if the therapist would want to teach all patients to "fight back" or just this one.	

TABLE 12 (Continued)

Analytic Therapists	Behavior Therapists
Therapist seemed to impose his own direction especially on later session and never allowed patient to freely answer questions or pursue own feelings.	Hard to judge improvement due to shortness of tapes.
Hard to separate therapist from patient. Therapist talked too much, challenged patient and seemed to think that giving rationale for behavior would cure the patient. Glad he's not my therapist!	I didn't consider the excerpts I heard to be behavior therapy-nor was it psychotherapeutic. It seemed an ineffectual session of lay-advice giving. Thus, it's difficult to fill in the questionnaire realistically.
I would be curious about the time period between the two sessions, number of meetings, length.	I don't know how you draw the line between behavior therapy and psychotherapy. To me, behavior therapy is psychotherapy.
Insufficient data to make judgment on.	I found it impossible to distinguish between "early" and "late" tapes.
I was disturbed by the therapist's insistence on the patient's fear of rejection as the central difficulty and his complete failure to listen to the patient. I was also unclear about what if any technique was used. I can see the value of using behavioral techniques in the treatment of homosexuality but it was not evident from the tapes that this was being done.	None, except on what basis do you distinguish behavior therapy from psychotherapy?
	It seemed almost like the late and early sessions were interchangeable. The ratings in many cases did not apply to the tapes or had insufficient information on which to judge improvement.
I wonder whether you may be prejudicing psychoanalytically oriented psychologists against you by choosing such a complexly motivated set of symptoms to present.	Comments and judgments about the therapy sessions were difficult to make after one listening. Thus, I tended to use the category "no change". Also, some

TABLE 12 (Continued)

Analytic Therapists	Behavior Therapists
The therapist likes to talk - not to listen.	questions, (ie. change in love) were irrelevant to my conceptualization of the sessions and again I used "no change."
The tape is too long.	Interesting.
	It appeared to me that therapist did not involve himself in pursuing hierarchies of anxiety with patient. I think the patient is getting cheated.
	Whatever intervening therapy that occured, it did not attack the basic problem of sexual malfunction. The interview did not seem to be coherent with the facts presented at first.
	This patient needs a new therapist!

kinds of therapy. In a sense, of course, the author of this paper is in a similar position, for he too found what he expected. In the hypothesis testing research so typical of psychology it is difficult to separate expectancy from hope, and therapists especially should know that if the wish is not the only father to the thought, the latter may unknowingly be influenced by the former. Thus, this would have been a better study had an experimenter unfamiliar with the hypothesis to be tested selected the subjects, ran them, and treated the results.

While these results demonstrate little about research on the effect of psychotherapy and behavior therapy which had not already been published, they suggest that demand characteristics may play an enormous part, in the form of experimenter bias in the conduct of the studies, and subjects' motivations. This study, in combination with the research of Orne and Rosenthal already cited, suggest it is premature to conclude anything about the effectiveness of psychotherapy or behavior therapy from research which has not controlled for the kind of bias demonstrated here. An ideal research program, for example, would have analytically oriented therapists conducting both behavior therapy and psychotherapy, and behavior therapists conducting both behavior therapy and analytically oriented therapy, with the same kinds of clients--assuming, of course, that each could learn the other's orientation to a criterion level

of competence agreed upon by professionals from both orientations and also agree upon criteria of improvement. This is, of course, a highly unlikely eventuality, not only for the obvious practical reasons, but because analytically oriented therapists and behavior therapists may be completely different kinds of people, with personality differences leading them, knowingly, or unknowingly, into their "chosen" fields (Temerlin and Weiss, 1969).

Psychotherapy and behavior therapy probably are not unified dimensions or processes; probably psychotherapy involves re-learning or conditioning in accordance with laboratory derived principles of learning, (for example, reality testing) and the manipulation of contingencies of reinforcement and desensitization in behavior therapy occurs in a relationship. Indeed, demand characteristics research suggests the patient in behavior therapy may have attitudes toward the therapist and expectancies about receiving help which might influence the results, even if all reinforcement were to be administered mechanically.

