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Results of Psychotherapy

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Introduction

To Shakespeare's famous question: "Can'st thou not minister to a mind diseased?", Eysenck (10) gave a decided negative answer. Hebb (11) has also asserted that "There is no body of fact to show that psychotherapy is valuable". From 1954 onwards, Rogers (12) has taken up the challenge and shown that changes occur in psychotherapy which do not occur without it, and has suggested that these changes are valuable.

However, some burning questions remain: there is the vexing problem of the natural history of mental and emotional disorder. Where does psychotherapy begin and natural history end? What is the baseline? Can one accept that three out of every four untreated neurotics remit or improve without treatment? This figure, bandied about in many quarters about nearly all types of psychiatric disorder, leaves no leeway to show the effect of psychotherapy.

After more than a decade of practice in psychotherapy, this author welcomed the restlessness that comes from concern lest rust should corrode the spirit and blind habit petrify both technique and expectations. Experience taught a healthy distrust of clinical impressions unchecked by counting. Curiosity provided the questions: "What am I doing with these good people: How am I doing it? Can I do better?" The more immediate questions were: "How can one measure psychotherapeutic changes? What changes do occur and on what do they depend?"

Methods

The Population

The population consisted of 201 consecutive private patients who underwent therapy between 1955 and 1960. The distribution of diagnostic grouping was as follows: psychoneurosis 56 per cent., psychopathic personality (character neurosis) 25 per cent., psychosomatic reactions 8 per cent., psychosis 8 per cent., and other 3 per cent.

Of these 201 patients, only 3·5 per cent. were hospitalized, and only 10 per cent. received medication. One hundred and sixty-three had ended their therapy in 1960. This was the operative sample. They had no medication while under treatment.

The Treatment Method

Within the limits of fluctuating emotions and apparent differences in encounter, and after allowing for maturation of experience and knowledge in the therapist, the therapeutic technique was remarkably uniform in essence, being a personal modification of analytical technique with a decided influence, though not an exclusive dominance, of applied Jungian theory. However, no patient was intellectually aware of this orientation, nor did it produce any dominant emphasis. Patients did not have Jungian dreams to please the therapist. Any tendency towards intellectual interests in psychotherapy, Jungian or otherwise, was discouraged. Learning theory, existentialist psychiatry and Freudian concepts were applied in the therapist's own schema, as were a number of broader interpersonal and social theoretical orientations. The overall matrix was phenomenological in the sense of a primary interest in what is presented and what the meaning of any particular behaviour might be, with some agnostic detachment from all theoretical encumbrances. This attitude was greatly enhanced by the therapist's sundry and various research interests, challenging any and all existing theories (1–9).

It was apparent that a number of incidental

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factors came into play in the course of this essentially analytic approach:

(*i*) Sensory and social altered variability of input: lying supine and relatively immobile in the therapeutic hour, in a quiet, dimmed room; hypnoidal states, evoking pre-logical and pre-verbal material, poured out the imagery of primary thinking during the 50-minute session.

(*ii*) Learning theory found many applications, (*a*) in the exhaustion emission of symptom provoking and of encouraging the patient to defy phobic symptoms and (*b*) in the de-habituating effect of an on-going transference, (*c*) in Skinner's application of successive approximation, built on the system of rewards and punishment implicit in psychotherapy, (*d*) even in the setting up of new associations of thought with the eventual expectation that this would penetrate into the oneiric process to show differences in organization and lysis (3) in dreams, there was learning behaviour.

(*iii*) The judicious use of magic is implicit in good therapy. The aura of the physician's name and power; the circumstances of the encounter following expectant waiting and hope; the play of nearness in sharing intimacies and secrets, yet remoteness in anonymity and in the "no touch technique"; the acceptance of the patient's hitherto unforgivable sins, as well as the investment of superhuman power occasioned by a million years of magic and the reliving of the magical experience of early childhood, makes magic an obligatory tool of healing, to be neither scorned, nor abused.

