Therapeutic experience in retrospect:
Examination of non-specific factors in therapy

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My family and friends, for their assistance over the last three years.
If the indiscriminate distribution of prizes argument carried true conviction, ... we end up with the same advice for everyone -

"Regardless of the nature of your problem seek any form of psychotherapy." This is absurd. . . (p.257)(Rachman & Wilson, 1980)
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ABSTRACT

In this study the relationship between non-specific factors and therapeutic outcome was examined, in a sample of 69 clients who had previously attended counselling. Non-specific factors in psychotherapy, therapeutic outcome (assessed by both client and therapist), client satisfaction, level of client functioning, social desirability, and demographic variables were assessed through a mailed questionnaire. Relations among these variables were explored. A strong relationship was found between non-specific factors and client rated outcome, with a weaker relationship evident between non-specific factors and therapist rated outcome. A positive relationship between the two outcome measures (i.e., client and therapist ratings) was evident. Therapeutic outcome was related to both the client's present level of functioning and level of social desirability response style. Client satisfaction was found to relate closely to client rated outcome and to a weaker extent to therapist rated outcome. The findings indicate that non-specific factors have an important role in determining therapeutic outcome. In particular, the nature and content of the client-therapist relationship are important, with the therapist displaying Empathy, Regard, Unconditionality and Congruence toward the client. At a practical level these findings may have implications for the training of therapists, where the emphasis should be on developing relationship skills (as evidenced by non-specific factors) rather than teaching specific techniques.
CHAPTER 1
Introduction

Over a number of years the relative importance of specific and non-specific factors in therapy and their relationship to outcome have been debated. This controversy has involved examining the relative importance in psychotherapy of therapeutic techniques versus client-therapist relationship factors. Specific factors refer to the theoretical orientation of the therapist, including techniques based on the theory. These factors are intentional, well defined actions of the therapist, such as interpretation, labeling of feeling, or correction of distortions in beliefs about reality (Jones, Cumming & Horowitz, 1988). Non-specific factors are the qualities inherent in any positive human relationship. They include: suggestion, client's expectations, encouragement, advice, rapport, warmth, trust, empathy and hope (Gelder et al., 1973; Shapiro, 1971). The focus of the present study is non-specific factors and their relationship to therapeutic outcome.

Initially, doubts in regard to psychotherapy came about as a result of the lack of evidence that any form of psychotherapy was particularly effective (Eysenck, 1961; Eysenck, 1969). More recently, skepticism has been re-initiated by the finding that a wide variety of different forms of psychotherapy are all effective and, furthermore, equally effective (Bergin & Lambert, 1978; Beutler, 1979; Klein, Zitrin, Woerner & Ross, 1983; Luborsky, Singer & Luborsky, 1975; Shapiro & Shapiro, 1982b; Sloane, Staples, Cristol, Yorkston & Whipple, 1975; Smith, Glass & Miller, 1980). This has been emphasised by Smith & Glass (1977) who assert that "Despite volumes devoted to the theoretical differences among different schools of psychotherapy, the results of research demonstrate negligible differences in the effects produced by different therapy types."(p.760)

Determining the relative importance of specific and non-specific factors would have implications for training, professional practice, funding, and policy decisions. For example, if non-specific factors are predominantly important then perhaps therapists should be chosen mainly on the basis of

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1 'psychotherapy' is used throughout the text as a general term for therapy, without specifying the theoretical school (e.g., behaviour therapy, psychodynamic)
their relationship skills rather than their academic qualifications. If this is the case, a greater proportion of time and money spent on training therapists should go toward developing relationship skills (Lambert, 1983).

Generally, therapeutic outcome studies in this area have been conducted in clinical settings. However, the present study utilised clients\(^\text{2}\) from a student counselling service as a means of demonstrating more general principles of psychotherapy.

Past research has shown that evaluating therapeutic outcomes is complicated as it requires the integration of a wide range of both methodological issues and theoretical frameworks. Therefore, this chapter has been divided into a number of different sections, each focusing on an area related to non-specific factors and their influence on therapeutic outcome. Finally, the experimental hypotheses have been summarised.

Student Counselling Literature

Very few published studies exist in the area of student counselling service evaluation. Metzler (1964) reviewed the literature on the evaluation of student counselling and guidance programs published during 1946-1962. He concluded that existing research was poorly designed, inadequately analysed and badly executed, which rendered the results unusable.

Since the Metzler (1964) review very few outcome studies of student counselling services have been published. The following are examples of available research. Wilson (1970) evaluated the effectiveness of therapy for 39 student clients and found that 70% reported at least some amount of desirable change. Raaheim (1984) compared the examination results of 21 students who had completed a study skills program with a group who had not. The findings indicated that those who had been counselled in

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\(^\text{2} \) 'client' used in the text unless explicitly referring to inpatients, in which case 'patient' will be used
study techniques achieved better examination results. Campbell (1965) found students who had received counselling had a 25% higher graduation rate, compared with those who had not. Szulecka, Springett & DePauw (1986) selected two evenly matched groups of students potentially vulnerable to psychological disturbance. One group was left to its own resources, while the other was offered psychological intervention. The results, although not statistically significant, indicated that students in the intervention group had fewer subsequent visits to general practitioners, improved their scores on tests measuring psychological disturbance, and were less likely to withdraw from university.

Despite the lack of evaluative data in this area, student counselling services are well utilised. Burke & Hampton (1979) surveyed students and staff at a university and found that 25% of students had consulted a counsellor and 50% expected to do so during their undergraduate study. Approximately 70% of staff expressed that they would refer a student in need, and 50% said that they may consult a counsellor themselves.

Some suggest that evaluation studies of student counselling services tend to measure attitudes towards the counselling service rather than an assessment of its effectiveness (Breakwell, 1987).

The problems presenting at tertiary counselling services are varied and diverse. They include academic and vocational issues, in addition to personal and social counselling (Burke & Hampton, 1979). Hooper and Stone (1989) surveyed university counselling services in the UK and classified presenting problems into specific areas. These were found to be: 27% emotional (including exam nerves), 19% relationship (including sexuality), 17% academic/emotional, 6% information related (including finance), 6% bereavement, 6% leaving the institution, 4% eating disorders, and 2% for each: pregnancy/termination, drugs/alcohol, and concern for others.

In summary, due to the lack of specific data on the evaluation and outcome of student counselling services, the general literature on therapeutic outcome will be examined.
General Psychotherapy Literature

The literature on psychotherapy contains examples of numerous distinct treatments (e.g., Parloff, 1984). A number of authors suggest that these different techniques appear more diverse in theory than they do in clinical practice (e.g., Sloane et al., 1975). Despite the diversity of psychological therapies, many influential reviews of outcome research have concluded that outcome of therapies are generally similar. Psychotherapy achieves clinically meaningful results and is more effective than no treatment (Rachman & Wilson, 1980). Some suggest that the benefits of treatment seem to diminish as the interval between termination of treatment and follow-up measurement increases (Barker, Funk & Houston, 1988; Marsh & Terdal, 1980). Smith et al. (1980) state that "The benefits of psychotherapy are not permanent, but then little is" (p.183).

It is important to identify those factors which have an impact on therapeutic outcome (specifically the relative potence of specific and non-specific factors). This would enable direction of attention toward those which are important, whether they be aspects of the patient, the therapist, the treatment, or their interactions. Potentially it is possible to distinguish those clients likely to succeed in therapy. Ultimately the question that outcome research strives to answer is: What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances (Paul, 1967; cited in Stiles, Shapiro & Elliot, 1986).

Methodological Issues in Outcome Assessment

Measurement at a number of different levels is possible when evaluating a mental health service. The most common division is structure, process, and outcome (Donabedian, 1966). Historically, process and outcome research have been viewed as separate domains. Process research refers to what occurred within the confines of the therapy session and outcome research refers to client change outside of the session (specifically determining whether clients improved significantly from the beginning to the end of therapy)(Greenberg & Pinsof, 1986). Lonnqvist (1985) suggests that the evaluation of
outcome involves five questions: (a) What are the goals of treatment; (b) How big a part of the total need of treatment does the planned treatment cover; (c) How well are the goals attained; (d) Is the treatment effective; and (e) What other effects apart from those intended does the treatment have.