The data demonstrate clearly that professional identity may bias the perceived effectiveness of therapy. A clinician's assessment of positive or negative therapeutic outcome may be as much a function of his knowledge of what "type" of therapist conducted the therapy as it is

of the actual course of treatment. The situation is further obfuscated by such factors as socio-economic status, prestige suggestion and pre-selection of clients so that the relationship between measure of therapeutic outcome and the researcher-clinician is one of exceeding complexity.

It is a well-documented sociological observation that prejudice and bias have their roots in attributing to the "outgroup" a discrepancy of values, a differentness, from that of the ingroup. Propinquity and increased intimate contact serves to disintegrate racial preconceptions (Deutsch and Collins, 1958).

It appears that a situation analogous to the social phenomenon of prejudice currently exists in the area of comparative psychotherapy research and that a solution, while by no means simple, is both feasible and desirable. It is becoming increasingly clear that psychotherapy is not a unitary process but "a heterogeneous collection of ingredients or psychological conditions that produce varying degrees of both positive and deteriorative personality change in patients" (Truax and Carkhuff, 1967, p. 21). In fact, Strupp and Bergin (1969) have suggested that eroding the barriers which currently separate the schools of psychotherapy can only be accomplished through a "non-school" approach to research, without dependence on doctrinaire allegiances. David Bakan's (1967) postulate,

"After all, we are all pretty much alike" is useful in helping us to appreciate the commonalities which cut across orientations. It may be argued, using the logic of Patterson (1968), that reinforcement and conditioning are part and parcel of all therapeutic relationships and, by the same token, that behavioral modification techniques are inextricably woven into a relationship. Thus, Lovaas delivers a jelly-bean to an autistic child while concurrently smiling and patting him on the head. What is the source of reinforcement--the jelly-bean, the relationship or both? Patterson may be correct in assuming that the difference between relationship therapy and behavior therapy is one of emphasis rather than one of kind:

> The behavior therapist emphasizes conditioning techniques, which he applies systematically, and is not systematic in his development of a relationship. The relationship therapist systematically develops a relationship but is not so consciously systematic in applying conditioning techniques. (p. 230).

It is not the purpose of this paper to engage in an appraisal of which orientation is more biased, more effective and more adherent to the tenets of "Science". Rather, the concern is to provide a signpost to the difficulties involved in obtaining non-biased research findings and to suggest a means whereby this can be accomplished. It would seem that before meaningful comparisons can be made we must acknowledge that biases in research and practice influence the perceived effectiveness

of therapy across all orientations. In so doing, we can begin to develop a non-partisan base for evaluating research outcomes.

No doubt, much of the difficulty toward accomplishing this end springs from the relative mutual isolation of the diverse training programs. Consequently, a therapist of any persuasion may have received his training at an institution which offered nothing more than a cursory exposure to other orientations. The ingraining of biases at such an early professional age typically results in a narrow scope of vision as to goals and criteria for successful outcomes and serves further to insulate the "indoctrinated" therapist from the rest of the therapeutic and research communities. To date, the ongoing conflicts between behavior therapists and analytic therapists have generated much heat but little light on the question of therapeutic effectiveness. It is felt that before the situation can improve, there must be an appreciably greater cooperative effort made on the part of all "schools" to communicate and to listen. We are not so naive as to expect that the name calling and banner-waving will vanish overnight. A feasible solution to the problem is no mean task. What we do know, however, is that no orientation has a monopoly on sound research or (for that matter) on biases. With this in mind, perhaps we can appreciate the value of pooling our resources

and profit from one another's mistakes and successes. Once we, as professionals, recognize that neither orientation has all the answers, our training institutions will assume their proper roles of training rather than indoctrination. In this atmosphere, perhaps our researchers will be able to direct themselves to the major task at hand, namely, to enrich our current body of knowledge and develop innovative ideas for the future.

