DIVERGENCE AND CONVERGENCE IN PSYCHOTHERAPY

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A survey of the major theories or approaches to psychotherapy (Patterson, 1966) reveals considerable diversity. Various points of view appear to differ widely in philosophy and concepts, in goals or objectives, and in methods or techniques. Not only do the points of view differ as presented by their principal proponents, but there are often schools within schools. And in addition there are differences among individual practitioners. Every psychotherapist considers himself different or unique in some respects.

This diversity, and even disagreement, has led some observers to despair about the state of psychotherapy. Ungersma (1981, p. 55) writes as follows: "The present situation in psychotherapy is not unlike that of a man who mounted his horse and rode off in all directions. The theoretical orientation of therapists is based upon widely divergent hypotheses, theories and ideologies.... Individual practitioners of any art are expected to vary, but some well-organized schools of therapy also seem to be working at cross-purposes with other equally well-organized schools. Nevertheless, all schools, given favorable conditions, achieve favorable results: the patient or client gets relief and is often enough cured of his difficulties. This equal success of apparently widely different approaches constitutes a problem requiring some explanation. "

Rogers (1961), who admits to having had hopes that therapists would be able to come to agreement on what constitutes psychotherapy, has recently expressed his disillusionment. Whereas he had felt that "we were all talking about the same experiences," he now feels that "we differ at the most basic levels of our personal experience." He concludes that "the field of psychotherapy is in a mess," although he also feels that the present confusion is a healthy climate for new ideas, theories, methods, and concepts.

According to an old adage, "Where there are many medicines the illness is incurable." Does this apply to the field of psychotherapy? Is there no agreement, no commonality, among the diverse approaches, no way of integrating them into a unified approach? This paper will review the basic divergences in various points of view, and attempt to sift out convergences to arrive at an integrated approach to psychotherapy.

DIVERGENCES

While there are numerous specific differences among theories of psychotherapy relating to the nature of man, these may be reduced to a single basic difference in what Allport (1965) refers to as the image of the nature of man. Allport describes three models. The first is that of man as a reactive being. Here man is viewed as a biologic organism reacting to stimuli from his environment. He is determined by his experiences, by his past learning or conditioning and by potential reconditioning. The concepts representing this point of view include the following: reaction, reinforcement, reflex, respondent, reintegration, reconditioning. This is the image of man assumed by the behavior theorist and by psychotherapists who take a learning or behavior theory approach to psychotherapy.

Allport's second image of the nature of man sees man as a reactive being in depth. Rather than man being conceived as a being reacting to his environment, he is seen as reacting to his innate drives, motives, and needs, and is influenced by their past frustrations and satisfactions. The concept includes repression, regression, resistance, abreaction, reaction formation, and recall and recovery of the past. This is the view of depth psychology, including psychoanalysis.

These two images are similar in basic respects. Both see man as reacting to forces or stimuli, in the one case from within, in the other from without. In the one case man is a victim of his environment, in the other of his innate needs and drives. They may thus be combined to constitute a single model of man as a reactive being.

In contrast to this image is a second (Allport's third) model. Allport designates this as man as a being in the process of becoming. This model sees man as personal, conscious, future oriented. It includes such concepts as tentativeness and commitment. This is the model of existentialism.

These two models appear to underlie differing approaches to psychotherapy, with behavior therapy, learning theory approaches, and psychoanalysis in one group, and client-centered and existential approaches in the other.

In addition to differences in philosophy, the therapy process is viewed differently by the various approaches. The writer (1966), reviewing various theories, adopted a continuum varying from highly rational approaches at one end to strongly affective approaches at the other end. In rational approaches, the process tends to be planned, objective and impersonal. In the affective approach it is emphasized as being warm, personal, and spontaneous. One emphasizes reason and problem solving, the other affect and experiencing. It appears that there may be two divergent trends in psychotherapy, one toward a more cognitive approach, and another toward a more affective approach, so that there may be a bimodal distribution, or a dichotomy in the making.