Measuring treatment outcome is very complicated and fraught with problems. Given the number of issues identified in the literature, it is not surprising that patients treated by one or another therapy do not show great differences in therapeutic outcome. The identified problems include:

(1) Change is Multidimensional
It is now common to use multiple criterion measures in research studies. This is illustrated by several studies of simple fears using multiple criterion measures that have not found unitary results (Mylar & Clement, 1972; Ross & Proctor, 1973; Wilson & Thomas, 1973). The results indicate that specific treatment used to reduce simple fears may result in a decrease in behavioural avoidance of the feared object but may not affect the self-reported level of discomfort associated with the feared object. Similarly, a physiological measure of fear may show no change after treatment whereas subjective self-report change may be substantial.

(2) Client's Responses to Therapy Differ
Irrespective of what type of therapy is used, some clients improve greatly, some improve a little, some do not improve and some get worse (Slone et al., 1975; Strupp, 1980a, b, c, d). The types of subjects used in research may influence the results obtained. For example, Prioleau, Murdock & Brody's (1983) meta-analysis found significant effects of psychotherapy for those studies using general clients, whereas studies using psychiatric inpatients or outpatients showed no significant evidence for the superiority of psychotherapy over placebo treatments. Contrasting evidence also exists to indicate that larger outcome effect sizes for studies involving outpatients than for students and university volunteers (Barker et al., 1988; Miller & Berman, 1983).
(3) **Outcome Reflects Value Orientation**
To understand the effects of psychotherapy, Strupp and Hadley (1977) suggest taking into account the three main points of view: society, the individual client, and the mental health professional. From the perspective of society, research should view change in relation to the degree to which treatments effect the maintenance of social relations, institutions and prevailing standards. For example, the concern may be on criminal behaviour, occupational stability, and social role behaviour.

From the point of view of the individual client, the concern is on subjective feelings of well-being, satisfaction, contentment, and fulfilment. Note that these feelings can be present in individuals who lack adequate role performance by societal values or can be absent in those who are by most standards functioning well in society.

Mental health professionals impose their own notion of ideal and adequate functioning. For example, client centered therapists may view success as the concept of the fully functioning person and psychoanalytic therapists may use models of integration as success.

It is evident that judgements of outcome from any single perspective may represent only one of the three possible value orientations and lead to a less than accurate view of the entire result of treatment. Empirical evidence supports this view and has shown that client and therapist perspectives of therapy differ significantly (Gomes-Schwartz, 1978).

(4) **Reactivity**
Reactivity is the phenomenon of the measurement process producing change in what is measured (Campbell & Stanley, 1963), that is, clients may distort their responses because of their awareness of being measured. Reactivity of the outcome measure has been found to account for most of the variance in outcome (Smith et al., 1980).

(5) **Others**
To compound the above problems comparative studies usually use short duration therapies (e.g., studies analysed by Smith et al. (1980) averaged approximately 15 hours in therapy duration), sample sizes in
comparative studies are small (typically 20 or less subjects per group)(Kazdin & Bass, 1989), and the attrition rate of subjects by the end of treatment and the end of follow-up is high (in some treatment programs between 40-50% of subjects may drop out of treatment)(e.g., Fleischman, 1981).

**Measures of Outcome**

Several studies have examined the types of measures of outcome used in psychotherapy outcome research. The following are examples of these.

Meltzoff & Kornreich (1970) reviewed outcome research published prior to 1970. The studies included both in- and out-patients, using a wide variety of individual and group psychotherapies. They found 39% of the studies used "observed behaviour", 27% personality inventories, 27% "rated behaviour", 19% projective techniques, 10% the Q-sort technique, 9% "Objective performance tools", and 8% studied physical signs. Very few studies used global ratings made by the patient (6%) or the therapist (7%). Approximately 50% of the studies analysed used more than one of the above types of criterion to measure outcome.

More recently Lambert, Christensen & DeJulio (1983) reviewed 216 outcome studies published in the *Journal of Consulting and Clinical Psychology*, between 1976 and 1980. They found nearly 75% of the studies used from 2 to 6 measures of outcome. However, 52% of the studies used assessment instruments from a single source of outcome (i.e., self-report, trained observer, significant other, therapist, and instrumental). Lambert et al. (1983) concluded that multiple criteria are being used in outcome studies but that the full range of data sources available is not being used.

Beutler & Crago (1983) reported that 83% of the studies surveyed used a combination of posttreatment ratings by client, along with either a measure of general psychopathology (e.g., MMPI, 16PF, EPI) or a measure of multiple symptoms (e.g., Hopkins Symptom Checklist, Multiple Affect Adjective Checklist).
Lambert (1983) concluded that assessment procedures are becoming more complex and also relying more on standardised instruments that deal with specific types of change. More accurate measures of psychotherapy outcome are necessary to enable progress in unraveling the complex causal relationships that exist between treatments and outcomes (Lambert, 1983).

Given the methodological problems related to the measurement of therapeutic outcome, it appears important to measure different perspectives (i.e., client, therapist, independent observer) and take a variety of measures (e.g., client evaluation, therapist evaluation, overt behaviours, personality measures).

**Comparative Outcome Studies**

The literature contains a large number of comparative outcome studies. The methods of analyses of these studies consists of both traditional narrative methods and the newer meta-analysis method.

**Narrative Methods**

A majority of reviews using traditional narrative methods of summarising comparative outcome studies have concluded that psychotherapy is effective, but no substantial differential effectiveness has been demonstrated (Bergin & Lambert, 1978; Beutler, 1979; Luborsky et al., 1975; Roback, 1971).

The first review of psychotherapy outcome studies was presented by Eysenck (1952). He concluded that two-thirds of neurotic persons improve independently of the treatment, as a result of spontaneous remission.

Since the Eysenck (1952) study, a number of other researchers have conducted comparative outcome studies using narrative methods. For example, Meltzoff & Kornreich (1970) found that in 81 studies psychotherapy was found to be effective, and in 20 studies a null result was found. They also noted that the better the methodology, the stronger the evidence for the effectiveness of psychotherapy.
Luborsky et al. (1975) reviewed outcome studies and found in 20 out of 33 comparisons (with untreated controls) psychotherapy proved to be effective. In the remaining 13 studies no significant differences were evident in improvement between those who had and those who had not received psychotherapy. In none of the studies was the outcome better for untreated than for treated subjects.

**Meta-Analysis**

Similarly, reviews using the quantitative approach of meta-analysis have concluded that different types of therapy produce negligible differences in outcome.

Meta-analysis has also been called "the analysis of analyses" (Glass, 1976), and is defined as the use of data analytic procedures, techniques or practices where multiple data sets or studies are used (Lambert, 1983). The methodological advantages and disadvantages of meta-analysis continue to be debated (Shapiro & Shapiro, 1982a; Wilson & Rachman, 1983), and these procedures have been criticised on both technical and methodological grounds (Cook & Leviton, 1980; Kazdin & Wilson, 1978; Wilson & Rachman, 1983). This technique provides the statistical magnitude of the effect of a treatment and is calculated as a mean difference between treated and control subjects divided by a common measure of the variance (Barker et al., 1988; Kazdin & Bass, 1989).

A large number of comparative outcome studies using meta-analysis appear in the literature. The following are prominent examples of these. Bergin (1971) meta-analysed the 52 best studies from 501 outcome studies and concluded that psychotherapy generally leads to improvement in about 65% of cases, whereas spontaneous remission occurs in about 30%.

Smith & Glass (1977) meta-analysed 375 studies and found that the average client receiving psychotherapy was 15% better off than the untreated controls.