Probably neither psychotherapists nor behavior therapists are a homogeneous group, and individual differences in personality factors may lead any therapist, of whatever theoretical orientation, to respond idiosyncratically to any client, whatever the problem for research this may mean. There is no easy solution to the problems involved in psychotherapy research, but it is unfortunate that the reputation of psychotherapy among psychologists was so tarnished by a premature acceptance of research which had the form but not the substance of science.

CHAPTER VI

SUMMARY

The study investigated the relationship between professional idenfication and the perceived effectiveness of psychotherapy. Twenty analytic therapists and twenty behavior therapists listened to two taped excerpts of sessions labelled as "early" and "late" sessions of either behavior therapy or psychotherapy, and then rated the effectiveness of treatment. The interviews were constructed to be ambiguous and, in fact, to portray no personality change. Eight additional subjects served as controls.

Instructions to each group varied the suggestion of whether a behavior therapist or analytic therapist conducted treatment. The control subjects received no suggestion.

It was hypothesized that analytic therapists who were told that a member of their own persuasion conducted the sessions would view treatment as more effective than when told a behavior therapist conducted the sessions. It was also hypothesized that behavior therapists would view

treatment as more effective when told a behavior therapist conducted the sessions than when told the therapist was analytically oriented. Finally, it was hypothesized that control subjects would view no change over the sessions when no suggestion was provided.

Results indicated that an individual's perception of the effectiveness of a given form of treatment may be a function of his particular orientation or professional identification, although the direction of the bias was not always consistent. It would seem that the relationship between the perceived effectiveness of therapy and professional identification is a complex one which has numerous implications for both research and practice.

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APPENDIX A

SCRIPT OF THE SESSIONS

Early (Late) Interview

P: Patient
T: Therapist

P: And, uh, you know, I have the feeling that maybe I'm sort of hiding behind sleeping, you know. I know--. I know I'm not getting the sex I'd like, so I go to sleep and sleep it off, you know (laughs)

T: Um-hmm.

P: That's the only thing I can figure--I don't feel frustrated in any--in any other area.

T: But when you're awake, do you feel sexually frustrated?

P: No, now that's the strange part. I was noticing this morning that since this, I mean, since I said I was gonna try really hard to get girl friends and things, I haven't been at all, uh, particularly feeling much desire for it.

T: Um, hmm.

P: But, like the times I've felt I wanted to have some, you know, sexual relief, it's just as easy to masturbate--I can always do it that way, which isn't, you know, doesn't really solve the problem particularly except--it's a relief.

(brief silence)

T: Well, again do you think your lack of sexual desire is an evasion for--

P: Yeah, I do--I think that on one hand, uh, I mean, you know I want this and logically this is what I want to do but like I'm fighting it, or something. I don't know--

T: All right now, let's ask ourselves, what do you think you're most afraid of--not having the desire for sexual intercourse or being afraid of girls, per se.

P: Now, that' the--that's the hard one, frankly, cause I don't think that I'm afraid in the sense of being afraid of girls--I mean what I'm really afraid of is probably just the going out and the, you know, the first contact, getting to meet and know a girl on my own.

T: Aren't you really saying you're afraid they won't like you?

P: Well, but it's really not that simple. I mean, just saying they won't like me--it's--

T: All right, let's get even a little more specific then. You're thinking, "If I go out and meet a girl, then there's a good possibility that she won't like me." What I'm trying to establish is the source of your fear. Is that the way you feel?

P: I don't really think so--I mean, It's like, you know I'm beaten before I go out. Just for example, a couple of months ago I joined the Museum of Modern Art and I've gone a couple of times and so I go in, look around and don't even see anybody that turns me on.

T: Um-hmm.

P: So, I'm, well, I'm like cutting myself off before I start.

T: Yeah, but--

P: (interrupts) I don't know whether--

T: Well, let's imagine a situation that's been particularly difficult for you (thoughtful pause). Imagine approaching a female--you're now in bed with her and you're at the point where you want to have sexual relations. Is this the point where the anxiety is greatest for you? (silence) Huh?

