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QUESTIONING THE QUESTION: THE EFFECTIVENESS OF PSYCHOTHERAPY*

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It is understandable that the topic, "The Effectiveness of Psychotherapy," should find its way onto the program of a congress of psychology. It is an important issue about which many people are curious and concerned, and psychotherapy is increasingly practiced by psychologists. Furthermore, the effectiveness of psychotherapy should, it would seem, be specifiable through the systematic thinking and emphasis on research which is traditional in psychology as an academic discipline. Yet, as we shall see, it is difficult to answer definitively a question about the effectiveness of psychotherapy. Rather, the greatest scientific and practical yield comes from addressing ourselves to the difficulties inherent in the question itself.

The first difficulty lies in the term *effectiveness*. One test of effectiveness is popularity, and increasingly psychotherapy seems to be accepted as part of our culture. This may be so because of the pervasive needs and hopes of mankind for improvement in its lot, which have led people throughout the ages to believe in one or another system of thought or activity which holds promise of making life better. Some therapy or growth experiences seem, at least temporally, to help people overcome their loneliness, to offer emotional peaks, to be refreshing and fun. Some people esteem their psychotherapy highly out of a need to believe they have spent their time and money wisely or out of their good feelings toward the therapist. It is likely, however, that if these were the only reasons for the popularity of psychotherapy, the enterprise would collapse. Much psychotherapy is too expensive, time-consuming, and stressful to have become popular without having been, in some ways, beneficial.

Another measure of the effectiveness of psychotherapy lies in the individual clinician's case examples, which portray what is done and accomplished. An implicit validity lies in our noticing that valued teachers spend ther lives in the activity of psychotherapy, and consider it worthwhile to teach. Though learning by authority has been sharply criticized as Western civilization has come to believe that truth comes about through the scientific method, most learning in fact does take place by way of authority. This is true whether the authority resides in an individual known to the student or whether the authority adheres to the printed word.

Formal research on whether psychotherapy is effective or ineffective has, on the whole, been unconvincing. Studies can be cited to show that untreated patients do as well over a period of time as treated ones, and vice versa; that patients improve, remain the same, and get worse no matter what interventions they are subjected to; that the training of the therapist makes for a better result, and that the therapist's training does not matter; that therapy based on dynamic principles is more effective than that based on learning theory, and vice versa.

Contradictory research findings are not the only reason why one remains unconvinced as to the effectiveness of psychotherapy. If one looks at the problems inherent in such research tasks, it becomes difficult to believe that definitive and consistent answers *could* be forthcoming.

The first of these problems lies in the patient. Unfortunately, for purposes of most research, there is no such thing as *the* patient, there is only *a* patient, not like any other. Psychotherapy is an intensely idiosyncratic enterprise to which different people can be expected to react in different ways. If dealt with at all, this problem is typically dealt with through diagnostic categorization. This is usually unsatisfactory for two reasons. One is the lack of homogeneity in methods of diagnosis. Some people rely exclusively on diagnostic interviews, others use psychological testing—sometimes group testing and sometimes individual testing, often with different tests and with examiners of differing levels of training and theoretical orientation. There is little agreement on what is meant by various diagnostic categories. For example, what is called schizophrenia in one country, or part of one country, is not called schizophrenia in another. And observations of the same patient by different clinicians can give rise to different diagnoses. The second reason is that even should diagnostic categories be homogeneous, and be arrived at with a high degree of reliability, the questions often asked about the effectiveness of psychotherapy are much finer than would be allowable by such gross categorization. People within diagnostic categories can still be expected to vary widely in relevant respects. For example, in the Psychotherapy Research Project of the Menninger Foundation, 42 patients were examined before treatment, at the termination of treatment, and at a follow-up point two years after treatment according to sets of variables having to do with the environment, the therapist, and the patient. There were 24 patient variables including such atomistic dimensions as ego strength, anxiety tolerance, qualities of interpersonal relationships, and psychological-mindedness. The degree to which patients had such capacities available for use in psychotherapy seemed to make for considerable differences in the nature and extent of the effectiveness of the psychotherapy. And

these differences cut across traditional diagnostic catgories. Furthermore, the measurement of effectiveness was often dependent upon the differing points at which patients started. Thus, the more severely disabled patients, with the greatest room for improvement, sometimes showed a more dramatic response to psychotherapy, by quantitative measures, than did less severely ill people. Can we say that psychotherapy was less effective among the less ill group, even in those instances when they had achieved their therapeutic goals? Thus, the effectiveness of psychotherapy requires the further specification, effectiveness of psychotherapy for *whom,* and that "whom" is a unique combination of many characteristics.