True religious values were always respected and always encouraged at a point when the patient was ready to apply charity at home, in the form of self-forgiveness and in exploring the attitudes to death. All creative impulses were cultivated.

At the end, the therapeutic door was always ajar.

All psychotherapy has its uniqueness in the hands of one person. But even if the technique herein described is not entirely replicable in its particulars, with a set of patients who brought much that favoured cure with them, it is still in accord with general practice, and should have provided conditions for optimal results.

Data Collection

At the first interview the following data were collected: establishment of the leading problem or symptom and its duration; the number of other symptoms which formed the complaint; their overall intensity or severity. At about the fourth interview, the following were added: diagnostic classification, its severity, a sleep-dream rating (on a 5-point scale) on the lines described elsewhere (3). At the end of therapy, a self-rating (5-point scale) of improvement, what others said about the patient and any residual disability. The dream index was repeated, the status of presenting symptoms determined and the type of termination was classified. At follow up, by mail, self rating was repeated, also a rating of impression by an independent observer who knew the patient was introduced. The dream index was repeated and the status of the presenting complaint and other symptoms, old and new, were reviewed descriptively. The flow of time was also a usable measure. The level of change or improvement employed throughout, unless specifically stated, was *marked* improvement (i.e. considerable, without doubt).

Results and Discussion

Psychotherapy may be seen, in over-simplified, schematic fashion, as a situation, with its variables, in which the patient presents himself, with his own ("organismic") variables, and to which he then responds.

The rather large amount of data collected for this study may be organized along the above-mentioned lines, to answer the following specific questions:

A. What were the "response" variables, or basic results? How were they measured? What affected these measures? What were the relationships between indices or measures?

B. What were the "organismic" variables studied? How were they measured? How did they affect results?

C. What were the "situational" variables? How were they measured? How did they affect results?

From the viewpoint of results, the theme of this paper was set by the discovery that what-

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ever was reported on any of these three sets of variables was primarily predicated by the measure used.

A. *The "Response" Variables*

The basic results are reported at two levels of time, the end of therapy and at follow up.

(a) *Results at end of therapy.* The numerical expression of psychotherapeutic results depended so much on the measurement used, that it would have had no meaning unless the method of measurement were also given. In this study the percentage of patients changing decidedly for the better varied from 21 per cent. to 76 per cent. depending on the method of measurement.

(*i*) The "optimistic" cluster of indices were: the therapist's rating of *marked* improvement, the patient's self rating of the same level of improvement, and the loss of at least one symptom. These indices yielded the commonly quoted statistic that three-quarters of all psychiatric patients entering therapy get better. However, the difference between these results and those quoted by others was two-fold: there was a reliable agreement between these three indices and, more importantly, the level accepted as "improvement" in this report was undoubted, *marked*, or considerable or very evident improvement (as seen by the therapist or by the patient *and* by an "outside" person who knew the patient well or as exemplified by the loss of at least one symptom). The agreement between the therapist's and patient's ratings is of course, not too impressive, because there was a "halo" effect or mutual influence between what were, after all, subjective, intuitive judgments. Nevertheless, one could not disregard these subjective ratings in the context of this study and at this level of improvement, because they indexed at least the degree of satisfaction the patient and the therapist had with each other. This was supported by the not entirely independent opinion of an outsider, e.g. spouse, parent or friend. Without this degree of success and satisfaction, psychotherapy could hardly be justified or even possible.

(*ii*) The pessimistic cluster of indices were: the loss of all symptoms in 21 per cent. of patients (N=158), the loss of the main or presenting problem or symptom in 40 per cent. of patients (N=149), and a *marked* change in dream rating index in 51 per cent. of patients (N=131). These indices were also reliably related.

Table I shows clearly the relationship between a change in the morphology, content and lysis of a five-dream sample and the loss of the main problem or dysfunction. It seemed that both these phenomena, as indexed by the measure used, were deeply rooted and reliably interdependent.