Since Smith & Glass' (1977) analysis, more specific questions about the outcome of psychological treatment have been asked. For example,
some have used meta-analysis to look at the effectiveness of treatment for specific disorders such as: unipolar depression (Steinbrueck, Maxwell & Howard, 1983) and headaches (Blanchard, Andrasik, Ahler, Teders & O'Keefe, 1980). Others have used meta-analysis to determine the effectiveness of specific treatments such as cognitive-behaviour therapy (Miller & Berman, 1983).

Generally, the results of meta-analyses of comparative outcome studies conclude that type of therapy (i.e., behavioural or verbal; psychodynamic or client centered; even drug treatment) does not produce obviously different degrees or types of benefit (Smith et al.; 1980). In addition, psychological treatment was found to be more effective than either no treatment (Andrews & Harvey, 1981; Landman & Dawes,1982; Shapiro & Shapiro, 1982b) or non-specific factor control groups (Landman & Dawes,1982; Prioleau et al.; 1983; Shapiro & Shapiro, 1982b). However, the evidence is not clear cut and contradictory results have also been found. A number of studies claim to demonstrate differences in effectiveness between treatment approaches (e.g., Gillan & Rachman, 1974; Emmelkamp, Kuipers & Eggeraat, 1978; Everaerd & Dekker, 1982).

In conclusion, a substantial amount of evidence indicates that the outcomes of different psychotherapies (both with general and clinical populations) are equivalent regardless of the statistical method of analysis used.

**Comparative Process Studies**

It has been estimated that the number of different therapies being practiced number into the hundreds (Goldfried, 1980). However, it appears that very few of these therapies have been subjected to detailed process or outcome analysis.

The theories of different schools of psychotherapy suggest that they differ in a number of important ways. These include: the therapists' mental operations, as well as the therapists' verbal and non-verbal techniques. The technical prescriptions of different schools are often contradictory (Stiles et al., 1986).
A large amount of empirical evidence exists to support the idea that the content of different therapies does differ significantly (DeRubeis, Hollon, Evans & Benus, 1982; Gomes-Schwartz, 1978; Luborsky, Woody, McLellan, O'Brien & Rosenzweig, 1982; Stiles, 1979). For example, the psychoanalyst remained more aloof and the client centered therapist in contrast was seen as warm, empathic and genuine. Whether these different ingredients in different psychotherapies are active ingredients or merely flavours and fillers remains to be determined (Stiles et al., 1986).

One major flaw in comparative outcome studies is that very few have included any measure of process and none have assessed process comprehensively (Stiles et al. 1986).

**Conclusion**

The paradoxical findings of content non-equivalence and outcome equivalence presents a major dilemma, as this implies that regardless of what the therapist does the end result is the same. This conclusion has lead to an upsurge in the number of studies to try to resolve the paradox. The equivalence verdict is unpalatable both theoretically and personally to a therapist who has spent a number of years specialising his/her skills.

**Attempts to Resolve the Paradox**

A number of different arguments have been put forward to resolve the equivalence verdict. Broadly these can be grouped into: methodological issues, that therapies may in fact differ in outcome; the core mechanisms or processes are the same for all therapies, despite apparent diversity of content; and others combine the two arguments into a higher order theory or challenge the assumptions underlying the equivalence debate. The following are representative arguments from each group.
Equivalence Verdict Mistaken

A number of methodological arguments have been developed in an attempt to explain that outcomes from psychotherapy may in fact differ. These include: that meta-analysis is not sensitive enough but potentially it will yield specific propositions in regard to treatment outcome and this will become clearer as the quality of research studies improves (Stiles et al., 1986); methodologies used in the evaluation of drug effects (i.e., clinical trials and placebo controlled designs) should be used in the evaluation of psychotherapy (Shapiro & Morris, 1978; Prioleau et al., 1983); and the failure to measure specific goals of treatment (as opposed to general changes)(Shapiro & Shapiro, 1982a).

Equivalence Verdict Supported (non-specific factors)

Some researchers accept that outcomes are equivalent and argue that underlying differences in therapists' verbal techniques are common features shared by all psychotherapies, and these common features are responsible for the equivalence in effectiveness. They argue for equivalence in mechanism despite non-equivalence of content.

Theoretical Explanations

A variety of theoretical explanations have been proposed to explain non-specific factors. Non-specific factors can be divided into a number of different categories:

1. **Patient-Therapist Relationship**
   The therapist shows concern for the client's welfare, and encourages the development of a confiding, trusting emotional relationship with him/her (Cornsweet, 1983; Frank, 1975).

2. **A Cognitive Set**
   The therapist provides for the patient by offering hope for improvement and by presenting a new framework within which the patient can understand his/her problems (Frank, 1971; 1973; 1975; Hobbs, 1962; Kazdin, 1980; Strupp, 1969; Wilkins, 1984) and awareness of available options. Frank (1971, 1973) suggests that specific theories and techniques can be seen as 'myths' and 'rituals' respectively, which
create an environment suitable for placebo/relationship variables to operate.

(3) Personality of the Therapist
Some researchers believe that the personality of the therapist makes the crucial difference to the efficacy of psychotherapy (Strupp, 1978) and may mediate their ability to provide non-specific factors.

(4) The Treatment Setting is Special
An aura about the therapeutic setting is established, which encourages clients to believe they are in a safe place.

The idea of the importance of non-specific interpersonal relationship factors in all forms of psychotherapy was made popular by Frank (1961). He pointed to the placebo effect in medical procedures and how this may depend on the therapist's capacity to arouse the patient's morale and hope for cure. Others have also equated non-specific factors with the 'placebo effect' (Shapiro & Morris, 1978).

Frank (1975) expanded the nonspecificity hypothesis to suggest that all forms of psychotherapy are beneficial because they have in common the ingredients essential for the effective treatment of the core problem of demoralisation. He suggests that most if not all patients who enter psychotherapy suffer a comparable psychological state identified as demoralisation. Demoralisation may include a number of characteristics: a sense of helplessness, inability to cope, self-blame, feelings of worthlessness, hopelessness, and a sense of alienation. Frank suggested that "psychotherapy functions chiefly to restore morale, increasing the patient's coping ability and reducing his symptoms" (p. 120). He proposed that psychotherapy achieves its effects mainly by directly treating demoralisation and only indirectly treating overt symptoms of covert psychopathology.

Parloff (1984) states that the non-specific hypothesis distinguishes two phases of treatment. In the initial phase, the provision of hope and positive expectations for therapy in the client is critical. Clients who present experiencing demoralisation require assurance of the potential utility of the treatment and especially of the therapist. The second phase involves specifying goals and teaching the client strategies. Parloff views treatment as beginning by artificially putting into the...
client a sense of confidence in the therapist, and ends with the client developing a realistic sense of confidence and mastery in themselves.

In addition, Parloff (1986a) suggests that initially in therapy the non-technical (non-specific) aspects (e.g., nature and quality of the relationship offered, characteristics of the therapist, context in which treatment is to be provided, and evidence of the therapist's skills) may be more important than specific techniques. As well as being particularly salient during the initial phases of therapy they also serve as catalytic agents during the entire course of treatment. Empirical evidence supports this idea. For example, Llewelyn & Hume (1979) found that clients reported non-specific factors to be more useful than specific factors. Strupp (1983) (cited in Jones et al., 1988) also noted that all forms of psychotherapy operate within an interpersonal context and therefore contain resemblances to nonprofessional human relationships.

**Empirical Evidence**

It has been suggested that the argument for non-specific factors is central to the recent growth of eclecticism in psychotherapy (Held, 1984). Eclecticism attempts to distil the common elements of treatments and to blend them into a maximally effective approach free from theoretical constraints.

In addition to theoretical explanations, empirical evidence exists to support the notion of non-specific factors. This evidence comes from a number of different areas: therapist factors, client behaviours or attributes, and therapeutic alliance.