Another classification of approaches in terms of process is the insight-action dichotomy of London (1964). London includes under the insight therapies client-centered therapy

and existential analysis, as well as the various schools of psychoanalysis. Although there are differences among the insight approaches, London sees these as insignificant in comparison to their commonalities. Action therapies, or behavior therapies, unlike insight therapies are not concerned with verbalizations, or talk, but with behavior, actions, or symptoms. Ullmann and Krasner (1965) propose essentially the same dichotomy in their distinction between evocative or expressive therapies and behavior therapy, although they recognize that there are overlappings in techniques.

If one examines the goals of different approaches, one finds an amazing range and variety. Some therapists speak of personality reorganization, others of curing a disease or illness, others of adjustment to the environment, society, or the culture. Still others are concerned with the development of independence, responsibility, or assisting the client to use his potentialities or to actualize himself. Still others are concerned with helping the client feel better, or with removing disturbing symptoms.

Recent research provides evidence of differences among psychotherapists. Sundland and Barker (1962) studied differences in orientation in a group of 139 psychotherapists who were members of the American Psychological Association, using a Therapist Orientation Questionnaire containing 16 subscales. These scales included, among others, Frequency of Activity, Type of Activity, Emotional Tenor of the Relationship, Spontaneity, Planning, Conceptualization of the Relationship, Goals of Therapy, Theory of Personal Growth, Theory of Neurosis, Theory of Motivation, and Criteria for Success. The therapists distributed themselves over the range of scores from "strongly agree" to "strongly disagree" on most of the scales. When the therapists were classified into three groups--Freudians, Sullivanians, and Rogerians--the three groups differed significantly on nine of the 16 scales, with the Sullivanians being in the middle position in eight of these comparisons. The Freudian group, compared to the Rogerian group, believed that the therapist should be more impersonal, plan his therapy, have definite goals, inhibit his spontaneity, use interpretation, conceptualize the case, and recognize the importance of unconscious motivation. Only one difference was found between therapists grouped by levels of experience.

A factor analysis of the 16 scales yielded six factors. A general factor cut across most of the scales, providing a major single continuum upon which therapists vary. One end is labeled "analytic" (not simply "psychoanalytic") and the other is designated as "experiential" by Sundland and Barker. The "analytic" therapist emphasizes conceptualizing, planning therapy, unconscious processes, and restriction of spontaneity. The "experiential" therapist emphasizes nonverbal, nonrationalized experiencing, the personality of the therapist, and therapist spontaneity. More therapists tended toward the "analytic" approach than toward the "experiencing" approach.

Wallach and Strupp (1964) obtained similar results from factor analysis of ratings of two groups of therapists on a scale of Usual Therapeutic Practices. The major factor was called the maintenance of personal distance. Four groupings of therapists-Orthodox Freudians, Psychoanalytic General, Sullivanian and Client-centered-were compared, with

the first group being highest in the personal distance factor, the second group next highest, and the remaining two about the same but lower than the other two.

McNair and Lorr (1964) studied the reported techniques of 192 male and 73 female psychotherapists (67 psychiatrists, 103 psychologists, and 95 social workers) in 44 Veterans Administration Mental Hygiene Clinics, using an instrument developed on the basis of the Sundland and Barker Therapist Orientation Scale. They hypothesized three dimensions to be measured by the AID scales: (A) psychoanalytically oriented techniques, (I) impersonal versus personal approaches to the patient, and (D) directive, active therapeutic methods. All three dimensions emerged in the factor analysis of the 49 scales included in the analysis. High scores on the A factor represent traditional psychoanalytic techniques. High scores on the I factor represent a detached, objective, impersonal approach, while low scores represent emphasis on therapist personality and the therapist-patient relationship. High scores on the D factor indicate therapist setting of goals and planning of treatment, leading of the interview, and acceptance of social adjustment as a major goal. Low scores indicate therapist lack of direction of the interview and belief in patient determination of therapy goals. While the three factors are intercorrelated, McNair and Lorr consider them independent.

The Sundland and Barker study provides support for the rational-affective continuum or dichotomy. The McNair and Lorr study also supports this ordering or classifying of approaches or techniques. These studies would not support London's classification of client-centered and existential approaches with psychoanalysis in a homogeneous insight therapy group. However, none of these studies included behavior therapists, and the results would, no doubt, have been different if they had. With the advent of behavior therapy, a new dimension has been added to psychotherapy, and it is the difference between this approach and all other approaches which now seems to present the major problem for the future.