P: (sigh) I don't know, I'm just sitting here imagining it. I really can't say. You know, it's like climbing the high diving board and just when you're at the top, you know, you look down at the water and it's like such a huge drop. So you think, maybe, you'll climb back down and chicken out but then you feel embarrassed cause everybody's watching you. So you stand up there, afraid of either thing, you know--

T: Yeah, that's a similar feeling, I imagine, but let's get back to this situation I was talking about.

P: Well,--being honest, I really don't think I could go that far or even kiss her. I really think I'd be too scared.

T: But, you're assuming that you would, in fact be rejected. What would happen if you didn't get rejected? Could you allow the possibility that you just might be successful?

P: (hesitation) I guess so but like now just more or less getting started is the big thing for me--I just don't think I can (sounds pained).

T: Well, of course--it's almost as if you're doomed to failure even before you start out--you keep telling yourself "I'll never succeed" so as of now there's no way you have of testing it out to see what would happen--I guess really to find out what could happen you have to get up off your ass, go out and meet some girls. But you never quite get to that when you're home sleeping.

P: (sounds a little angry) Well, I wouldn't say that all I do is sleep--I mean, lately I have been noticing pretty girls but I still really haven't gotten the nerve to go up to one and say, I'd like to call you or something, (laughs) I mean, you know I just haven't--But I'm seeing a lot prettier girls than I have and discovering that I'm--that the pretty girls are younger than me which I never really noticed before.

T: You didn't notice all--?

P: They always seemed so much older than--

T: Yeah, because you edited out the best looking and most eligible ones.

P: Mm-huh, but now at least I can look (laughs) but I keep asking myself if that's enough and if it isn't, can I ever do more.

T: Well, it seems to me that you--

Late (Early) Interview

P: Patient
T: Therapist

T: Yeah, I agree. Your conflict of not approaching an attractive, eligible girl is apparently so overwhelming that you don't pursue your ultimate goal. But you don't seem to see the alternatives either, see what I mean?

P: Yeah, but--I don't really see how I can get rid of these feelings. I mean, I--

T: Let's talk about what you really do. It seems to me that what you're saying is you shouldn't have to knock yourself out in a situation where you feel you're behind and then when you compete for a girl, you tend to give up if you can't win right away so that there's no conflict anymore, you're just out of it but you talk yourself out of it, you know?

P: Um-hmm, but actually, I mean, it really isn't much of a contest.

T: Yes, it is--

P: I don't understand what you mean.

T: OK, you say you want to change, right? But then when it comes down to the nitty-gritty and doing something about it, you find something else to do like sleeping or something because these other things are for the moment more attractive, more compatible or stronger and have less conflict connected with them.

P: (sounds a little angry) Are you saying that I really don't want to change?--I mean that's amazing, that's really amazing! Why the hell would I come down here and pay all this money if--

T: (sympathetically) No, I'm not saying that, I'm not saying that at all--all I'm trying to point out is that at times there's a discrepancy between what you say you want for yourself and how you behave.

P: (dejectedly) I guess I just don't know how I can go about it. I mean, all my life it's been the same damn way--always feeling like I'm left out and that's not my imagination either--I am left out. With the girls it's the same feeling--I feel as though, it's like every time I take some kind of lead--well, I'm imposing and they're laughing at me (forces a laugh) It's comical, in a way, you know?

T: I don't think you're feeling it's very funny at all.

P: But--it--I mean--I just don't want to find out that people--I mean women don't like me--I don't try to get that close to them to find out--I don't, well, I think I don't even want to know.

T: OK, but there are all kinds of rejection, some hurt more than others. For example, suppose you're walking down the street and you run into a female acquaintance, and you expect her to say hello but she just walks past. Does that bother you?

P: (hesitates) Not a whole lot, just a little, maybe.

T: Well, that's my point--you're--you don't sound as if you're devastated by this kind of--minor rejection.

P: No, but that's different--I mean, I get all this shit from everybody like you're a good looking guy and--you know.

T: You shouldn't have any problems meeting people? That kind of thing?