TABLE I

Relationship Between Sleep Dream Indexing Improvement and Loss of Presenting Symptom at the End of Therapy

	Patients with Dream Improvement	Patients without Dream Improvement
Number of patients losing main problem	31	23
Number of patients not losing main problem	11	58

$\chi^2 = 23 \cdot 3$, $p < \cdot 001$ for 1 d.f.

One may hear the depth psychotherapists echoing "of course, we have said this for half a century", and reply that they have said it, but never proved it. It is worth adding that the measures used to index the results of psychotherapy ought to be at least as meaningful as those used in this work, in order to establish the basic facts of the therapeutic process. That is, analytical psychotherapists, if they are to survive the criticism of their scientific colleagues, ought to fashion the tools of their trade into meaningful measures.

The cluster of radical or "pessimistic" measures seemed more objective in that one could have a high degree of certainty that patients who qualified really changed for the better, even in their innermost psychic life, viz. sleep dreams. That fewer patients qualified for inclusion in this cluster of measures of therapeutic change was due to the severity or strictness of the criteria.

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It cannot be emphasized too strongly that by manipulating the measure one could obtain such a wide spread in results as from one-fifth to three-quarters of patients showing marked change for the better. Thus the expression of results of psychotherapy was, in part, a function of the measure used.

Notwithstanding, these results were strikingly convincing, for the following additional reasons: these patients had their presenting or main problem or dysfunction for an *average of 15 years* before treatment. In 4 out of 10 the main problem disappeared at the end of treatment; and in 2 out of 10 all symptoms disappeared at the end of treatment. As we shall see, the duration of treatment was relatively short (6½ months) compared with the duration of the main symptoms; the actual hours spent in patients who qualified really changed for the therapy were few and follow-up showed minimal loss of therapeutic gain. These admittedly modest results, in terms of actual numbers of patients who changed considerably for the better, made the changes which occurred hard to ascribe to anything else than the therapeutic process.

(b) *Follow-up results*. The most important "response" variable next to the results obtained at the end of therapy were the therapeutic results at a point of follow-up, e.g. the effect of time on therapeutic results. Fifty-three per cent. of the patients returned follow-up forms, from 4 to 68 months, with a mean of 19·9 months, after the end of treatment. The follow-up sample was biased in that these patients did twice as well, at the end of therapy as rated by the therapist, as those who did not return the forms ($\chi^2=8\cdot1$, $p<\cdot01$ for 1 d.f.).

All indices showed a remarkably constant relapse rate. The overall loss of therapeutic gain was 10 per cent. At the two extremes (optimistic to pessimistic) the indices showed as follows: the therapist's rating index dropped from 76 per cent. to 65 per cent., while the loss of the presenting or main problem dropped from 40 per cent. to 31 per cent. Thus the different indices or parameters, which might be measuring different aspects of the total psychotherapeutic process, all seemed to register the same proportion of relapse. This suggests that loss of therapeutic gain was a powerful factor whose main determinant may have been the lapse of time.

Even the relapse rate on the most pessimistic or the strictest index seemed not too disappointing. Twenty months (average) after therapy, of 149 patients, 31 per cent., or 48 patients, were still free from their main problem, which had vexed them for a decade and a half. On the other hand, this sample was biased by a factor of 2 in favour of better results. It is suggested that the difference between this follow-up report and that of others is that the strength of bias is known. All follow-ups relying on the co-operation of patients would tend to have a bias, which should be reported.

The Cornell Medical Index (C.M.I.) among other measures, applied before therapy and repeated at follow-up, showed that the operative patient sample (N=158) was still different (sicker) from a control normal sample, at the time of the follow up. Patients showed more than 4 times the symptoms of normals. This ensured the fact that the sample was indeed composed of patients.