It is here that the greatest differences in philosophy, methods, and goals appear. The behavior therapists are apparently interested in specific, immediate, concrete results. To obtain them, the therapist takes responsibility for the process, and controls and manipulates the situation. He may disavow any ethical implications of his control by contending that he is a technician in the service of the client, who determines what the goals of the process should be.

The experiential therapist is concerned about more general, long-range goals. He gives the client the responsibility for the direction and the pace of the counseling process. While he may be very active, his activity is not the directing, manipulative activity of the behavior therapist, but the activity of empathizing with and understanding the client and communicating that understanding. Paradoxically, however, he may not accept the specific goals of the client, but may impose his own goals of self-understanding, self-realization, or self-actualization on the client. But implicit, if not explicit, in this goal is greater freedom for the client in his specific behavior. By choosing the goal of maximum future freedom for the client, a goal which is presumably that of our society, he resolves the value issue of imposing his own specific goals on the client.

CONVERGENCES

With all the differences among approaches, are there no commonalities or similarities among all, or even some, of the major systems? The search for common elements is stimulated by the observed fact that all approaches report successes.

It would seem to be difficult to find a common philosophy, or even a single common concept, among the many points of view which exist. There would seem to be little if anything in common between a concept of man as determined by his environment, or by his internal needs and drives, on the one hand, and the concept of man as a person capable of making choices and free to do so on the other hand, or between the concept of man as essentially an organism to be manipulated by rewards and punishments, on the one hand, and on the other as having the potential for growth and development in the process of self-actualization. There are, however, some agreements. All approaches recognize that neurosis, disturbance, maladjustment, conflict, the presence of an unsolved problem, and so on, are (a) unpleasant and painful for the client, and (b) such a state of affairs is undesirable and warrants attempts to change it. Secondly, all approaches regard man as capable of changing, or at least of being changed. He is not hopelessly predetermined, but at any stage may still be pliable.

A third common element is the recognition of the influence of the future, or of anticipations, hopes, or expectations related to the future, on present behavior.. This is an element that appears to tie together approaches as different as operant conditioning and existentialism. In other words, the recognition that behavior is not entirely "caused" by the past, but is also influenced by future consequences, or expectation of consequences, seems to be accepted by most points of view. Lindsley (1963) states it as follows, referring to operant conditioning: "The discovery that such [voluntary] behavior is subject to control by its consequences makes it unnecessary to explain behavior in terms of hypothetical antecedents." May (1958), presenting the existentialist position, writes that "The future, in contrast to the present or past, is the dominant mode for human beings."

Therapists of different persuasions have common characteristics. All therapists expect their clients to change. This expectation may vary in its degree, in some instances approaching a highly optimistic or even enthusiastic expectation, while in others it may be minimal. But it is always present. There is always an attitude of hope and expectation of change. Not only do counselors or therapists accept the possibility and desirability of client change, but they are genuinely and strongly interested in being the agent of change in their clients. If they were not, they would not be engaged in counseling or psychotherapy.

An element which appears to be common to the process in all approaches is given various designations. In the client-centered approach it is referred to as therapist genuineness or self-congruence. Others refer to it as sincerity, honesty, or openness. The existentialists use the term authenticity. Some approaches do not refer specifically to this characteristic,

but it is apparent in their discussions, and particularly in their protocols, that this element is present.

One final characteristic unites therapists of widely differing approaches -the fact that each therapist believes in, or has confidence in, the theory and method which he uses. Again, if he did not feel it was the best method or approach, he would not use it, but would adopt a different one.

