

FURTHER IMPROVEMENT FOLLOWING THERAPY

JOHN PALAU
SUNY, Buffalo, N.Y.

LEWIS LEITNER
Pomona, N.J.

FRITZ DRASGOW
Albany, N.Y.

JAMES DRASGOW
Buffalo, N.Y.

The main purpose of this study is to introduce a new *specific outcome criterion* to measure our success with training and treatment groups. Anthony et al. (1) have already encouraged both researchers and practitioners to report their results using more specific criteria and the present paper is a very concrete step in that direction. The lack of these criteria has led to either initially misleading conclusions (12) even though positive results were eventually extracted (4) or to the necessary reexamination of global concepts in a field, e.g. spontaneous remission (18). The presence of specific criteria not only helps to compare and evaluate different studies, but also to direct and organize our work toward helpful goals. The concept of specific outcome criteria has extensive utility and using it more fully in our research work can increase our progress.

For several years prior to and during the present study different empathy training and treatment groups were conducted either as part of Ph.D. dissertations or as independent research studies (6, 9, 10, 13, 15, 16, 17). Progress was assessed not only from measures made before and after treatment but more importantly at several follow-up times that included up to five years post. *We regard it as even more important that therapeutic gains be either maintained or preferably increased after therapy than during therapy.*

Primarily measurements were made in terms of an individual's Level of Functioning and included either the standard measurement items (7, Vol. I, Ch. 8) or variations of them (e.g. 15) with the responses being either written open-endedly or checked from multiple choices or spontaneously verbal e.g. via telephone contact. Altogether 13 follow-ups were done on 6 different groups with the follow-ups ranging from one to four per group. The most

repeated and overall general follow-up finding was that the groups' post-treatment average levels of functioning were not statistically significantly different from their treatment termination levels ($p > .05$). This indicates that the groups as a whole stayed better after treatment for as many as 4 follow-ups conducted over 5 year periods.

Even though the follow-up post-treatment group averages were significantly higher than pre-treatment levels, the outcome *group averages* covered up the most interesting finding of all: *some of the individuals in each of the groups continued to improve after treatment*, others maintained their treatment gains and some returned to their pre-treatment levels. The percent of each group that continued to increase their measured level of functioning varied from 8 to 30. This continuing-to-gain percent (CGP) is proposed as a new specific outcome criterion measure of treatment effectiveness. It is the confirmation and verification of the prognosis generated with treatment. It can be used to compare and evaluate studies having the same or different treatments and to organize or mobilize research efforts. Furthermore the relatedness of the level of functioning as an outcome measuring instrument has been corroboratively established (8, 11) using success and failure in a variety of external reality indices, e.g. vocational, economic and marital.

HELPER ROLE

The levels of functioning of the therapists who were associated with the different 8 to 30 GCPs were not statistically significantly different ($p > .05$). Therefore the therapists' levels could not be used to explain the differential CGP outcomes. Furthermore some of the highest functioning therapists did not have groups with the highest CGP. Since the groups' pre-treatment levels were not significantly different the possibility exists for other operant factors than the helpers' levels of functioning to account for the gains. These possible factors could be localized in either or both the therapist and the therapee. Even though the therapist has been the usual target to account for therapeutic gains, there has been enough unaccounted for outcome variance to rationally hold the helpee responsible for some of his own progress.

Extensive previous research (7, 8, 19) has indicated that the therapists' levels of functioning can be used to account for the gross difference between success and failure in treatment, but the current studies (6, 9, 10, 13, 15, 16, 17) indicate that the levels of functioning of *successful therapists* cannot be used to account for their differential CGP success. In effect, previous research data indicate that we can predict from a therapists's level of functioning whether or not he will be therapeutically successful, but the current research data on levels will not let us predict more accurately exactly how successful he may be when compared with other successful therapists. Consequently we

considered a variety of possibilities other than level of functioning to account for the differential CGPs, e.g. years of experience in both individual and group work, compositions of groups, socioeconomics, etc., and eventually successfully narrowed down our hypotheses to a lone survivor: the Bierman Hypothesis (5). Bierman proposed an "active" and "passive" positiveness in successful therapists. When we ranked our successful therapists from passive to active in comparison to each other and correlated these ranks with the rank order of their groups' CGP, the resulting correlation was +.60. We interpret this as rather strongly indicating that among successful therapists the ones who are more actively positive are usually more successful.

Not only the relevant applicability but also the interpretative consequences of the Bierman Hypothesis in the contextual garden of differential CGPs is corroborated if not confirmed by Berenson's research work with confrontation (2, 3). He found that active positive, constructive confrontations by successful therapists were related to increased therapeutic gains in individual therapy. Our present results can now be seen as a group reflection of Berenson's individual encounters and may be conceptually if not empirically related to the same active positive constructive confrontational ingredients.