P: Yeah, but I do--I mean, I just flat out do. And sometimes I go out with this great feeling of, gee, you know I'm God's gift to women--and then nothing happens (laughs).

T: So you're safe again--until next time.

P: I guess so (silence) but I, I'm just beginning to realize this, I want the women to chase me--too. Why the hell should I do all the chasing and competing? They get just as much fun out of it. That's something I could never understand about--

T: And it's a lot safer because then you couldn't get rejected. You can refuse them but, they're not going to refuse you.

P: Yeah, that's true because--

T: Well, let's get back to changing. Would it be so terrible if you got refused, even by a girl you didn't know very well?

P: You know, at times, I can logically believe that it wouldn't be all that bad.

T: But that's only at times, right?

P: Yeah,--and it's kind of after the fact. Like, after I go to sleep--I mean wake up--I think, "Shit, it's 9 o'clock, you wasted the whole evening."

T: OK, but if you see it so clearly after the fact and keep admitting it to yourself and get to the point where you really don't want this to happen don't you think it's possible for you to stop being so afraid and to try some other ways?

P: Yeah--but, like, it's an old pattern that I got myself into--I'm just not sure.

T: Well, maybe you don't have to be sure to try it.

APPENDIX B

RATING SCALES AND QUESTIONNAIRE FORMS

INFORMATION FURNISHED BY PSYCHOTHERAPISTS AND BEHAVIOR THERAPISTS FROM QUESTIONNAIRE

Age		% of Time Devoted to Research, Practice, etc.					
		Psy.			Beh. Th.		
Psy.	Beh.Th.	R*	P*	O*	R*	P*	O*
26	25	25	75	0	30	0	70[t]
25	24	20	80	0	30	0	70[t]
26	26	10	40	50[t]	20	20	60[t]
28	27	10	30	60[o]	5	90	5[t]
29	29	30	70	0	60	40	0
26	36	20	80	0	40	60	0
27	26	20	50	30[t]	30	40	30[t]
25	27	10	70	20	33	33	33[t]
27	33	20	40	40[t]	50	50	0
29	31	5	60	35[t]	30	70	0
23	29	40	40	20[d]	25	75	0
28	26	10	40	50[s]	45	55	0
27	25	0	67	33[d]	55	45	0
26	35	10	25	65[d]	25	75	0
23	28	10	75	15[t]	10	90	0
31	26	5	50	45[a]	20	80	0
26	31	20	55	25	70	0	30[t]
23	24	0	60	40[c]	100	0	0
26	25	10	70	20[c]	25	60	15
31	22	80	10	10[t]	40	40	20

(Continued)

Areas of Research

cognitive style by factor analysis	social psychology
projective testing	physiological psych.
social perception	physio. correlates of emotion
community psychology	gradients of reinforcement
humor	individual differences in conditioning
child development	cognitive style
self-concept	child reinforcement in language development
birth order of children	power theory
delinquency, learning, grp. th.	autonomic conditioning
psychotherapy	auto-kinetic effect
stuttering, diagnostic categories	developmental psychology
social psychology	none
legal psychology	contingencies of reinforcement
personality, brain functioning	placebo effect
animal research	generalization with respect to phobias
none	computer programing
effects of rubella on offspring	perception
psychotherapy	desensitization
psychanalytic theory	learning & neural processes
	cognitive attribution theory

(Continued)

Future Work

***p.t. & res.	uncertain
p.t.	mental health
grp. p.t.	res. in physiology
p.t.	**b.t. with autistics
p.t.	b.t., adults & children
p.t.	b.t., research, teaching
p.t. & teaching	b.t. & teaching
p.t., children	b.t., research
p.t.	b.t., child.
teaching	b.t. adult
p.t., community	b.t., research
milieu th. & research	b.t., adults
uncertain	teaching
clinic setting & p. practice	b.t., teaching
grp. therapy	teaching, research
p.t.	teaching, b.t.
p.t. & teaching	b.t., child.
p.t. & teaching	b.t.
res. in social perception	teaching, research
p.t.	teaching, research