The intention of this work was not so much to prove that results were actually due to psychotherapy as to show some of the relationships of the results. Consequently, there was no obsessive preoccupation with "controls" as the *sine qua non* dictate of science. Notwithstanding, the follow-up period, in which no active treatment went on, could be considered as a severe or strict control period, in which the bias was against the direction of the point to be proved, because improvement was more likely to occur in a 20-month period *after* therapy than in any 20-month period without previous therapy. This bias was even stronger because the follow-up sample favoured improvement by a factor of two. A comparison between rates of improvement over the time span of active therapy, the experimental period (viz. 6½ months) against the inactive time span, the control period (viz. 20 months) showed that *twice* as many patients changed for the better on active treatment on most indices, viz. on self rating from 76 per cent. (N=158) to 32 per cent. (N=75); on loss of at least one symptom from 66 per cent. (N=158) to 36 per cent.

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(N=64); on dream rating from 51 per cent. (N=131) to 24 per cent. (N=67), and on loss of referral symptoms from 40 per cent. (N=149) to 10 per cent. (N=51). The converse indexing was even more impressive: if worsening rather than improvement were rated, 4 to 15 times as many patients changed (got worse) in the follow-up (control) period compared with the therapeutic (experimental) period, depending on the index used, i.e. the stricter the index the more worsening in the control period. One must remember that the follow-up period averaged 20 months and the active therapeutic period some 6½ months. This fact alone casts grave doubt on Eysenck's data on spontaneous remission which led him to the false conclusion that patients did better without treatment than with treatment.

B. *The "Organismic" Variables*

There were three classes of these variables taken into account: the diagnostic category, the severity of symptoms, and the duration of the main problem or dysfunction. Each of these was measured by the various therapeutic indices used. Because there was agreement within the two orders of indices only the results of two indices, one representing the "optimistic" and the other the "pessimistic" cluster, will be reported on each of these organismic variables.

(a) *The diagnostic category.* It was surprising that this organismic variable did not come through forcefully enough to compel all therapeutic measures to show significant effect.

(*i*) Using a soft or optimistic cluster index, the therapist's rating at the end of treatment and 4 categories of diagnosis: neurosis (PN), psychosomatic reactions (PS), psychopathic reactions (PPP) and psychosis (PP), there was a reliable difference.

TABLE II

Relationship Between Category of Diagnosis and Therapist's Rating of Marked Improvement at the End of Therapy

Diagnosis	PN	PS	PPP	PP
Patients rated markedly improved ..	59	9	18	3
Patients rated not improved ..	29	3	32	10

$\chi^2=12\cdot4$, $p<\cdot01$ for 3 d.f.

(*ii*) But with the same diagnostic categories, and N's (as in Table I), but using the loss of the main problem or dysfunction as an index, there was no reliable difference.

(b) *The severity or intensity of symptom*, was taken at 3 levels: mild, moderate and severe, within diagnostic categories and overall diagnoses.

Again surprisingly there was no reliable difference on either cluster or order of therapeutic measure, between these levels of severity or intensity of symptoms, when the neuroses (PN), the numerically largest category (56 per cent.) were calculated. On inspection there was no likelihood of a reliable relationship within any of the diagnostic categories.

(c) *The duration of main problem* was taken at two, arbitrarily chosen, time cut-offs, i.e. 1–5 years (short) and 5 years and over (long).

The soft index showed a trend but no reliable difference between duration of main problem and the therapist's rating at the end of therapy.

The hard index, e.g. loss of this main problem, showed a stronger tendency to differentiate, though it also failed to reach a level of acceptance of reliability ($p<\cdot10$).

Thus these organismic variables did not appear strong enough to show an effect across the different measures of therapeutic response.

C. *The "Situational" Variables*

Three of these variables were looked at: the duration of therapy, the number of sessions (these two being functions of yet another variable: the density of interviews) and the type of termination of therapy. Here again, one of each type of therapeutic measure was used, a soft or optimistic index and a hard, or pessimistic, one.

(a) *The duration of therapy* was taken at 6 different time levels.

(*i*) Using a soft index, the relationship between duration of therapy and therapist's rating at the end of therapy, yielded a $\chi^2=22\cdot5$, $p<\cdot001$ for 5 d.f.