The most widely known studies of commonalities of the therapy process are those of Fiedler (1950a, 1950b, 1951). Fiedler found that therapists from different schools agreed upon the nature of the ideal therapeutic relationship, and that factor analysis yielded one common factor of goodness of therapeutic relationships. But how are these results to be interpreted in view of the studies referred to above which found important differences? The solution seems to lie in the nature of the instruments used in the studies. Sundland and Barker developed their instrument by eliminating items upon which therapists agreed. Fiedler, on the other hand, appears to have assembled a group of items on which therapists agree. Sundland and Barker point out that items which they discarded because they did not result in a distribution of responses were similar to items in Fiedler's studies. These items were concerned with empathy. There appears to be evidence, therefore, that therapists agree upon the importance of empathy and understanding. The behavior therapists seem to deny or minimize the presence and importance of empathy. Nevertheless, it would appear that a minimum of empathic understanding is necessary for the continuation of the interaction of therapist and the client, as well as being a: factor in effecting change. It appears that a relationship characterized at least to some extent by interest, acceptance and understanding is basic to influencing others therapeutically. Other factors may direct change along the lines the therapist desires, but the relationship makes possible any change.

Most, if not all approaches therefore seem to include a relationship which on the part of the counselor or therapist is characterized by a belief in the possibility of client change, an expectation that the client will change, interest in and concern for the client, including a desire to help, influence, or change him, sincerity and honesty in the process, and confidence in the approach which is used to achieve client change.

It is necessary to add one other point, namely, that the crucial aspect of the therapist's impact or contribution is not his actual personality or behavior, nor even his intent, in the relationship. It is the client's perception of the therapist which determines the therapist's characteristics and contribution. Thus the client's characteristics, his attitudes and set, are important aspects of the relationship.

There are apparent some common aspects of individuals who come to therapists for help. In the first place, they "hurt"-they are suffering, or are unhappy, because of conflicts, symptoms, unfulfilled desires or aspirations, feeling of failure or inadequacy, or lack of meaning in their lives. They thus are motivated to change.

Second, clients also believe that change is possible, and expect to change, to be helped. Frank (1961, Rosenthal & Frank, 1956) has emphasized the universality of this factor in clients.

Third, the client must be active in, or participate in, the process. He is not a passive recipient, as is the physically ill patient being treated by a physician. All learning (behavior change) appears to require activity (whether motor, verbal, or thinking) on the part of the learner. This kind of behavior in psychotherapy includes self-analysis or self-exploration. Truax and Carkhuff (1965) refer to it also as intrapersonal exploration or self-disclosure. Jourard (1964) and Mowrer (1964) also speak of self-disclosure. It appears that the client as well as the therapist must be genuine, open, and honest in the process. Thus, all approaches appear to deal with clients who are in need of help, recognize this need, believe they can change, believe that the counselor can help them change, and engage in some activity in the attempt to change.

It may be more difficult to find commonalities among goals than among concepts and techniques. The differences may not be as great as they at first appear, however. The behavior therapists, though they emphasize the removal of symptoms as an objective goal, also appear to recognize a broader goal. They seem to expect the client to feel better, to function better in life and its various aspects, to achieve at a higher level-in short to live up to his potential. Salter (1951, p. 24), for example, speaks of freeing the individual by "unbraking" him. There is a similarity here to the concept of self-actualization, which is accepted in one or another form, in varying terminology, by most other approaches. The conditioning therapists also appear to see increasing freedom and expressiveness as desirable results of therapy. This is similar to the spontaneity and openness to experience of Rogers. There also seems to be general acceptance of the desirability of responsibility and independence as outcomes of counseling or psychotherapy.

There thus appears to be a good deal in common among the various and diverse approaches to counseling or psychotherapy. To some extent the various theories or points of view represent different ways of describing or explaining the same phenomena. Differences are in part related to the use of different emphases, to different perceptions of the same events, to differences in comprehensiveness of formulation. To some extent differences may appear greater than those that actually exist. This may be due in part to the use of different terminology to refer to the same or similar concepts. Differences may also be exaggerated by the propensity to emphasize differences rather than similarities.

The question to which we now turn is whether it is possible to develop a tentative integration of the common aspects which appear to exist, and to propose, in very general form, an approach which will include the necessary and sufficient conditions for psychotherapy.