**General Therapist Factors**

General therapist factors can be broadly defined as attitudes, qualities, or conditions provided by therapists in their relationships with clients; qualities that cut across the various psychotherapy schools' variation in response modes, techniques or specific verbal content. This viewpoint has received support from a number of empirical studies.
A long time ago Fiedler (1951) (cited in Stiles et al., 1986) who found that both clients and therapists from different schools rated ideal therapy similarly in relation to global aspects, such as overall quality of the therapeutic relationship and warmth.

Significant relationships have been found between perception attribution and both the process and outcome of therapy. Particularly the clients perceptions of the therapist as empathically understanding (Luborsky et al., 1980; Truax & Mitchell, 1971), affirming the patient's value as a person, being genuine and congruent, and possessing therapeutic skill and positive personal attributes (Barrett-Lennard, 1962; Orlinsky & Howard, 1978; Rogers, 1957). Truax & Carkhuff (1967) point out that it is the patient's perception of therapist qualities that is important, rather than whether or not the therapist actually possesses them.

Hollander-Goldfein, Fosshage & Bahr (1989) studied clients choice of therapist and found that chosen therapists compared with rejected therapists were rated as more: competent, likable as people, understanding and desirable as a therapist, and possessed more qualities that the patient wished to emulate.

Frank (1961) found that clients look for a therapeutic relationship in which they feel trust, understanding and confidence. A number of studies have supported this by finding that "good" therapists were described as: sincere, warm, energetic, respectful, self-confident, supportive of others and able to become emotionally involved without losing objectivity (Caudill, 1957, cited in Hollander-Goldfein et al., 1989; Parloff, 1956). Further support comes from Lambert (1983) who states that therapist variables that have been found to be related to poor outcome include: rejection of the patient, low levels of interpersonal skills or therapeutic attitudes (empathy, genuineness, warmth), manipulation of the client to meet the therapist's needs, and lack of energy to invest into the therapeutic relationship.

Studies that have compared clients with good and bad outcome by the same therapist indicate that therapists tended to foster warm and mutually respectful relationships with clients who turned out to be
high changers. However, the same therapists tended to respond in a 'reciprocal' way to negativistic, resistant clients (Henry, Schacht & Strupp, 1986; Strupp, 1980a, b, c, d).

General therapist factors can be divided into two main groups: (a) warm involvement with the client (including empathy, acceptance, and respect), and (b) communication of a new perspective on the client's issue and situation (Stiles et al., 1986). Both of these factors have been empirically demonstrated (Cross, Sheehan & Khan, 1982; Frank, 1973; Gomes-Schwartz, 1978; Llewelyn & Hume, 1979; Murphy, Cramer & Lillie, 1984; Orlinsky & Howard, 1978).

The above evidence illustrates that a number of therapist factors appear to be important and influence therapeutic outcome.

**Client Behaviour or Attributes**

Certain client characteristics have been found to be liked by therapists and most likely to lead to success in therapy. These include being: young, attractive, verbal, intelligent, and successful (Schofield, 1964).

Generally researcher's conclude that client variables rather than therapist or therapy process variables are the best predictors of a wide variety of outcome measures (Gomes-Schwartz, 1978; Kolb, Beutler, Davis, Crago & Shanfield, 1985; Luborsky et al., 1975). Client behaviour or attributes can be divided into two main groups:

1. **Client exploration**
   
   This view holds that the major active ingredient in all psychotherapies is the client's involvement in therapy and the verbal exploration of his/her own internal frame of reference. The diverse techniques used by different schools of therapy represent alternative approaches to facilitating client exploration.

   In practice, however, it appears to be difficult to establish a relationship between specific client behaviours and therapeutic outcome (Strassberg, Anchor, Gabel, & Cohen, 1978). Stronger and more consistent evidence exists to suggest that less differentiated measures predict therapeutic benefit. For example, the overall level of client
participation (Baer, Dunbar, Hamilton & Beutler, 1980; Gomes-Schwartz, 1978; Moras & Strupp, 1982; Nelson & Borkovec, 1989), total number of client utterances in therapy (McDaniel, Stiles & McGaughey, 1981), level of insight (Baer et al., 1980), and client disclosure (Baer et al., 1980). More specifically, Gomes-Schwartz (1978) found that a patient's active, positive involvement in therapy was predictive of positive outcome.

(2) Client expectancies
Contradictory evidence exists in regard to client expectation and therapeutic outcome. A number of studies have found a significant relationship between client's expectations and treatment outcome (Martin, Friedmeyer, Moore & Claveaux, 1977; Karzmark, Greenfield & Cross, 1983; Friedman, 1963; Goldstein & Shipman, 1961). Some have specifically found a curvilinear relationship. That is, moderate client expectations for benefit were optimal, whereas either unrealistically high or low expectations were not beneficial (Goldstein, 1962; Goldstein & Shipman, 1961; Tollinton, 1973). Others have found client expectation not crucial to successful outcome (Barker et al., 1988).

The above evidence suggests that the relationship between therapeutic outcome and client behaviour has not yet been well established.

Therapeutic Alliance
This view suggests that all therapists (regardless of theoretical orientation) are able to establish a positive emotional bond and mutual collaboration with receptive clients, and this relationship carries a majority of the therapeutic weight. From this point of view, specific techniques, tasks, and theories are seen as relatively unimportant except as a mechanism for establishing the therapeutic alliance.

The terms therapeutic alliance, working alliance, and helping alliance tends to be used interchangeably in the literature, however, some believe them not to be identical but rather related concepts (Foreman & Marmar, 1985). Hartley (1985) views therapeutic alliance as having two components: the real relationship and the working alliance. The real relationship is the mutual human response of the therapist and client to each other (including trust and respect for each other,
undistorted perceptions and authentic liking) (Bordin, 1979; Marziali, 1984). The working alliance reflects and is dependent upon the ability of the therapist and client to purposefully work together in treatment (Greenson, 1967; Zetzel, 1956). A more specific explanation is offered by Rush (1985) who defined therapeutic alliance as the working relationship between therapist and client that facilitates the application of therapeutic techniques and positive changes in behavioural, emotional, and cognitive patterns. The alliance is based on "...the nonneurotic, rational rapport that the patient has with the therapist and includes an identification with the sympathetic, empathic understanding part of the therapist" (p.562).

It has been found that typically the first 3-5 sessions were used by the therapist and client to explore compatible modes of relating to each other (Marziali, 1984). This alliance has been found by some to be relatively resistant to change (Eaton, Abeles & Gutfreund, 1988; Luborsky, 1976; Horowitz, Marmar, Weiss, DeWitt & Rosenbaum, 1984; Marziali, 1984; Marziali, Marmar & Krupnick, 1981). Specifically, Moraś & Strupp (1982) found initially negative or highly ambivalent client-therapist relationships to be associated with poor outcomes. Conflicting evidence also exists to suggest that therapeutic alliance is not always fixed early in therapy and can change over the course of therapy (Horowitz et al., 1984).

The therapeutic alliance concept originated in the psychoanalytic school, where there has been a long term debate over its exact definition and clinical usefulness (Weiner, 1975). The concept is relevant across a broad range of therapies that have acknowledged the importance of the client-therapist relationship. The importance of the therapeutic relationship is recognised not only in psychoanalytic therapy but also cognitive and behaviour therapies (Beck, Rush, Shaw, & Emery, 1979; Goldfried, 1980; Wilson & Evans, 1976), and client centered therapy (Rogers, 1957).

Interest in therapeutic alliance in psychotherapy research came out of an increasing dissatisfaction during the 1970's with the concept of "therapeutic conditions" (Lambert, DeJulio, & Stein, 1978). This was
initiated by Bordin (1979) who distinguished three aspects of the helping alliance that are generalisable to all schools of psychotherapy:

(a) the emotional bond between therapist and client;
(b) the quality of therapist and client involvement in the tasks of therapy; and
(c) the degree of concordance between the therapist and client on the goals of treatment.