Just as patients vary widely as individuals, so too do therapists. In many psychotherapies the personality of the therapist is as significant a variable as his theory and his technique. In many studies, this presumably potent source of difference is usually ignored as is the level of the therapist's training. In other studies therapists are categorized as "experienced" or "inexperienced." In the Psychotherapy Research Project of the Menninger Foundation the criterion for "experience" was considered to be at least two years beyond the residency. Such a categorization is probably only a slight improvement over ignoring individual differences in therapists entirely. Kind and quality of training of psychotherapists varies so extensively that years of training as a measure of skill, or as a means of equating therapists, is all but meaningless. Even should training be homogeneous, individual differences in skill would likely erode the effects of small differences in years of training.

Finally, one must add to the various sources of individual differences among patients and therapists the match between them. People who assign patients to therapists have long been at least informally aware of the effects of such matches. Research on the effects on marriage and friendship relationships between partners of varying sibling positions, for example, sugegsts that therapist and patient relationships may be influenced by sibling position as well. Recognizing the factor of matching, the Psychotherapy Research Project of the Menninger Foundation made separate ratings on a therapist's skill with a particular patient and his level of skill in general.

The fact is that much psychotherapy research errs in using experimental designs which are modeled on testing for the effectiveness of medicines. Psychotherapy is not like aspirin, a homogeneous product to be dispensed in a standard way. The psychotherapeutic transaction is one of a kind, taking place in a particular way between a particular patient and a particular therapist, and only once.

The outcome of psychotherapy has also been treated in many psychotherapy researches as if it were analogous to the outcome of

conventional medical treatments: the patient is conceived to have an illness which is judged to have remained the same, gotten worse, or improved to some degree. In such a model there is an implicit assumption that the best one can hope for is that the patient has returned to his premorbid functioning. This is inapplicable to much psychotherapy. The complaint, symptom, or whatever passes for illness which ostensibly brought the patient to treatment often turns out to be more a ticket of admission than the main focus and goal of psychotherapy. True, there are instances of specific symptom complaints which can be judged as worsening, improving, or being removed. Usually, however, the beginning symptom or complaint gives way to hope for change in the patient's way of life or quality of life, in his self-knowledge, feelings about himself, his relationships with others, and in his effectiveness on various life tasks. Judgments of this kind are extremely difficult to make, not only at the end of treatment but at the baseline when one is dependent upon history or retrospection. Such judgments may differ when made from the points of view of the patient, of society, of the therapist, or of the researcher. Each may have his own set of values, wishes, and means of making comparisons and judgments. For example, a patient may give up an alloplastic behavior to the delight of the environment. But cut off from this way of managing anxiety, he may feel in greater distress than he did before. Or the patient may increase his self-esteem by being able to stand up for his own rights, much to the dismay of those in the environment who have benefited from his submissiveness. The patient may be happy with a life plan which, to the therapist, is a compromise significantly below what the therapist expects could have been possible had the patient been able to resolve or work through conflicts in a better way.

Some clarity of research on outcome could be achieved if treatment goals were considered separate from life goals. Treatment goals are to overcome symptoms and impediments to continued lines of development within a pattern, while life goals are those having to do with the way and quality of life as a total and perhaps changed pattern over time. Psychotherapy may bring about an improvement in one, and not the other.

At what point in time does one measure the effectiveness of psychotherapy? Usually, this is done at the termination of the treatment. But there are good reasons to believe that this is an unfortunate time, since termination of psychotherapy is, almost by definition, a special and stressful moment. At termination some patients tend to exaggerate their gains, out of gratitude to the therapist and out of a need to justify their investment. Other patients are inclined to minimize their gains out of resentment at having the treatment brought to an end, and out of disappointment that their

fantasied wishes are now seen as irrevocably beyond them. Even without the artifacts introduced by the factor of the termination itself, the attainment of certain goals cannot be judged until some time after the end of therapy. Especially with respect to life goals, the psychotherapy may be a beginning rather than an ending, making it possible for the patient to meet challenges which before the psychotherapy seemed beyond his capabilities. To the extent that the effectiveness of the psychotherapy is measured by the quality and nature of life, the time to assess these goals is not at the end of treatment, but at the end of life. Few research designs include even temporally modest follow-up assessments. Yet some follow-up assessments show substantial change from the time of termination. A finding of the Psychotherapy Research Project of the Menninger Foundation was that during the two years after the termination of treatment many patients changed. Some did better than they were judged to have done at termination, and some did less well than at termination. But change of one kind or another was more the rule than the exception.