***p.t. - psychotherapy
**b.t. - behavior therapy
t - teaching
c - consulting
d - diagnostic evaluation
a - administration
- study of self & people
s - study
*R - Research
*P - Practice
*O - Other

RATING SHEET

Indicate the extent and direction of change between sessions in the following dimensions: (circle one)

1. symptomatic relief (a) increased (b) no change (c) decreased

2. level of productivity (a) increased (b) no change (c) decreased

3. sexual adjustment (a) increased (b) no change (c) decreased

4. adequacy of interpersonal relations (a) increased (b) no change (c) decreased

5. capacity to cope with stress (a) increased (b) no change (c) decreased

6. appearance of substitute symptoms (a) increased (b) no change (c) decreased

7. self-acceptance (a) increased (b) no change (c) decreased

8. freedom to experience feelings (a) increased (b) no change (c) decreased

9. capacity to enter into satisfying relations with others (a) increased (b) no change (c) decreased

10. capacity to rely on internal or external reinforcement with respect to behavior (a) increased (b) no change (c) decreased

11. development of adaptive new behavior patterns (a) increased (b) no change (c) decreased

12. degree of relaxational responses (a) increased (b) no change (c) decreased

13. capacity to love (a) increased (b) no change (c) decreased

14. This treatment had an overall (a) positive (b) no (c) negative effect on the individual seeking help

15. In general, the therapist was (a) effective (b) inconsequential (c) detrimental in being of help to this individual

QUESTIONNAIRE

1. Name:

2. Age:

3. Degree (list those received and state expected date of graduation for degree presently sought):

4. My major interest lies primarily in the (a) psychotherapeutic (b) behavioral (c) other (specify) approach toward therapy.

5. State approximate percentage of time devoted to

   (a) research - specify type of research
   (b) practice of therapy
   (c) other (specify)

6. Most of my research has been done in (specify area)

7. Other things being equal (that is, assuming therapists are comparable in competence) and considering the pitfalls of rigid dichotomies, which form of therapy in your opinion would be of greater use to a neurotic individual with clear-cut symptoms?

   (a) behavior therapy (b) psychotherapy

8. What type of work would you like to be doing 5 years from now. Be specific.

9. Is there anything about the nature of this investigation on which you would like to comment?

APPENDIX C

RAW DATA

Ratings of Therapeutic Effectiveness

	Suggestion	Increase	Decrease	No Change	Totals
Behavior Therapists	B	14	18	118	150
	P	11	4	135	150
Analytic Therapists	B	21	40	89	150
	P	37	25	88	150
Totals		83	87	430	600

Item Analysis of Behavior Therapist's Ratings Irrespective of Suggestion

	Item	Increase	Decrease	No Change	
1.	Symptomatic relief	0	1	19	
2.	Level of productivity	2	1	17	
3.	Sexual adjustment	0	0	20	
4.	Adequacy of interpersonal relations	1	1	18	
5.	Capacity to cope with stress	2	3	15	
6.	Appearance of substitute symptoms	0	1	19	
7.	Self-acceptance	6	1	13	
8.	Freedom to experience feelings	4	1	15	
9.	Capacity to enter into satisfying relations with others	0	0	20	
10.	Capacity to rely on internal as opposed to external reinforcement with respect to behavior	2	1	17	
11.	Development of adaptive new behavior patterns	1	1	18	
12.	Relaxational responses	7	0	13	
13.	Capacity to love	0	0	20	
14.	Treatment effectiveness	0	5	15	
15.	Therapist effectiveness	0	6	14	
	Totals	25	22	253	300