A debate exists in the literature as to whether the patient-therapist relationship is a necessary and/or sufficient condition for therapeutic outcome. Some believe that the triad of therapeutic qualities (warmth, empathy and genuineness) are necessary and sufficient conditions for therapeutic change (Rogers, 1957; Truax & Carkhuff, 1967; Truax et al., 1966). However, others believe them to be necessary but not sufficient (Frank, 1971; Parloff, Waskow & Wolfe, 1978).

Research evidence

Since Bordin's (1979) study, a variety of measures of therapeutic alliance have been developed and applied in research (e.g., Marziali, 1984; Marzaili et al., 1981; Moras & Strupp, 1982). Client's reports of therapist empathy, warmth, and genuineness can be seen as measures of therapeutic alliance. The results of this research shows that alliance is an important ingredient contributing to successful outcome (Frieswyk, 1986; Orlinsky & Howard, 1978; Rush, 1985; Wilson & Evans, 1977).

Urban & Ford (1971) emphasised that the central focus of the therapy must be the personal relationship between therapist and patient. Some have gone as far as to suggest that the ability to form this alliance may be the most important factor in the therapist's effectiveness (Luborsky, McLellan, Woody, O'Brien & Auerbach, 1985).

Contradictory evidence exists in relation to who's (i.e., client, therapist, or both) contribution to the therapeutic alliance is most important. Some have found that the client's contribution to and perception of the therapeutic alliance, more than the therapist's, best predicts successful outcome (Hartley & Strupp, 1983; Horowitz et al., 1984; Luborsky, Crits-Christoph, Alexander, Margolis, & Cehen, 1983;
Marziali et al., 1981). For example, patients rated as contributing in a strong positive way to the therapeutic alliance had good treatment outcome and clients contributing negatively to the alliance had poor treatment outcomes (Marziali et al., 1981; Moras & Strupp, 1982).

Other authors have found that constructive therapeutic alliance requires both the patient and therapist to make contributions to the relationship (Gomes-Schwartz, 1978; Luborsky, 1976; Marziali, 1984; Marziali et al., 1981). Some have emphasised the importance of therapist contributions. Another group suggest that the therapist's positive contribution to therapy including the therapist's attitude toward the client has been found to have a powerful impact on the therapeutic relationship (Eaton et al., 1988).

The concept of therapeutic alliance has several limitations:

(1) correlations with outcome may actually reflect confounding of earlier outcome (Glass, 1984). That is, early success or partial symptom relief is likely to strengthen the therapeutic alliance so that the relationship with outcome may be bidirectional (Stiles et al., 1986).

(2) The construct is merely a conceptual framework for uniting a number of client and therapist contributions, the exact operation of these factors is yet to be determined.

(3) like general therapist factors, therapeutic alliance locates the common core at too high a level of abstraction (Stiles et al., 1986).

Correlates of therapeutic alliance
A number of variables have been found to predict the client's contribution to therapeutic alliance. These include assessment of pretreatment levels of: degree of defensiveness and availability of environmental support (Gaston, Marmar, Thompson & Gallagher, 1988; Marziali, 1984; Moras & Strupp, 1982; Morgan, Luborsky, Crits-Christoph, Curtis & Solomon, 1982); psychological health, adaptive functioning and social adjustment (Eaton et al., 1988; Luborsky, Crits-Christoph, Alexander, Margolis & Cohen, 1983; Marziali, 1984; Moras & Strupp, 1982).
Therapeutic alliance has also been found to be associated with fewer terminations, better client satisfaction and greater improvement (Saltzman, Luetgert, Roth, Creaser & Howard, 1976).

Client Satisfaction

The concept of client satisfaction is closely related to therapeutic outcome. Client satisfaction being a set of positive and/or negative feelings resulting from receiving mental health services (Berger, 1983). Measures of client satisfaction have been found to correlate with other measures of outcome. Some have found low to moderate correlations (Berger & Callister, 1981), while others report significant correlations (Edwards, Yarvis, Mueller & Langsley, 1978; Gomes-Schwartz, 1978; Greenfield, 1983; Larsen, Attkisson, Hargreaves & Nguyen, 1979; Willer & Miller, 1978). These findings indicate that the client's perception of outcome is associated with their satisfaction rating.

Therapist variables have been found to be important in predicting the client level of satisfaction (Doyle & Ware, 1977; Fisher, 1971). More specifically, Ware & Snyder (1975) found that therapist variables accounted for more variance than did any other set of variables.

There has been an increasing shift toward including the recipient's opinion when evaluating a human service program (Nguyen, Attkisson & Stegner, 1983) and a number of researchers argue for client satisfaction as an outcome instrument. It is important to take this perspective into account when evaluating a service, otherwise the evaluation will be incomplete and probably biased toward the provider's or evaluator's perspective. It has demonstrated that client and therapist seldom agree on the amount of progress made in therapy (e.g., Larsen et al., 1979; Strupp, Fox & Lesser, 1969).

Although it is important to assess client satisfaction of a service, this is not a substitute for other indicators of therapy outcome (Green, Gleser, Stone & Seifert, 1975). Other measures include: psychopathology change scores, and ratings from other perspectives (e.g., therapist and significant other).
Methodological Issues

When assessing client satisfaction a number of methodological issues must be considered.

The measurement of client satisfaction is based on four assumptions:
(a) individual clients are capable of evaluating their own feelings and making judgements about those feelings;
(b) clients can and are willing to accurately express judgement about their experiences;
(c) similar therapy given by the same therapist in the same therapeutic situation will elicit similar responses across several clients; and
(d) judgements about subjective experience have some correspondence with a system used to quantify these judgements (Berger, 1983).

There are serious fundamental problems in using client data for service evaluation. These include: (a) high reported rates of 'satisfaction'; (b) the lack of meaningful comparison bases; (c) the lack of a standardised scale; and (d) difficulties in obtaining an unbiased sample (Nguyen et al., 1983).

(1) The mental health literature is filled with studies that find high levels of reported satisfaction (e.g., Frank, 1974; Larsen et al., 1979). Also the therapist's positive contribution to therapy including the therapist's attitude toward the client has been found to have a powerful impact on the therapeutic relationship (Eaton et al., 1988). Linn (1975) reviewed studies of the patient evaluation of health care and concluded that level of satisfaction is very high regardless of the population sampled, the method used, or the object of rating. The high level of satisfaction rating can be interpreted in a number of ways. At one extreme, this finding may reflect the client's desire to be grateful for the service provided. On the other hand, the data may reflect the effectiveness of the service. The accurate interpretation would lie somewhere between these extreme views.
(2) The reported level of satisfaction in absolute terms is not meaningful in isolation from other data. This is linked to the lack of a standardised scale for measuring client satisfaction.

(3) When conducting research into client satisfaction, investigators tend either to invent their own measurement instruments or modify existing scales. These modifications, however, are made in a manner that leaves the user unsure as to whether the modified version measures the same construct as the original scale (i.e., the psychometric relationships between the two scales have not been established). Clearly it is unreasonable to make meaningful and valid comparisons of different programs or components of the same program, when the conditions of measurement differ with respect to the instruments used, data collection methods, or data analyses.

(4) It is commonly recognised that a large proportion of clients dropout of programs especially when services extend over a long time period. Biases in the data will be found depending upon the time of data collection. Positive bias (in favour of the program) will increase if data is collected a long time after the point of client entry and clients who have terminated are not surveyed. However, if data is collected close to the point of client entry in order to overcome the bias of dropouts, then the clients will not have undergone the complete program. Collection of data through mailed questionnaires after clients have terminated from the service also has problems. The return rate is usually very low, often below 35% (Larsen et al., 1979; Nguyen et al., 1983), and satisfied clients are more likely to return questionnaires than dissatisfied clients. Another option is to sample clients cross-sectionally (e.g., sample all clients who receive services during a two week period). This approach is often less expensive than others but again biases may arise from clients who drop out early or who miss appointments during the period of data collection.