In probably no other body of research is the independent variable less homogeneous and specifiable than in research on the effectiveness of psychotherapy. It is almost embarrassing to notice that what is called "psychotherapy" may take place in such periods of time as four days to four years. It may refer to a remarkably large number of diverse techniques based upon remarkably diverse theories of personality. And change may be brought about by factors not specified in theory or self-consciously employed in practice. Even granting a similarity of names of theories or approximate styles and techniques of intervention, it is very difficult to be confident that, in fact, what is actually done by all practitioners fits the name given to it. Even psychoanalysis, whose basic model is among the most uniform and homogeneous of treatments, was likened by Freud to a chess game in which the beginning and ending moves could be known, while the rest were subject to innumerable variations. This is probably even more true now as the range of technical problems and kinds of patients treated with psychoanalysis has widened since the basic model was set forth with respect to hysterics —a kind of patient rarely seen nowadays in most psychiatric centers in the United States.

All of the difficulties in doing research on psychotherapy noted thus far could be subsumed under the problem of individual differences. For the researcher, these limit the validity and generalizability of his findings. For the prospective patient, they imply that with respect to his particular decision as to whether or not to have therapy, there is little precedent by which to be guided. One may ask, then, what the value is of attempting to do research on psycho-

therapy if psychotherapy is a scientifically unwieldy enterprise with limited practical value for a particular prospective patient.

The main potential value, it seems to me, is to be had from investigating the means by which people change. Ordinarily, such investigation precedes the question of effectiveness—observation comes first, which leads to specification of the independent variable and its relationships. This stage of research has been somewhat slighted in research on psychotherapy because of psychological research being modeled after medical research, which in turn sometimes inappropriately followed the model of research in the physical science. A consequence of modeling psychological research after medical research was the pragmatic drive to see whether psychotherapy worked, to some extent slighting the careful, delineated knowledge of what psychotherapy substantively was. This pragmatic drive also led to the assumption that distinctions between psychotherapies in fact accounted for most of the observed differences. Thus, most researchers in psychotherapy over the last two decades categorized psychotherapy as individual or group (according to orthodox Freudian principles or those of so-called deviant psychoanalysts), as psychoanalysis or psychotherapy, or as dynamic versus client-centered psychotherapy. Rough, imperfect, and partially illusory as such categorizations are, they at least referred to verbal treatments, and were usually dependent upon the development of insight as a means toward achieving the goal of the therapy. In recent years, however, the means by which people are alleged to change and the way this is to be brought about have expanded greatly. In the United States, new ways of understanding and bringing about change have been spearheaded by the human potential movement and by behavior modification.

In this situation of as yet unknown and undelineated variables, knowledge and ultimately practice might best be served through first-order observations of the elements in the various therapeutic enterprises which might be instrumental in bringing about change. Should any of these elements prove to be markedly superior to others, and be employed by a particular school of therapy, that would suggest the superiority of that form of therapy. Or such an investigation could lead to changes within established forms of therapy. It could, in principle, lead to the creation of a new therapy. Let us look now at the newly expanded field of observation for such elements.

One factor which is common to all psychotherapies has to do with the patient rather than with treatment interventions, and takes place even before the patient sees the therapist. This is the patient's decision to embark upon psychotherapy. Usually the patient's complaints have existed for some time before this moment of decision, and so the decision itself represents a change, often arrived at

by the patient alone. If the decision is a force in the treatment, then patients brought to treatment against their will lack this force. Even some patients who come to treatment of their own free will need to develop their attitudes towards change within the treatment situation; if not, they can compliantly go through the motions of participating in therapy without ever having really decided to make a change in their lives. Such a factor has ordinarily been subsumed under the idea of motivation. I am talking here, however, as much about conscious as unconscious motivation. Such conscious motivation has a relationship to decision-making, the theory of games, rationality, willpower, judgment, and action, all of which may be relatively separate as well as intimately connected with unconscious, dynamic aspects of motivation.