The same results held for another soft index, the loss of at least one symptom ($\chi^2=15\cdot8$, $p<\cdot01$ for 4 d.f.).

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(*ii*) Using a hard index, the relationship between duration of therapy and loss of main problem at the end of therapy, yielded a $\chi^2=11\cdot2$, $p<\cdot05$ for 5 d.f.

These tables (Tables III and IV) show quite clearly that the duration of therapy had an effect on results. This situational variable was strong enough to come through on both orders of measures, the soft and the hard. On scrutiny of the different cells it appears that 4 to 6 months was a critical period for therapy.

What is not shown too closely in these tables, but appeared obvious from reviewing the data and then in subsequent clinical observations (from 1960–1963) was that 6 months was the peak of change for at least one symptom, and between 6 and 7 months the peak of change for the loss of the main problem. In other words, the bulk of patients who are going to change at all will get better at about this time (representing average of 15 sessions) and the change will be heralded by the loss of at least one symptom and followed with the loss of the main problem a month or so later. Meanwhile both therapist and patient (and an "outsider") will confirm marked improvement. In this march of change for the better, some patients took longer than the majority, once they passed the critical period. Beyond the optimal time (up to 12 months) there was a decrement or diminishing return which dwindled to a dribble after 2 years of therapy. It would be of considerable interest to find out whether this suggestion of a critical period in analytical psychotherapy is borne out by the experience of others; clearly if this were a fact, its recognition would save time, effort and money and lend psychotherapy stronger powers of prediction and control.

It is quite obvious from the first cells of these tables that one could hardly speak of psychotherapy when it lasts less than a month and that no patient showed changes in this period. This again, tends to negate the factor of spontaneous remission, in this series of patients, treated in these circumstances and measured by these measures. This too makes nonsense of Eysenck's data. Furthermore, the progression of numbers in the cells shows clearly that, up to a critical or optimal period, psychotherapy must develop over time to have an effect. Furthermore, the effect on results could hardly be ascribed to the mere passage of time, not only because of the short time of therapy, within the optimal or critical therapeutic period, but because the more time given to the person, within this period, the more effective the results, in terms of the greater number of persons benefiting from therapy. Lastly, it is shown that the problem or dysfunction of a lifetime disappears after 3 to 12 months of therapy, and this can hardly be a coincidence.

A modest therapeutic effect, as indexed by the softer measures, can be achieved more quickly;

TABLE III

Relationship Between Duration of Therapy and Therapist's Rating at the End of Therapy

Duration of Therapy in Months	<1	1–3	4–6	7–12	13–24	24+
Patients rated markedly improved	0	26	31	16	10	6
Patients not rated markedly improved	13	26	12	8	7	2

$\chi^2=22\cdot5$, $p<\cdot001$ for 5 d.f.

TABLE IV

Relationship Between Duration of Therapy and Loss of Main Problem at the End of Therapy

Duration of Therapy in Months	<1	1–3	4–6	7–12	13–24	24+
Patients who lost main problem	0	20	19	12	5	3
Patients who did not lose main problem	12	31	22	10	10	5

$\chi^2=11\cdot2$, $p<\cdot05$ for 5 d.f.

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an ambitious effect, e.g. the loss of the main problem, takes longer in most patients. That it takes longer to deal radically with a psychiatric problem is axiomatic for those who believe in psychotherapy, but needed proof for the sceptics. That it should not take *much* longer, viz. 1–6 months after the disappearance of any one symptom, is worthy of notice.

(b) *The number of therapeutic sessions.*

(*i*) Table V shows that in using the therapist's rating, as a soft index, the relationship between number of therapeutic sessions and therapist's rating at the end of therapy gave a $\chi^2=25\cdot0$, with a $p<\cdot001$ for 4 d.f.

(*ii*) Table VI shows that in using a hard index, on relationship between number of sessions and loss of main problem at the end of therapy, $\chi^2=11\cdot5$, $p<\cdot05$ for 4 d.f.