It appears to be impossible to completely eliminate the biases fundamental to various sampling strategies. However, it is important to be aware of the possible biases and their consequences (Nguyen et al., 1983).
Correlates of Client Satisfaction

Client satisfaction has been found to correlate with a wide variety of variables. These include client characteristics, characteristics of therapy and others (e.g., presenting problem, anonymity of responders).

Client Characteristics

(1) Demographic variables
Mixed results have been found in regard to demographic variables and client satisfaction. Ware (1978) reviewed the literature and found: older persons tend to be more satisfied, less educated people tend to be less satisfied, persons in large families tend to be less satisfied, lower income persons tend to be less satisfied, no clear trend in regard to marital status, individuals in higher levels of occupation tend to report greater satisfaction, no clear trend in relation to race, females tend to more satisfied, and no clear trend in relation to social class.

Larsen et al.'s (1979) study found significant relationships between satisfaction and race (nonwhite clients less satisfied than white clients), sex (women tended to respond in extremes compared with men who responded in the middle ranges), and employment status (unemployed clients less satisfied than employed clients or those not in the job market). They also found no relationships between client satisfaction and years of education, family income, marital status, amount of service, age at admission, social class, or previous treatment at another facility.

In regard to race, others have found nonwhite males and those who drop out of therapy after a few sessions report lower levels of satisfaction (Berger & Callister, 1981; Larsen et al., 1979; Read, 1980, cited in Berger, 1983).

(2) Client expectation
Client expectation is a powerful variable in regard to client satisfaction (Greenberg, 1970; Greenfield, 1983; Karzmark et al., 1983). For example, Greenberg (1970) found that clients who were told that their therapist was warm and experienced evaluated therapy more favourably than did control groups.
(3) **Psychiatric symptoms**
A relationship between prior severity of client rated psychiatric symptoms and satisfaction has been found (LeVois, Nguyen & Attkisson, 1981; Attkisson & Zwick, 1982). Others have not found this relationship (Greenfield, 1983). More specifically, pre-post reduction of symptom levels have been found to be related to service satisfaction (Attkisson & Zwick, 1982; Larsen et al., 1979). LeVois et al. (1981) specifically found that the total symptom score accounted for 16% of the variance of client satisfaction.

**Characteristics of Therapy**

(1) **Remainer-terminator status** (Attkisson & Zwick, 1982; Larsen et al., 1979). Specifically, those still in treatment have been found to be more satisfied than those who had left treatment (Larsen et al., 1979). Planfulness of termination was also an important factor (Greenfield, 1983).

(2) **Length of time in therapy and number of sessions** (Attkisson & Zwick, 1982; Berger & Callister, 1981; Greenfield, 1983; McNeil, May & Lee, 1987). Specifically, Greenfield (1983) found satisfaction being lowest for a single session, then increasing reaching a maximum at 16 to 20 sessions, then fell slowly in the 21 to 98 session range and sharply to another low above 98 sessions.

(3) **Clients with previous experience** in the program were less satisfied (Larsen et al., 1979).

(4) **Clients paying partial fee** were more satisfied than those who paid either no fee or a full fee (Larsen et al., 1979).

**Others**

(1) **Anonymous versus identified responders**
Anonymity of reporting of results reduced the high ceiling effects present in reports of client satisfaction or evaluation (Miller, 1978; Soelling & Newell, 1984), with clients reporting fewer positive changes (Greenfield, 1983). McNeil, May & Lee (1987) found that subjects who responded anonymously saw their counsellors as significantly less
attractive and trustworthy, and also expressed less satisfaction with services than identified clients. Sorenson, Hammer & Windle (1976) (cited in Berger, 1983) point out that dissatisfied clients return fewer mailed surveys than satisfied clients.

(2) **Primary presenting issue**
Type of personal problem has been found to be related with client satisfaction (Greenfield, 1983; LeVois et al., 1981). Greenfield (1983) found those seeking help for personal problems expressed significantly more satisfaction than those presenting with academic or vocational issues. Specifically, clients with presenting problems of depression and anxiety less satisfied than those with other problems, in particular those presenting with self-concept and self-esteem being most satisfied.

Other Correlates of Outcome

In addition to the non-specific factors already examined, a wide variety of variables have been found to correlate with psychotherapy outcome. These include client variables, therapist variables, and others (e.g., length of time in treatment, likeness and similarity of therapist and client).

**Client Variables**

A number of client variables appear to be related to outcome. These include measures of the client's personality: overall capacity of personality (Luborsky et al., 1980); presence of affect (Luborsky et al., 1980); emotional freedom (Luborsky et al., 1980); dynamic pretreatment variables (such as ego defenses of reaction formation, undoing and rationalisation) (Buckley et al., 1984).

The client's level of symptomatology and adaptive functioning also appear to be related to therapeutic outcome including: pretreatment adjustment (Jones et al., 1988; Luborsky et al., 1980); motivation for treatment (Bergin & Lambert, 1978; Luborsky, Chandler, Auerbach, Cohen & Bachrach, 1971; Staples, Sloane, Whipple, Cristol & Yorkston, 1976); interpersonal relationships (Lambert, 1983; Moras & Strupp,
clients with increased levels of Anxiety improved the most (Luborsky et al., 1980; Conte, Plutchik, Picard, Karasy & Vaccaro, 1988) and increased levels of Histrionic, Paranoid, and Obsessive-Compulsive Personality Scales improved least following therapy (Conte et al., 1988).

In addition, client demographic variables have been found to be related to outcome. These include: client wealth and social assets (Luborsky et al., 1980), age and education level (Horowitz et al., 1984).

**Therapist Variables**

Therapist variables have also been found to be related to outcome. Findings on the relationship between therapists' level of experience and outcome seem to vary. Some have found a positive relationship (Auerbach & Johnson, 1977; Bergin, 1971; Lerner, 1972; Scher, 1975; Slipp & Kressel, 1978; Stein & Lambert, 1984), others have found no relationship evident (Epperson, 1981; Krauskopf, Baumgardner, & Mandracchia, 1981; Smith & Glass, 1977), and one study actually found an inverse relationship between experience and outcome (Durlack, 1979).

Some have suggested that the relationship between experience and outcome seems more evident when therapist groups are quite distinct on the dimension of experience and where techniques other than non-specific counselling or specific behavioural techniques are the focus (Stein & Lambert, 1984; Reder & Tyson, 1980).

**Others**

Other variables in addition to those related to therapist and client have been found to influence therapeutic outcome. Length of treatment is one such variable. That is, the longer the treatment the more favourable the outcome (Gomes-Schwartz, 1978; Luborsky et al., 1980).

Similarities in client-therapist values have been found to aid collaborative relationships early in treatment (Luborsky, Woody, McLellan, O'Brien & Rosenzweig, 1982). More specifically, it has been
suggested that therapeutic gain is aided by both initial similarity of client-therapist values of social ascendance and social background, and dissimilarity on values of interpersonal attachment and commitment (Arizmendi, Beutler, Shanfield, Crago & Hagaman, 1985).

Extensive research exists on therapist-patient similarity. Positive outcome has been found to be positively associated with similarity on a number of variables including: social class, personality traits (e.g., dominance, social participation), interests, values, and compatibility or orientation to interpersonal relations (cited in Hollander-Goldstein et al., 1989). Favourable therapeutic outcome has also been found with therapist-patient dissimilarity in self-abasement, dominance, aggression, original thinking and exhibitionism (Heller, Myers & Kline, 1963; Snyder & Snyder, 1961). Others have found a curvilinear relationship between outcome and similarity of personality types (Mendelson & Geller, 1965).

Outcome has also been found to correlate significantly with patient-therapist liking. Some studies have found patient liking of therapist important (Bent, Putman & Kiesler, 1976) and others therapist liking of patient (Brown, 1970; Sloane et al., 1975). It has been suggested that liking is a reciprocal experience in the therapist-patient relationship (Heller et al., 1963). Goldstein & Simonson (1971) found that patients highly attracted to their therapists were rated significantly more attractive by their therapists than patients indicating low attraction. The greater this attraction between patient and therapist, the more positive was their approach to therapy.