Another factor common to all psychotherapies is the interruption of the patient's usual life. This often refers concretely to the schedule of his life, with therapy appointments being a regular addition. This interruption is, by definition, a change, brought about by the psychotherapy, and therefore a manipulation. Whatever else it may be, it is a novel and different experience. When things seem to be going badly, almost any change is a change for the better, as many people notice when they follow their doctor's advice simply to take a vacation. Underlying such common sense and concrete advice is the fact that when one does the same things repeatedly, one's perception of self and others, of one's existence, tends to take on a sameness and inflexibility. When one lifts up his eyes from their habitual points of focus, one is in a position to see new horizons. An altered state of consciousness opens the system to new stimuli, to new perspectives, to new possibilities. One's self becomes a percept. When daily scheduled existence is a firm bulwark against disorganization, some disorganization is necessary for change to occur. Some psychotherapies take advantage of this fact by taking place in secluded retreats over extended, continuous periods, thus breaking up environmental and temporal familiarities and routines. For example, in the human potential movement it is a common practice for patients to live for a while in wilderness areas where the supposedly helpful effects of putting people in touch with natural surroundings is exploited. The amount and kind of daily stimuli may be altered also. For example, some therapies require periods of sensory deprivation, such as prohibiting television, books, and conversations with friends. People who take drugs are deprived of them. People who do not take drugs may be encouraged to do so. The unifying idea in all these practices is to open the system to different experiences through changing the conditions heretofore regular to that system.

Other factors common to all those therapies which include an interpersonal relationship mediated by verbal interchange are: the

patient has the unique experience of talking to somebody whose own interests are clearly defined and at a minimum, with the patient the center of attention, and the therapist dependably scheduled; the patient is offered the opportunity to say what he has on his mind without fear of the consequences (indeed, the consequences he anticipates do not happen, even though he takes the momentous step of translating thought into words); and the patient learns that what he may have considered madness has method, that what he might have considered as strange is understandable to the therapist and, therefore, shared. For many patients, especially early in psychotherapy, such experiences are greatly reassuring. All of these common factors are likely to contribute to greater self-acceptance regardless of the theory and technique of the therapist.

Once one gets past the fiction that the therapist is a mirror, one has to recognize that the therapist designedly or inadvertently offers many cues about his agreements and disagreements with the patient, what he considers important and unimportant, what he esteems and what he thinks less of. His judgments usually are not made according to conventional standards or moralities, but rather according to implicit or explicit standards or moralities on which the therapy itself is based. Thus, in a therapy which proceeds by way of insight, psychological thinking is esteemed, encouraged, and informally rewarded, as are the dynamic formulations offered by patient or therapist.

In some ways the therapeutic process can be conceptualized as a series of reinforcements and extinctions. To the extent that these take place within the awareness of the therapist, they can be considered as manipulations. The word "manipulation" is often used to refer to crafty, faintly diabolical activities. It has, however, a respectable usage in psychoanalytic technique. In addition to subtle manipulations, based upon principles of learning, the therapist may make a number of decisions about the structural arrangements of the therapy which, if decided upon with respect to an understanding of the patient, are also manipulations, i.e., how often the meetings take place, their length, whether extra hours are given, how the bill is presented, and when and how termination is arrived at. Such manipulations could also include whether to say good morning, the tone of voice and expression used for different patients and in different situations, the giving or withholding of advice, the management of cleansing tissue, seating arrangements, smoking and ash trays, physical sickness, and crises in the patient's life.

"Suggestion" is another word whose meaning is often explicit and has a faintly pejorative ring. It, too, can have a respectable and systematic usage. The phenomenon of suggestion is commonplace, easily observable in children and in cultures and the systems

of thought in which magic is acceptable. Witch doctors do, in fact, cure people despite the apparent irrelevance of the specific interventions they might make. The weight of conviction offered by a person of prestige and power ought not to be underestimated. A child learns definitively from his parents because he is dependent on them, and because the parents in his eyes are omnipotent, omniscient figures, who are loved and by whom it is important to be loved. These are the early and decisive conditions for learning. They continue, as Anna Freud has pointed out, in the child's learning out of love for his teachers, and are never entirely given up. This is what makes it possible for people to accept the passivity and narcissistic hurt and injury to their self-esteem of being a patient, and why the brilliant and wealthy patient can accept learning and help from one who may be younger, less bright, and less wealthy.

We turn now from those factors which are common to all or most therapies to specific means by which people are alleged to change, which may or may not be shared by one or another school or technique of treatment.

While there are differences even within psychoanalysis as to the relative contribution of insight to changed behavior, insight is held to be the major means by which cure or change is to be obtained through dynamic psychotherapy. In the Psychotherapy Research Project of the Menninger Foundation, the patients who did best were those who developed the most insight. In this same study, however, a substantial number of patients were judged as having improved, despite the absence of much in the way of new insights. Explanations for these changes were offered in terms of the interpersonal relationship, but there are other explanations which could be made.