Though the stricter index shows a less reliable relationship, it seems that this situational variable also has a decisive effect on results.

Of course, the number of sessions and the time given to therapy are dependent and would influence each other. Nevertheless, it is reassuring that the pattern holds and tends to prove that there is a *critical period* of 6–7 months or 35 sessions (of 50 minutes) beyond which there are diminishing returns.

To confirm this point, there was no reliable difference between patients seen for 2 years and those seen for longer, or those seen for 35 sessions and those seen for more, up to 217 sessions. Also it cannot be coincidence that in the first 4 sessions (usually diagnostic) hardly any patients remitted (spontaneously) but as soon as psychotherapy began in earnest (5–35 sessions) the majority of those who were going to get better showed changes. Those who were not going to get better tended to quit or be discharged over the same time span and number of sessions.

A density of less than once a week was reliably less effective than once or twice a week, but there was no difference between a density of once a week and more than once a week, even if the critical time span (past the 6–7 months) and optimal number of sessions (5–35) were taken into consideration and notwithstanding the index. Irregular sessions scattered over time were reliably less effective than regular sessions over the same time span.

These findings argue for the effectiveness of systematic psychotherapy, with a regular schedule over a limited time span. But the density of interviews depended on the therapeutic needs discovered in and satisfied by the process rather than on any preconceived notion that for psychotherapy to be effective it must be prolonged and with a high density of sessions.

TABLE V

Relationship Between Number of Therapeutic Sessions and Therapist's Rating at the End of Therapy

Number of Sessions	1	2–4	5–15	16–35	35+
Patients rated markedly improved	0	11	43	37	11
Patients not rated markedly improved	4	10	11	4	2

$\chi^2=25\cdot0$, $p<\cdot001$ for 4 d.f.

TABLE VI

Relationship Between Number of Sessions and Loss of Main Problem at the End of Therapy

Number of Sessions	1	2–4	5–15	16–35	35+
Patients who lost main problem	0	3	24	20	5
Patients who did not lose main problem	4	17	27	17	8

$\chi^2=11\cdot5$, $p<\cdot05$ for 4 d.f.

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Altogether, these situational variables suggest that there is such a thing as very effective systematic psychotherapy, but the notion that it must go on for more than a year and be carried out more often than once a week is not supported at all. This fact is a direct challenge to rigid psychoanalysts and others who have a preconceived notion about the length of time required, the number of sessions and their density for effective treatment. The results suggest that not only are the time and money invested in analytical therapy wasted in a depressing number of instances, but that this wastage is enormously increased by insistence on this preconceived notion. Moreover, the faster the curative results on lifetime problems in patients receiving no other help, undergoing no other external change and treated within the optimal period of systematic psychotherapy, the more convincingly are they due to nothing other than psychotherapy.

(c) *Termination of therapy* was divided into five categories: by common consent (CC), successful; by CC unsuccessful (e.g. not achieved goals, but agreed to part); patient broke before diagnosis; before therapy; during therapy. For the purpose of this report, the main cleavage was made between common consent termination and the patient breaking contact.

(*i*) Using a soft index:

TABLE VII

Relationship Between Type of Termination of Therapy and Therapist's Rating at the End of Therapy

Type of Termination	Common Consent	Broken
Patients rated as markedly improved ..	67	22
Patients rated as not improved ..	29	39

$\chi^2 = 17 \cdot 34$, $p > \cdot 001$ for 1 d.f.

(*ii*) Table VIII shows that in using a hard index this situational variable, the type of termination, is also powerful enough to come through on these different orders of measures. Of course, this is not too impressive a discovery, but it is reassuring to find some order and therefore some means of prediction. It appears that termination by common consent is more likely to occur when the patient loses his main problem (or vice versa) and breaking therapy is more likely to occur when the patient does not lose his major dysfunction. Yet by definition of common consent and in all likelihood, it would have been equally possible to arrive, as often, at a mutual agreement to part when there was no loss of the main problem. Indeed, it would have been this therapist's guess that he subtly persuaded patients to part from him, or allowed himself to be easily persuaded by patients to let them part from him, as often when the problem was not clearing up, as when it did clear up. The appropriate cells in Table VIII show that this very nearly was the case, but also it happened much more frequently that the patients who were not going to lose their main problem broke therapy (or vice versa).