HELPEE ROLE

Even though the fairly high correlation of the helpers' positive-active contribution to the CGP is an encouraging and promising discovery, it does not account for the majority of the CGP helper-helpee-helped interactional variance. This statistical consideration alone is enough to drive a researcher to look for the sources of differential CGP in the gainees. But the earlier finding that even the *same helpers* had different CGPs across groups was enough to suspect the helpee as a heavy contributor to his own progress. Regardless of these differences, it is worth noting that the two findings even though made years apart point in the same direction: *those who improve the most after treatment can be held heavily responsible for their own continued improvement.*

Over the years we found no statistically significant relationships that could be cross-validated between CGPs and the helpee variables contained in their case or family histories, physical and psychological measures, demographic or environmental sources.

The lack of any initially significant relationships between the different treatment outcomes and any of the originally collected helpee data was one of the strongest sources of our motivation for continuing the follow-ups in an effort to discover a plausible explanation. Since none of the initially collected data could account for the differential outcomes we developed a host of contextual hypotheses which were tested on both old and new groups. Examples of the hypotheses included relating CGP outcome to (a) percentage

of helpee gain achieved during treatment as measured by increase in level of functioning, (b) maximum helpee gain per unit time in treatment, (c) extent of helpee verbal participation and (d) several indices of similarity between helpee and helper, e.g. socioeconomic backgrounds, family size, sibling position, areas of interest, personality similarities or differences. None of these contextual hypotheses approached even the most liberal levels of significance.

Despite the facts that all of the initially gathered helpee data and none of the hypotheses were helpful, it was still empirically evident that the CG's levels of functioning scores continued to increase during follow-ups. All of the interviewed CGs reported knowing that they were feeling better, being better and still improving. They experienced psychological growth and were aware of it, but they did not provide a cognitive, rational, causative accounting for it. Each CG grew in his own individual way and no one reported it the same way as anyone else. It was a uniquely psychological experience in the sense of being totally feeling oriented rather than a logical cognitively mental experience.

During the follow-up interviews the CGs flowed freely and sparkled with a clean freedom from hesitations, indecisions or hang-ups. Their statements were clear, concise, and direct. They spoke openly, positively, confidently and encouragingly. They continuously confronted with genuineness, honesty and inner strength. During successive follow-ups they not only communicated increasingly more but also reported feeling increasingly better. In effect, working independently they had taken over as their own therapists: self-improving, self-reinforcing and self-fulfilling. They had become responsible for themselves and their own betterment. They were active-positive products in the process of becoming even more active-positive.

HELPER-HELPEE RELATIONSHIPS

During the conduct of the various treatment groups it was frequently observed that the helpee's measured levels of functioning approached the helpers' levels. The follow-up CGP data indicate that many of the CG helpees even surpassed their helper's level. Since the level of functioning measuring instrument has been frequently validated as an accurate discriminator of psychologically "healthy" and "sick" (7, 11, 19), it is conceptually if not empirically possible that patients do not get as well during therapy as their therapists are, but *after* therapy some of them do get better. Future research may find more valuable information for discoveries about therapy when the researchers select subjects who have become more successful after therapy rather than during it.

Previous research with successful therapists (14) found no statistically significant differences among the therapists' high levels scores on the core conditions of empathy, regard, concreteness and genuineness. We have found

the same results for these variables with the CGP groups. The increase of helper-helpee similarities in both the core conditions and other measures of success beyond therapy has also been reported in previous research with other groups (11). The inference we propose from this conglomerate context is that during treatment the core conditions of the levels of functioning are planted as the seeds of health and success since among the CGs the seedlings grow and flourish in fertile, self-nourishing soil as the CGs provide themselves with their own high level core conditions to facilitate their own growth and development. This implies that therapy as we have known it is at best only a precursor to success and that the real measures of therapeutic effectiveness are only made years later. From this point of view it may also be proposed that therapeutic *effectiveness* is only really measurable among CGPs since with non-CGPs we only measure *ineffectiveness* among those who simply maintain their treatment termination levels and *defectiveness* among those who return to their pre-treatment level.

Earlier we pointed out the rather robust relationship between Bierman's active-positiveness and the differential CGPs when they were associated with their respective responsible therapists. One of the most noticeable characteristics of the CGs was their active positiveness irrespective of who their therapist was. The CGs may have taken the best that their helpers had to offer and made it work for them. Their success may have begun both where and when their therapists left off. Contrasted to the group who only maintained their treatment termination levels, the CGs had the ability not only to emulate the best their helper had to offer but also to internalize the learning process to make themselves their own eventual emulative model.

If we admit that continuing to improve after treatment is a desirable goal, then we should concern ourselves with more follow-up research that studies groups where the primary aim is continuing improvement and the immediate improvements during treatment or training are used merely as contextual examples of ways and means to achieve that goal.

SUMMARY AND CONCLUSIONS

A total of 13 follow-ups were done on six different treatment groups with four of the follow-ups extending over a five year period. While it was found that on the average the groups maintained their treatment termination levels of functioning, it was also found that 8 to 30% of the group members continued to improve after treatment. A positive correlation of .60 was found between the active-positiveness of the successful group therapists and their group's continued gainers' percents (CGP). Those who continued to improve seemed to do so by their own efforts and became their own active-positive therapists. The CGP was offered as a new outcome criterion to assist in the comparison and evaluation of different studies and also to put the emphasis in

group treatment research where it belongs on what happens to the individuals after treatment termination.

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