Item Analysis of Analytic Therapist's Ratings Irrespective of Suggestion

	Item	Increase	Decrease	No Change	
1.	Symptomatic relief	2	7	11	
2.	Level of productivity	5	1	14	
3.	Sexual adjustment	0	3	17	
4.	Adequacy of interpersonal relations	4	2	14	
5.	Capacity to cope with stress	4	5	11	
6.	Appearance of substitute symptoms	4	3	13	
7.	Self-acceptance	5	4	11	
8.	Freedom to experience feelings	9	4	7	
9.	Capacity to enter into satisfying relations with others	2	4	14	
10.	Capacity to rely on internal as opposed to external reinforcement with respect to behavior	5	6	9	
11.	Development of adaptive new behavior patterns	2	1	17	
12.	Relaxational responses	4	7	9	
13.	Capacity to love	2	3	15	
14.	Treatment effectiveness	5	7	8	
15.	Therapist effectiveness	5	8	7	
	Totals	58	65	177	300

ITEM ANALYSIS FOR BEHAVIOR THERAPISTS' RATINGS BY SUGGESTION B

	Item	Suggestion B		
		Increase	Decrease	No Change
1.	Symptomatic relief			5
2.	Level of productivity			5
3.	Sexual adjustment			5
4.	Adequacy of interpersonal relations			5
5.	Capacity to cope with stress	1		4
6.	Appearance of substitute symptoms		1	4
7.	Self-acceptance	2		3
8.	Freedom to experience feelings	1		4
9.	Capacity to enter into satisfying relations with others			5
10.	Capacity to rely on internal as opposed to external reinforcement with respect to behavior	1		4
11.	Development of adaptive new behavior patterns	1		4
12.	Relaxational responses	3		2
13.	Capacity to love			5
14.	Treatment effectiveness		2	3
15.	Therapist effectiveness		3	2
	Totals	9	6	60

ITEM ANALYSIS FOR BEHAVIOR THERAPISTS' RATINGS BY SUGGESTION B (Continued)

Suggestion B (Order of Tapes Reversed)

	Item	Increase	Decrease	No Change
1.	Symptomatic relief		1	4
2.	Level of productivity	1	1	3
3.	Sexual adjustment			5
4.	Adequacy of interpersonal relations		1	4
5.	Capacity to cope with stress		1	4
6.	Appearance of substitute symptoms			5
7.	Self-acceptance	2		3
8.	Freedom to experience feelings		1	4
9.	Capacity to enter into satisfying relations with others			5
10.	Capacity to rely on internal as opposed to external reinforcement with respect to behavior		1	4
11.	Development of adaptive new behavior patterns		1	4
12.	Relaxational responses	2		3
13.	Capacity to love			5
14.	Treatment effectiveness		2	3
15.	Therapist effectiveness		3	2
	Totals	5	12	58

ITEM ANALYSIS FOR BEHAVIOR THERAPISTS' RATINGS BY SUGGESTION P

		Suggestion P		
	Item	Increase	Decrease	No Change
1.	Symptomatic relief			5
2.	Level of productivity			5
3.	Sexual adjustment			5
4.	Adequacy of interpersonal relations			5
5.	Capacity to cope with stress	1		4
6.	Appearance of substitute symptoms			5
7.	Self-acceptance	2	1	2
8.	Freedom to experience feelings	2		3
9.	Capacity to enter into satisfying relations with others			5
10.	Capacity to rely on internal as opposed to external reinforcement with respect to behavior	1		4
11.	Development of adaptive new behavior patterns			5
12.	Relaxational responses	1		4
13.	Capacity to love			5
14.	Treatment effectiveness		1	4
15.	Therapist effectiveness			5
	Totals	7	2	66

ITEM ANALYSIS FOR BEHAVIOR THERAPISTS' RATINGS BY SUGGESTION P (Continued)

Suggestion P (Order of Tapes Reversed)

	Item	Increase	Decrease	No Change
1.	Symptomatic relief			5
2.	Level of productivity	1		4
3.	Sexual adjustment			5
4.	Adequacy of interpersonal relations	1		4
5.	Capacity to cope with stress		2	3
6.	Appearance of substitute symptoms			5
7.	Self-acceptance			5
8.	Freedom to experience feelings	1		4
9.	Capacity to enter into satisfying relations with others			5
10.	Capacity to rely on internal as opposed to external reinforcement with respect to behavior			5
11.	Development of adaptive new behavior patterns			5
12.	Relaxational responses	1		4
13.	Capacity to love			5
14.	Treatment effectiveness			5
15.	Therapist effectiveness			5
	Totals	4	2	69