TABLE VIII

Relationship Between Type of Termination of Therapy and the Loss of the Main Problem at the End of Therapy

Type of Termination	Common Consent	Broken
Number of patients who lost the main problem ..	62	14
Number of patients who did not lose the main problem	43	38

$\chi^2 = 14 \cdot 9$, $p > \cdot 001$ for 1 d.f.

Also it is quite possible to contemplate a therapeutic situation in which the referral symptom, the initial primary dysfunction, the main problem as settled by diagnosis, was not a good enough criterion of recovery; that the therapist would disagree with the patient when the latter was too easily satisfied with merely solving that problem or main symptom, and would not terminate by mutual consent (or vice versa). It appears that this was rarely the case. Altogether it appears that the main problem, as indicated by diagnosis and agreed upon by the patient, was a good criterion of therapeutic "cure", or, at least, goal.

Furthermore, it appears clearly that common consent termination is a most desirable aim for the successful analytic process, and breaking for

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the process that is going to be unsuccessful and has passed the critical period in terms of time of therapy and number of sessions.

Conclusions

This study has attempted to demonstrate that the results of psychotherapy depend largely on the measure of change used. In the case of the measures herein employed, the therapeutic response of *marked* improvement varied from 21 per cent. to 76 per cent. of the operative sample.

The measures of change used could be grouped into two orders or clusters: the harder, stricter, or more radical or pessimistic indices, measures or parameters, namely: sleep dream change index, the loss of the referral or main problem or dysfunction, and the loss of all symptoms; and the softer, or more optimistic indices, namely: the patient's self-rating, the therapist's rating (both supported by an "outsider's" opinion which was biased by the fact that he or she was close to the patient) and the loss of at least one symptom.

There was a close relationship *within* these two orders of indices, which was statistically reliable. But, as can be seen from their behaviour over the three main classes of therapeutic variables (response, organismic and situational), the relationship *between* these two clusters of indices was not always there.

Looked at most optimistically, three-quarters of all ambulatory psychiatric patients, referred to an analytical psychotherapist for treatment on a private basis, at least in this urban area of North America, should show *marked* improvement at the end of an average of 6½ months of therapy. That is, these patients will feel much better, they will lose at least one symptom, the therapist will evaluate them as much improved, and an outsider who is close to the patient will concur.

Looked at most pessimistically, only 1 in 5 of such patients, in the circumstances described, can expect to lose all symptoms. Only 4 out of 10 can expect to lose the referral or main problem or dysfunction. Only 1 out of 2 can expect to change in thinking (as indexed by sleep dream patterns) or in unconscious processes. Yet the 4 out of 10 patients who lost the main symptom or problem, had had it for a lifetime, or an average of 15 years, and they lost it in 6½ months or some 40 sessions (in 2,000 minutes, or 33⅓ hours of therapy).

Once there has been therapeutic gain, the effect of time (average 20 months) is to lose some of it in only 10 per cent. of patients. This came across all indices suggesting that there is a uniform loss of therapeutic gain over an average space of time. It was reassuring to learn, from the C.M.I. (Cornell Medical Index) that the patients who got better were not normal or even near normal to begin with because both the moderately and the severely psychologically ill patients differed reliably from normal controls, both before treatment, and at follow up.

These results are probably better than most of the results of treatment by internal medicine or surgery. Yet they are not good enough. They are biased in favour of cure by the type of patient who comes for private care; and the follow up results are loaded by a factor of 2.

This suggests that while basically the results are worthwhile and this form of treatment can be very effective, there is an enormous wastage of time, skill and money, which it should be possible to save through more precise knowledge.