It may be that an overemphasis on the power and exclusiveness of insight as a means of change has created a backlash. Many of the new therapies explicitly downgrade or even disallow insight as a helpful factor. Statements to this effect, available in the writings of Fritz Perls on gestalt therapy and Arthur Janov on primal scream therapy, may be helpful in broadening and intensifying observations, but they are to a large extent inaccurate with respect to the place of insight in their own therapies. When one examines closely what occurs in such therapies, it is clear that insight plays an important role. For the most part the anti-insight emotionalism which abounds in the new schools stems from the practitioner's concern about the tendency for insight to become intellectualized—to be *only* insight, pure cognition, which may prevent other kinds of change.

Another way that the movement against intellectualized insight expresses itself is in those therapies which strongly emphasize abreaction and catharsis. It is hardly news to psychoanalysis and other dynamic therapies that emotional expressiveness is important, and

that those insights which come about in an emotional context are most helpful in bringing about change. However, the range of emotion usually sought in such dynamic psychotherapies is much narrower than the range that new therapies which emphasize feeling show can be made available. (Some of them also claim to recapture by way of clear memory and feelings the birth experience. To them, this is a crucial variable in the development of the personality.)

Until recently, the use of the body in psychotherapy has been minimal. Freud first attempted to spell out psychological processes neurologically in his *Project For A Scientific Psychology*. Although he gave up this model, he hoped that physico-chemical processes underlying psychological events would eventually be specifiable. But he was content, himself, to carry on his explorations in psychological terms. Bodily aberrations continued to supply psychoanalysis with psychological data and were the object of analysis, as were general appearance of face, hands, posture, and gait. However, once past the brief period when Freud encouraged free associations by laying hands on the patient's forehead, direct intervention on the body or use of the body to promote psychological events was ignored. By contrast, in the human potential movement the body has been exploited. Observations of it are increased by the little-structured physical arrangements, with the patients walking around and sitting on the floor. Psychological processes are stimulated through physical exercises designed to release energy. Structural integration, or "rolfing," which involves a manual rearrangement of the musculature of the body, results in changed posture and other physical changes and is held to be curative, in and of itself. Some practitioners also work verbally with memories and feelings literally unlocked by the manual interventions.

The interpersonal relationship between therapist and patient is said to be the main or sole means of change in some humanistic therapies and as more or less influential in bringing about change within the dynamic psychotherapies. It may be ignored as in behavioral modification, or downgraded as in gestalt therapy.

Freud's construct of psychic energy has been made concrete in the neo-Reichian movement, especially in bioenergetics. Through various exercises particular areas of blockage are said to be opened up, with energy consequently achieving an unrestricted flow. In principle this is like Kundalini yoga tradition. In recent years Zen and other Buddhist traditions have permeated the therapies of the West, prominent among which is meditation. While Freud was willing to settle for the altered state of consciousness encouraged through the use of the couch in a quiet office, these other therapies are much more direct in their attempt to change or expand consciousness. In keeping with their roots in Eastern traditions, con-

sciousness is not only altered but can transcend itself. In these beliefs and in such psychotherapies as psychosynthesis, a person is alleged to be able to achieve a qualitatively new spiritual self, to become weller than well and more human than human.

Perhaps partly in reaction to the emphasis on the unconscious, there has been a return to recognizing the power of consciousness. Within psychoanalysis this occurs through increased attention to the roles of will and action, adaptation, and autonomous ego functioning. Outside psychoanalysis it becomes the central means of change, as in rational therapy and in therapies which focus on decision-making and the theory of games, such as transactional analysis.

One hears from many sides, nowadays, that the curative effects of psychotherapy come about through attention to the here-and-now, to the present rather than through recovery of childhood memories. The importance of the here-and-now is hardly news to dynamic psychotherapists. The most effective interpretations have always been understood as those which can be experienced between patient and therapist. Once again it seems that many of the new therapies are so troubled about the possibilities of minimizing affect in favor of cognition or explanation that they overstate their case. Nonetheless, patients in dynamic psychotherapy may tend to recollect experiences that have taken place in the past, factually, rather than with the emotion connected to them at the time, or which could be experienced with respect to them in the present. In addition, psychoanalysis and the dynamic psychotherapies take an uneasy, sometimes contradictory position toward reconstructions of the past. On the one hand, these reconstructions may be held to be actual events; on the other hand therapists may be content that patients merely believe that such events occurred. Talking about the past can be enlisted as a defense against feelings in the present, just as absorption with the present can be a defense against feelings connected with past events. The relative contributions of exploration of past and present remain to be fully understood and dealt with.