AN ATTEMPT AT INTEGRATION

Perhaps the greatest divergence is that between the behavior therapies on the one hand, and the experiential or relationship approaches on the other. In spite of the similarities or agreements noted above, it appears that these points of view are perceived by their adherents and by others as inconsistent and contradictory. The behavior therapies appear to be objective, impersonal, technique oriented, mechanical. The relationship approaches may be seen as subjective, personal, and not concerned with technique. Is it possible to reconcile these apparently inconsistent approaches? Rogers (196l, p. 85), recognizing these divergent trends, not only in psychotherapy but in psychology, states that they "seem irreconcilable because we have not yet developed the larger frame of reference that would contain them both."

A possible reconciliation is suggested. It derives from a consideration of the different models of man delineated by Allport. Allport (1965) writes: "The trouble with our current theories of learning is not so much that they are wrong, but that they are partial." It may be said, then, that the trouble with the behavior therapy approach is not that it is wrong, but that it is incomplete as a description or theory of the nature of man and of his behavior and its modification. There can be no question about the existence of conditioning, about man as a reactive being, who can be conditioned and reconditioned. But man is more than this; he is also a being in the process of becoming. He is not merely a mechanism, or organism, who is controlled by objective stimuli in his environment He is also a being in the process of becoming. He is not merely a mechanism, or organism, who is controlled by objective stimuli in his environment. He is also a being who lives, or exists, who thinks and feels and who develops relationships with other beings.

The essential nature or characteristic of psychotherapy is that it is a relationship. It is a complex relationship, with various aspects. It is not simply a cognitive, intellectually impersonal relationship, but an effective, experiential, highly personal relationship. It is not necessarily irrational, but it has nonrational aspects. The behavior therapists appear to be unconcerned about or to minimize the relationship. However, it appears that the relationship is of greater significance in their methods than they admit. It should be apparent that the characteristics of the therapist and of the client discussed above are manifested in, or manifest themselves in, a relationship.

The therapy relationship always involves, or includes, conditioning aspects. The accepting, understanding, non-threatening atmosphere offers the opportunity for the extinction of anxiety, or for desensitization of threatening stimuli. In this relationship, where external threat is minimized, anxiety arousing ideas and words, images, and feelings are free to appear. Moreover, they appear in a sequence in the kind of hierarchy which Wolpe establishes, that is, from least anxiety arousing to more anxiety arousing. Thus, in any non-threatening therapy relationship, desensitization occurs naturally in the manner achieved artificially by Wolpe (1958). The relationship, by minimizing externally induced anxiety, makes it possible for the client to experience and bring out his internally induced anxieties, or anxiety arousing experiences, at the time and rate at which he can face and handle them in the accepting relationship.

In addition, operant conditioning serves to reinforce the production of verbalizations which the therapist believes are therapeutic, or necessary for therapy to occur. The therapist rewards these verbalizations by his interest and attention, or by explicit praise and approval. At the beginning of therapy, negative elements may be rewarded-for example, the expression of problems, conflicts, fears, and anxieties, negative self-references, and so forth. As therapy progresses, the therapist may reinforce positive elements--for example, problem solving efforts, positive thoughts, attitudes and feelings, and positive self-references. The therapist expects progress of this kind, and is sensitive to its expression in the client.

Conditioning principles have thus contributed to an understanding of the nature of the therapeutic process and the therapy relationship. But the conditioning which occurs is not the mechanical conditioning of a rat in a Skinner box. The conditioning is an aspect of, takes place in, and is influenced by the relationship. There is considerable evidence that the rate and extent of conditioning is influenced by the personality and attitudes of the experimenter and his relationship to the subject (Ullmann & Krasner, 1965). This relationship involves characteristics of the client--his interest, motivations, thoughts, attitudes, perceptions, and expectations--as well as those of the counselor.

It also is affected by the total situation or setting in which the relationship occurs-what are called the demand characteristics in a research experiment. As Ullmann and Krasner (1965, p. 43) note, "both the subject's and the examiner's expectancies, sets, and so forth, have major effect on the individual's response to the situation," and "the best results are obtained when the patient and the therapist form a good interpersonal relationship." The relationship therefore cannot be ignored even in behavior therapy. The most powerful influencers of behavior, or, in conditioning terms, reinforcers, are the respect, interest, concern, and attention of the therapist. The demonstration by research of the effects of these generalized reinforcers supports the importance of the relationship in counseling or psychotherapy.