Alternative Explanations

Some researchers in the area feel that dichotomising therapy into "specific" and "non-specific" factors is unwarranted and unproductive.

Some believe that the delineation is arbitrary because what may be regarded as "specific" by followers of one school of psychotherapy may be classed as "non-specific" by followers of another school and all forms of psychotherapy contain both components to varying degrees. For example, the psychodynamic therapist would view some of the
procedures of the behaviour therapist as placebos; the behaviour therapist may see non-behavioural therapies (particularly client-centred therapy) as placebo controls. "The validity of labeling certain interventions as specific and others as non-specific remains questionable because the practice appears to depend more on sheer conformity to theory than on inferences drawn from empirical evidence of differential therapeutic effects" (p.83) (Parloff, 1986b). Others suggest that drawing a priori lines around specific therapist behaviours by referring to these behaviours as techniques may be premature, arbitrary, and ultimately meaningless in many instances (Butler & Strupp, 1986).

One reason suggested for the inability to find consistent and strong correlations between aspects of process and treatment outcomes is that typically studies try to identify simple, direct associations without reference to the complex interaction of the multiple variables that make up psychotherapy (Jones et al., 1988).

For example, Butler & Strupp (1986) believe that therapy is made up of 'factors' dependent on a particular interpersonal context.

Given these factors it may be more relevant to ask different questions and use different methods than the traditional specific/non-specific hypothesis.

There is a long history to the debate about the relative importance of specific and non-specific factors in therapy, and this debate will inevitably continue. The present study examines the relationships between therapeutic outcome (rated by both therapist and client) and a wide variety of predictor variables. These include: non-specific factors, the client's level of functioning, client personality, characteristics of therapy and demographic variables. The relationship that client satisfaction has to the above variables will also be examined.
Summary of Hypotheses

1. Non-specific factors will have a positive relationship with outcome (both client and therapist) and client satisfaction. Specifically:
   (a) The greater the level of therapist congruence the better the outcome and the higher the level of client satisfaction;
   (b) The greater the level of therapist empathy the better the outcome and the higher the level of client satisfaction;
   (c) The greater the level of therapist regard the better the outcome and the higher the level of client satisfaction; and
   (d) The greater the level of therapist unconditionality the better the outcome and the higher the level of client satisfaction.
2. There will be a positive relationship between client and therapist ratings of outcome.
3. A significant positive relationship will exist between the two outcome measures (i.e., client and therapist outcome) and client satisfaction.
4. The level of client functioning will be positively associated with outcome and client satisfaction.
5. The greater the client's level of the personality attribute social desirability, the better the rating of outcome and client satisfaction.
6. The literature suggests that associations will be exist between client demographic characteristics and client satisfaction. Specifically, this study will test Ware's (1978) findings:
   (a) Sex - females report greater levels of satisfaction than males;
   (b) Age - older people report higher levels of satisfaction; and
   (c) Education level - less educated tend to report lower levels of satisfaction.
7. Relationships from the literature suggest that characteristics of therapy will be related to outcome. Specifically, the longer the treatment period, the more favourable the outcome (Gomes-Schwartz, 1978; Luborsky et al., 1980).
8. Relationships from the literature also suggest that characteristics of therapy will be related to client satisfaction. Specifically, the greater the number of treatment sessions, the higher
the reported level of client satisfaction (Attkisson & Zwick, 1982; Berger & Callister, 1981; Greenfield, 1983; McNeil et al., 1987).
CHAPTER 2
Method

Subjects

A total of 317 successive subjects were selected from all clients who had completed therapy between the period of January 1989 and June 1990, at a counselling unit attached to a tertiary education institution. The unit serves staff, and both current and perspective students, with a wide range of problems. Presenting problems include: depression, anxiety disorders, stress management, bereavement, self-esteem, relationship issues, habit disorders, psychiatric disorders, career/vocational issues, study and welfare related issues. Subjects were excluded from the present study if they: (a) were psychotic; (b) had an incomplete contact address; or (c) the contact address was for temporary accommodation.

Twenty-eight of the 317 questionnaires were “returned to sender”. In total seventy-six (26 per cent) clients responded to the questionnaire. Of these eight were excluded from the analysis: two psychotic clients, and six due to incomplete data. This left 69 completed questionnaires.

The clients participating in the present study consisted of 18 men and 51 women. Their mean age was 32 years (range: 16 - 61; SD = 10.8). 44% were single, 39% married or defacto, and 17% were either divorced, widowed, or separated. The mean number of therapy sessions attended was 4 (range: 1 - 27; SD = 5.5). The main presenting problems included: 54% personal issues (most commonly: stress management, depression, self-esteem, parenting and marital problems), 21% career related issues, 15% study/educational issues, and 10% not specified.

Therapists

Five psychologists (all female) provided therapy to the clients in this study. The therapists ranged in experience from 10 to 13 years, with a median of 11.5 years. Preferred theoretical orientations varied: one
Cognitive-Behavioural, two Eclectic (one based on Feminist therapy principles), one a combination of Client Centered and Cognitive-behavioural, and one both Eclectic and Client Centered. The different theoretical schools adhered to by the therapists is not expected to be problematic given that all therapy contains both specific and non-specific factors to varying degrees. Some believe that specific techniques and theories are relatively unimportant except as vehicles for establishing a collaborative relationship between client and therapist (Stiles et al., 1986). Further support comes from Fiedler (1951) (cited in Stiles et al., 1986) who found that clients and therapists from different orientations rated ideal therapy similarly in relation to global aspects (such as overall quality of the therapeutic relationship and warmth).

The psychologists were unaware at the time of therapy that the client’s records would serve as a basis for a retrospective research study.

**Measures**

The questionnaire consisted of a number of different measures that had been identified in the literature as being related to and/or influencing measures of therapeutic outcome. These included: demographic variables (e.g., sex, age, education level), measures of outcome (by client and therapist), client satisfaction, social desirability response style, non-specific factors (i.e., Congruence, Empathy, Regard and Unconditionality), and client level of functioning (i.e., Life Adjustment Rating, Overall Life Satisfaction and the General Health Questionnaire). Table 1 contains a list of the measures. The questionnaire appears in Appendix 1.
Table 1

Client Measures
Target complaints (Battle, Imber, Hoehn-Saric, Stone, Nash & Frank, 1966)
Life Adjustment Rating (Koss, Graham, Kirkhart, Post, Kirkhart, & Silverberg, 1983)
General Health Questionnaire (12 item version) (Goldberg, 1972)
Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1964)
Client Satisfaction Questionnaire (LeVois, Nguyen & Attkisson, 1981)
Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960)

Therapist Measures
Therapeutic outcome

Outcome
Outcome was measured from both the client's and therapist's perspectives. Clients identified up to three specific target complaints for which they had sought counselling. The amount of change for each complaint was rated on a 5-point scale, ranging from "much worse" (-2) to "much better" (+2). A mean client outcome score was then calculated.

Therapist measures of outcome were identical to those of the clients'. That is, therapists rated each complaint specified by the client on the same 5-point scale and again a mean outcome score was computed.

Similar outcome measures have been used by others (e.g., Battle et al., 1966; Lerner, 1972; Sloane et al., 1975).