ITEM ANALYSIS FOR ANALYTIC THERAPISTS' RATINGS BY SUGGESTION B

	Item	Suggestion B		
		Increase	Decrease	No Change
1.	Symptomatic relief		1	4
2.	Level of productivity	2		3
3.	Sexual adjustment		1	4
4.	Adequacy of interpersonal relations	2		3
5.	Capacity to cope with stress	1	1	3
6.	Appearance of substitute symptoms		1	4
7.	Self-acceptance	1		4
8.	Freedom to experience feelings	4		1
9.	Capacity to enter into satisfying relations with others		1	4
10.	Capacity to rely on internal as opposed to external reinforcement with respect to behavior	1	2	2
11.	Development of adaptive new behavior patterns		1	4
12.	Relaxational responses	1	2	2
13.	Capacity to love		1	4
14.	Treatment effectiveness		3	2
15.	Therapist effectiveness		3	2
	Totals	12	17	46

ITEM ANALYSIS FOR ANALYTIC THERAPISTS' RATINGS BY SUGGESTION B (Continued)

Suggestion B (Order of Tapes Reversed)

	Item	Increase	Decrease	No Change
1.	Symptomatic relief		2	3
2.	Level of productivity	1	1	3
3.	Sexual adjustment		1	4
4.	Adequacy of interpersonal relations		1	4
5.	Capacity to cope with stress		3	2
6.	Appearance of substitute symptoms	1		4
7.	Self-acceptance	1	2	2
8.	Freedom to experience feelings	3	1	1
9.	Capacity to enter into satisfying relations with others		1	4
10.	Capacity to rely on internal as opposed to external reinforcement with respect to behavior	1	2	2
11.	Development of adaptive new behavior patterns			5
12.	Relaxational responses		2	3
13.	Capacity to love		1	4
14.	Treatment effectiveness	1	2	2
15.	Therapist effectiveness	1	4	
	Totals	9	23	43

ITEM ANALYSIS FOR ANALYTIC THERAPISTS' RATINGS BY SUGGESTION P

		Suggestion P		
	Item	Increase	Decrease	No Change
1.	Symptomatic relief	1	2	2
2.	Level of productivity			5
3.	Sexual adjustment			5
4.	Adequacy of interpersonal relations	2	1	2
5.	Capacity to cope with stress	2		3
6.	Appearance of substitute symptoms		2	3
7.	Self-acceptance	2		3
8.	Freedom to experience feelings	1	1	3
9.	Capacity to enter into satisfying relations with others	2	1	2
10.	Capacity to rely on internal as opposed to external reinforcement with respect to behavior	2	1	2
11.	Development of adaptive new behavior patterns	1		4
12.	Relaxational responses	2	1	2
13.	Capacity to love	2		3
14.	Treatment effectiveness	2	1	2
15.	Therapist effectiveness	3		2
	Totals	22	10	43

ITEM ANALYSIS FOR ANALYTIC THERAPISTS' RATINGS BY SUGGESTION P (Continued)

Suggestion P (Order of Tapes Reversed)

	Item	Increase	Decrease	No Change
1.	Symptomatic relief	1	2	2
2.	Level of productivity	2		3
3.	Sexual adjustment		1	4
4.	Adequacy of interpersonal relations			5
5.	Capacity to cope with stress	1	1	3
6.	Appearance of substitute symptoms	3		2
7.	Self-acceptance	1	2	2
8.	Freedom to experience feelings	1	2	2
9.	Capacity to enter into satisfying relations with others		1	4
10.	Capacity to rely on internal as opposed to external reinforcement with respect to behavior	1	1	3
11.	Development of adaptive new behavior patterns	1		4
12.	Relaxational responses	1	2	2
13.	Capacity to love		1	4
14.	Treatment effectiveness	2	1	2
15.	Therapist effectiveness	1	1	3
	Totals	15	15	45