A further point emphasizes the importance of the relationship. Many if not most of the problems or difficulties of clients involve interpersonal relationships. It is being increasingly recognized that good interpersonal relationships are characterized by honesty, openness, sincerity, spontaneity. Psychotherapy is an interpersonal relationship having these characteristics. It is therefore a place where the client can learn good interpersonal relationships. In fact, therapy would be limited if it tried to influence the client's interpersonal relationships by providing a different kind of relationship. If it attempted to influence interpersonal relationships by avoiding establishing a therapeutic relationship, psychotherapy would seem to be inefficient. Teaching, or conditioning individual behavior in a mechanical manner would not appear to offer much hope of generalization to personal relationships outside of therapy.

There is thus no basic or necessary contradiction between behavior therapy and relationship therapy. One emphasizes shaping or changing specific aspects of behavior by specific rewards or reinforcers. The other emphasizes more general behavior changes

(including attitudes and feelings), using generalized reinforcers. Both utilize the principles of learning, one rather narrowly, emphasizing conditioning, the other more broadly, emphasizing what might be called a social learning approach (Murray, 1963). The behavior therapists are, as Ullmann and Krasner (1965, p. 37) point out, systematic in their application of specific learning concepts. But it might also be said that relationship therapists are also systematic in the application of generalized reinforcers. The conditioning or behavior therapy approach is supported by research evidence, including laboratory or experimental research. The relationship approach is also supported by research, including some of the research on conditioning. It is interesting, and significant, that both groups are coming to the same conclusions, one from laboratory work in conditioning, the other from experience and research in counseling or psychotherapy. It is important, however, that behavior therapists come to recognize the complexity and the social or relationship aspects of the learning process, and also that relationship therapists be aware of the conditioning that is an aspect of psychotherapy. The therapists behavior is most effective when it is sincere and spontaneous, not when it is a contrived technique.

TWO QUESTIONS

The conclusion that the essence of psychotherapy consists of a genuine human relationship characterized by interest, concern, empathic understanding, and genuineness on the part of the therapist leads to two questions.

1. What is there unique about this relationship? How does it differ from all good human relationships? If the answer is, as should be obvious, that there is nothing unique or different, then what is there special about the practice of counseling or psychotherapy? Fiedler (1950) concluded from his studies that "a good therapeutic relationship is very much like any good interpersonal relationship."

This view may be opposed by those who feel that it deprives therapists of unique powers, who fear that "it leaves the practitioner without a specialty" (Mowrer, 1964, p. 235). But it should not be surprising that the characteristics of psychotherapy should be the characteristics of good human relationships. Nor does it follow that, if they are not limited to psychotherapy, they are not relevant or specific. The essence of emotional disturbances is disturbed human relationships. The client's relationships with others have become ruptured or have been placed on an insecure, false, or untenable basis. He needs to reestablish good relationships with others.

Therapy offers the opportunity for learning how to relate to others in a different, more effective way. It utilizes or embodies the principles of good human relationships, which, although they appear to be simple, are not widely practiced outside of therapy. While there is merit in Schofield's (1964) analysis of psychotherapy as the purchase of friendship, therapy is, however, more than the offering of friendship, at least in the usual sense of the word. While viewing psychotherapy as something dark and mysterious classifies the therapist with magicians and witch doctors, viewing it as bought friendship places him in the same category as taxi-dancers, gigolos, and call girls.

2. The characteristics of psychotherapy which have been developed above have frequently been considered nonspecific elements. It is often assumed that they are not related to the specific nature of the disturbance present in clients, and that, while they may be considered as necessary conditions, they are not sufficient. Further, such characteristics as attention, interest, concern, trust, belief, faith, expectation are part of what is designated as the placebo effect in the treatment of physical diseases. While it is not usual to insist that these effects be eliminated from counseling or psychotherapy, it is generally accepted that these factors, as nonspecific, are not sufficient and that other methods or techniques must be included to deal with the specific aspects of the disturbance. It is generally argued that any method or technique must produce greater effects than those obtained by placebo elements in order to be considered useful.