A fervent revolt is now occurring against the medical model, the doctor-patient relationship which, in its extreme form at least, involves the professional expert's doing something to the patient in order to make the patient change. In the course of attempting to overturn this model, patients are sometimes alleged to have more knowledge than the expert, a democratizing of the relationship which sounds at times as if it borrows as much from political philosophy as from psychology. The doctor-patient roles become blurred, with at least the implication among some of the new therapies that the "doctor" is as likely as the patient to benefit from the relationship. Instead of "cure" or "therapy," the goals of interventions may be the expanding of consciousness, the achieving of intensified aware-

ness, or of transcending one's self. These points of view tend to undermine rebellious resistances to interventions (since the interventions do not come from a higher-up) and to encourage the patient's responsibility for himself. However, if suggestion, based on the perceived omnipotence and expertise of the treater, is a force for change, then these movements are likely to undermine that force. If, in fact, the doctor-patient relationship, even in its most sophisticated variations and applications, encourages undue dependency and minimization of patients' capacities for self-help, then a shift away from this model, buttressed by structural arrangements, may encourage change.

These are some, though not all, of the newly recognized and popularized variables to be considered in the ideal research on the effectiveness of psychotherapy. One can see at a glance that most of these variables function in most therapeutic endeavors, either inadvertently or by design. To isolate each one for research purposes would be an ideal and probably unrealistic aspiration. Moreover, it would be of only academic interest. It is unlikely that the ideal psychotherapy intervention could be designed which would eliminate the participation of other means by which people change. And it is further unlikely that one would ever be in a position, for practical therapeutic purposes, of wanting to do so. More likely the ultimate answer to what brings about change in psychotherapy would involve the relative and interacting contributions of several means by which people change. In the ideal research design the contributions of the different ways people may change would be assessed relative to the kinds of interventions made, under what structural arrangements, and according to what theory. And all of this would be subject to the variations introduced by different kinds of patients and different kinds of outcomes to which the interventions give rise. These are staggering, if not utopian, requirements. Insofar as formal research in psychotherapy is concerned, we shall have to be content with partial and suggestive answers for an indefinite time.

Perhaps, in the recent decades of enthusiasm for formal scientific methods as applied to behavioral science, with its implicit overconfidence if not worship of technology as a panacea, we may have overlooked simpler ways of providing at least modest answers. We may have overlooked our skills as clinicians as applied to research. If, indeed, generalizability and validity are so difficult to arrive at because of the uniqueness of each psychotherapeutic endeavor, then examination of single cases may be the research design appropriate to the problem. Such examinations may make it possible to include, and perhaps to control, a greater number of the possibly relevant variables than would be possible in designs involving groups of patients. There are a number of ways in which clinicians, working

with single cases, can systematize and collect their observations. For example, it could become regular practice to have patients tested before and after treatment. It could be a regular practice for therapists to assess the results of diagnostic examinations or the notes of the therapy at periodic intervals as well as at termination. It could become a regular practice for patients to be seen some time after the completion of treatment, long enough after so to be minimally influenced by the termination process, and routine enough so that the invitation would not be experienced as a seductive continuation of the relationship. In short, a great deal more can be done with the case history method than is usually done. Case histories can be more than illustrations, they can comprise systematic data.

Many psychotherapists, it seems to me, have been intimidated by the aura and paraphernalia of formal research processes to the point that an unnecessarily wide schism has developed between clinicians and researchers. Such workers seemed to have forgotten a lonely clinician at the turn of the century named Freud, who saw his patients until 9:00 in the evening, then systematized his observations in writing as a research scientist for several hours after that. In addition to the attitudes of physician and humanitarian, he brought from the laboratory to the armchair a research attitude. And what is a research attitude? Surely included would be the capacities for, and values attached to, logic and systematic thinking in general. Superseding even these would be the wish to know—zest, enthusiasm, curiosity, and a sense of adventure in the pursuit of knowledge. I am inclined to think that this kind of attitude can be found in many clinicians who have not yet identified themselves as researchers or exploited this precious commodity in themselves.

The final comprehensive answer to the question of the effectiveness of psychotherapy may always lie just beyond our fingertips. But the quest may be shared by many of us, and in the process we will likely enrich our capacities to help others. While the effectiveness of psychotherapy may never be proved, it could be increasingly better demonstrated.

FOOTNOTE

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