Using the follow-up, inactive period as a control period, for the same patient, the therapeutic gain or change in the active, experimental period was significantly greater than in the control period; and the worsening in the control period even greater than in the experimental period. In view of the factors loading the likelihood of "spontaneous remissions" in the longer control period (20 months) and generally in view of these results, Eysenck's findings, derived from obviously faulty data, are categorically denied.

In an attempt to gain further knowledge, while using the rather crude tools of measurement herein reported, the author has looked at the effect of the two sets of variables affecting therapeutic response (the organismic and the situational).

It was somewhat surprising that diagnostic category, severity of symptoms and duration of the main dysfunction or problem were not powerful enough variables, representing what

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the patient brought into therapy with him, to affect the basic results on all indices. It seemed as though the "organismic" predictor of unsuccessful therapy may be a factor of extreme and chronic illness in this kind of ambulant private patient, while moderate illness of relatively short duration (less than 5 years) is more radically curable by psychotherapy. It was reassuring to learn, from the C.M.I. (Cornell Medical Index) that the difference here was not due to a distinction between "real" patients and near-normals, because both groups, representing degree and chronicity of illness, differed reliably from normal controls, both before treatment and, when collapsed, at follow-up.

The situational variables came through very strongly in that duration of therapy, number of sessions, density and type of termination, affected results on all indices. Clearly systematic therapy determined therapeutic response.

This study showed the trend, recently appreciated by many therapists, that the duration of therapy does not have to be prolonged, nor the density of sessions high, for the best kinds of results. In fact 6–7 months, or some 35 sessions, at a density of once or twice a week were sufficient to "catalyse" insight, integration and sufficient personality reconstruction for recovery and minimal relapse thereafter. There may be a turning point, in the natural course of analytical psychotherapy, as it affects the natural history of the psychiatric illnesses represented by this sample of patients, which is around 6½ months and 35 sessions, when at first symptoms are lost, heralding a fundamental change.

To predict the results of (analytical) psychotherapy more accurately, to prevent the considerable wastage of time, money and effort and the somewhat disappointing fact that only 4 out of 10 patients tend to complete psychotherapy successfully (by common consent and with excellent and lasting results) a great deal more must be learnt. It is unlikely that much progress can be achieved without a unified theory of behaviour, without an adequate taxonomy based on firm psychopathogenesis, and on longitudinal and epidemiological research on the natural history of psychiatric disorders.

In reaching for such goals, studies on the evaluation of psychotherapy have a crucial place. Here is a laboratory-like "situation" or condition, which is more standardized than life itself. The unknown factor (the patient with his "organismic" variables) is fed through it with results which can become known. This brings one to the vital necessity for adequate measures, so that results can be known. The measuring tools need not be derived from the realm of the fancy of clinical or even of experimental or empirical psychologists, but from within the realistic context of psychotherapy itself. The measuring need not eschew the subjective, for it is the reality we deal with and it is eminently measurable. Nor need measures circumvent the patient and the therapist, who remain the two persons with the greatest knowledge of the change that has taken place. The need here is for objective measures to be related to the subjective ones. Also it is imperative that every psychotherapist who is not practising in inspirational or "supportive" pill-giving fashion, should submit himself and his observations at least to the discipline of standardized self-scrutiny and honest self-appraisal.

Summary

The paper reports the results of analytical psychotherapy on 201 consecutive ambulatory private patients. The amount of therapeutic change depended on the measure used. This varied from 20 per cent. and 40 per cent. to 75 per cent. marked improvement. The illness of a lifetime (average 15 years) had been "cured" in 4 out of 10 cases, the improvement lasting with only a 10 per cent. loss at follow up (20 months). To be effective, therapy must be regular at least once a week, over a minimum period (15–42 sessions in 3–7 months) but not necessarily prolonged or with high density of sessions. Other factors affecting results were discussed.

The statement supported throughout this report is that it is highly improbable that there were operative factors other than therapy itself more crucial in producing the changes reported.

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