The placebo effect is a psychologic effect. Where the interest or concern is with determining the physical or physiologic effect of a drug or medication, on a known physical disease or disturbance, it is reasonable to consider this effect as extraneous and nonspecific. But this reasoning may not be applicable in psychotherapy. Here, the disorder or disturbance is psychologic. Is it not logical that the specific treatment for a psychologic condition should be psychologic? Is it not reasonable to suggest that the specific treatment for disturbed human relationships is the providing of a good relationship? Is the placebo effect, then, as Rosenthal and Frank (1956) claim, "a nonspecific form of psychotherapy?"

It is strange that, with all the evidence of the power of the placebo effect, it has not been recognized as the most effective approach to the treatment of psychologic problems. As Krasner and Ullmann (1965, p. 230) put it, "Whereas the problem had previously been conceptualized in terms of eliminating the 'placebo effects,' it would seem reasonable to maximize placebo effects in the treatment situation to increase the likelihood of client change."

NECESSARY AND SUFFICIENT CONDITIONS FOR PSYCHOTHERAPY

Are there any necessary and sufficient conditions of psychotherapy, and if there are, what are they? Ellis (1959), criticizing the necessary and sufficient conditions proposed by Rogers (1957), concludes that there are no necessary conditions but there are a number of sufficient conditions. With the wide variety of approaches and methods in psychotherapy, all of them claiming success with some apparent justification, this would appear to be a reasonable position to take.

But if there is a common element in all methods and approaches, it would also be reasonable to conclude that this would be the necessary and sufficient condition of psychotherapy. We have attempted to show that this common element is the relationship between the client and the therapist. This relationship is a complex one, and it is possible that we do not understand it completely and are thus not able to specify all its aspects. But at least some of its aspects are known, and include those enumerated above. They have been demonstrated to be sufficient conditions for therapeutic personality change

(Truax, 1963; Truax & Carkhuff, 1965a; Truax & Carkhuff, 1965b). In addition to the research on psychotherapy, there is considerable evidence of the positive influences these conditions have on behavior when they are incorporated into the programs of institutions ranging from industry to schools to mental hospitals. The effects of the use of environmental treatment in the form of the therapeutic milieu in mental hospitals seem to be evident, and to come essentially from the change in human relationships between staff and patients.

If these conditions are necessary as well as sufficient, then it must be shown that therapeutic personality change not only occurs when they are present, but that it does not occur when they are absent. It can, of course, be demonstrated that changes in behavior can be obtained when they are not present, as in simple conditioning, which may not involve the presence of another person, or in instances of coercion by the use of threat or physical force, including punishment. But it can be questioned whether such changes are therapeutic.

There is some evidence from research on psychotherapy that in the absence of these conditions in psychotherapy positive change does not occur. Truax (1963) found that while the (schizophrenic) patients of therapists evidencing high conditions of accurate empathy, unconditional positive regard, and self-congruence improved, patients of therapists evidencing low levels of these conditions showed negative personality change. Similar results have been found with clients in college counseling centers, according to Truax. There also appears to be considerable evidence that the absence of these conditions in other situations leads to psychologic disturbance. This evidence includes studies on the influence of schizophrenogenic mothers, the effects of the double bind, the effects of an institutional environment lacking in human attention on infants and children, the results of sensory isolation, and the effects of imprisonment.

There seems to be evidence that the elements of the therapeutic relationship described in this paper are common to all approaches to psychotherapy, and that where they are absent positive change or development does not occur. There thus appears to be a basis for considering them the necessary and sufficient conditions for psychotherapeutic change.

SUMMARY

An examination of various schools or approaches to psychotherapy indicates differences in philosophy, in the psychotherapy process, and in goals which appear to be irreconcilable. Nevertheless, there are some basic commonalities. These commonalities contribute to a relationship between therapist and client which is shared to some extent at least, by all therapists or schools. Perhaps not surprisingly, the characteristics of this relationship are the characteristics of all good human relationships. But they also involve what is commonly called the placebo effect. It is concluded that this relationship is the specific treatment for psychologic disturbances, and includes the necessary and sufficient conditions for psychotherapy.

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