Non-Specific Factors
Non-specific factors were assessed by the client's responses to the Barrett-Lennard Relationship Inventory (BLRI). The major source of theory for this instrument was Carl Rogers' (1957) conception of the necessary conditions of therapy (Barrett-Lennard, 1986). The scale consists of 64-items and four broad dimensions are defined: Regard, Empathy, Unconditionality, and Congruence. In responding to this instrument clients are asked to rate each item from -3 (strongly felt disagreement) to +3 (strongly felt agreement). This scale is the most frequently used instrument to assess the patient's perception of the therapeutic relationship (Cramer, 1986; Marziali, 1984) and has been used in over 100 studies (Jarski, Gjerde, Bratton, Brown & Matthes, 1985).
Its reliability and validity have been well established in the literature. In general, internal consistency reliabilities and test-retest stabilities have been adequate across a number of studies (Ponterotto & Furlong, 1985). For example, Gurman (1977) reviewed studies that had examined the psychometric properties of the BLRI and found the means of internal reliability coefficients for Regard to be .91, Empathy .84, Unconditionality .74, and Congruence .88. Test-retest reliability over varying periods of 2 weeks to 12 month intervals were .83 for Regard, .83 for Empathy, .80 for Unconditionality, and .85 for Congruence. The scale has been validated on a variety of populations (Barrett-Lennard, 1986; Gurman, 1977; Jarski et al., 1985), more frequently in actual counselling situations than in analogue counselling situations (Ponterotto & Furlong, 1985).

Client Satisfaction
Client satisfaction was measured by the Client Satisfaction Questionnaire (18-B) (CSQ). Procedures used to develop this instrument are described by LeVois et al. (1981) and Larsen et al. (1979). It consists of 18 Likert-type items with four response choices, where 1 indicates the lowest level of satisfaction and 4 the highest. This instrument includes a wide variety of aspects of satisfaction (i.e., physical surroundings, accessibility, professional skillfulness, therapist-client interactions, expectations). This is important as these may differentially affect the client's overall satisfaction with the service (Larsen et al., 1979).

Reliability of the scale is high. Studies have found internal consistency reliability to be between .83 and .91, and median item-total correlations between .41 and .64 (Attkisson & Zwick, 1982; Pascoe, Attkisson, Clifford & Roberts, 1983; Roberts, Pascoe & Attkisson, 1983). Validity of the scale appears acceptable as significant correlations have been found between CSQ (18-B) and measures of remainder-terminator status, number of therapy sessions attended, change in client reported symptoms (Attkisson & Zwick, 1982).
Level Of Functioning
The client's present level of functioning was measured by several different scales: Life Adjustment Rating, Overall Life Satisfaction, and the General Health Questionnaire (GHQ).

Life Adjustment Rating included 8 areas of functioning: work, social life, sexual life, relationship with spouse, relationship with children, self-concept, physical complaints, and overall symptomatology. Each area of functioning was rated on a 5-point Likert scale (1 = extremely poor; 2 = poor; 3 = neutral; 4 = good; 5 = extremely good). This measure has previously been used by others (Koss et al., 1983).

The measure of Overall Life Satisfaction developed by Andrews and Withey (1976) was used to assess global well-being. The question "How do you feel about your life as a whole?" is scored on a seven-point scale (1 = terrible; 2 = unhappy; 3 = mostly satisfied; 4 = mixed; 5 = mostly satisfied; 6 = pleased; 7 = delighted).

The General Health Questionnaire (12 item version) was used to obtain a measure of psychological symptoms. The scale is made up of six negatively and six positively worded items. Subjects indicate whether they had recently experienced a particular symptom on a four point scale (0 = not at all; 1 = same as usual; 2 = rather more than usual; 3 = much more than usual). Few studies have been conducted on the psychometric properties for this shortened version of the GHQ. However, it appears to be psychometrically reliable (Goldberg, 1978) and valid (Bandyopadhyay, Sinha, Sen & Sen, 1988; Goldberg, 1978; Mari & Williams, 1985; Tennant, 1977).

Social Desirability
The Marlowe-Crowne Social Desirability Scale (M-C SDS) was used to assess the client's social desirability response style. This scale is one of the most commonly used measures of social desirability (Reynolds, 1982). It consists of 33 items, each rated either true or false.

A number of studies have found this measure to have good reliability. Internal consistency of the scale has been found to range from .70 to .88 (Crino, Svoboda, Rubenfeld & White, 1983; Crowne & Marlowe, 1960;
O'Grady, 1988), and test-retest reliability coefficients range from .86 to .89 (Crino et al., 1983; Crowne & Marlowe, 1960). The validity of the scale also seems acceptable (Reynolds, 1982; Shulman & Silverman, 1974).

Demographic Variables
Additional client information obtained included sex, age, marital status, number of children, nationality, and education level. Information about the client's parents was sought such as, nationality, occupation, and education level. Additional information in relation to therapy was also obtained including previous counselling experience, referral source, number of sessions, date of last session, and reason for termination.

Procedure

A total of 317 subjects were sent a questionnaire, freepost return envelope, raffle ticket, and a covering letter explaining the research and requesting participation (See appendix 2). It was made clear that the completed questionnaire was confidential and would not be seen by the therapist. A follow-up letter was sent two weeks after the initial mailing (See appendix 3).

The therapists were also required to complete a brief questionnaire, indicating their opinion of the outcome of therapy for each target complaint identified by the client.

The response rate of 26% is not atypical. Response rates to mailed questionnaires, including a second mailed reminder, generally range from 30-50%. However, it is not uncommon to report client satisfaction rates as low as 15-20% (Berger, 1983). Despite this drawback with mailed questionnaires, Warner (1981) (cited in Berger, 1983) concluded that for the return on the investment of time, effort, and expense, mailed questionnaires were by far the most efficient technique for assessing client satisfaction.

In an attempt to increase the response rate an incentive measure was incorporated into the research design. Research has shown that the use
of cash and non cash rewards increases the response rate in mailed surveys. Kanuk and Berenson (1975) reported improvements varying from 1.3 to 4.7 times the rate without the incentive.

The incentive method used was the use of a lottery. For completing and returning the questionnaire clients were given the opportunity to participate in a draw, the prize was $50.00 cash. There appears to be some evidence to support this as a method for increasing response rates and Blythe (1986) concluded that researchers should be encouraged to try the lottery incentive technique in mailed questionnaire studies.

Review of the client records of both responders and nonresponders revealed no significant differences between the groups, in terms of sex and age distributions.

The returned questionnaires were double keyed to ensure accuracy of the data. SPSS/PC+ (V3.1) (SPSS, 1989) was used for data management. The statistical analyses used included: correlations (Norusis & SPSS, 1988a), discriminant analysis (Norusis & SPSS, 1988b), regression (Norusis & SPSS, 1988a), and reliability (Norusis & SPSS, 1988b).
CHAPTER 4
Results
Reliability Of Scales

A majority of the measures used (i.e., Barrett-Lennard Relationship Inventory (B-LRI), Client Satisfaction Questionnaire (CSQ), General Health Questionnaire (GHQ), Marlowe-Crowne Social Desirability Scale (M-C SDS)) had the question responses balanced so that some run from high to low and others from low to high. The balancing is designed to reduce acquiescent response set (Ware, 1978; see Roberts et al. 1983), which can inflate estimates of reliability. Scale reliabilities were estimated by Chronbach's (1951) alpha, and are shown in Table 2. This measure of reliability depends on scale length and average inter-item correlations.

Table 2
Scale Reliabilities

<table>
<thead>
<tr>
<th>Non-specific factors</th>
<th>N</th>
<th>Coefficient alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congruence</td>
<td>52</td>
<td>.80</td>
</tr>
<tr>
<td>Empathy</td>
<td>56</td>
<td>.81</td>
</tr>
<tr>
<td>Regard</td>
<td>58</td>
<td>.86</td>
</tr>
<tr>
<td>Unconditionality</td>
<td>52</td>
<td>.60</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of functioning</th>
<th>N</th>
<th>Coefficient alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Adjustment Rating</td>
<td>24</td>
<td>.82</td>
</tr>
<tr>
<td>General Health Q</td>
<td>65</td>
<td>.90</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social desirability</th>
<th>N</th>
<th>Coefficient alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marlowe-Crowne SDS</td>
<td>50</td>
<td>.84</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level of satisfaction</th>
<th>N</th>
<th>Coefficient alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Satisfaction Q</td>
<td>60</td>
<td>.93</td>
</tr>
</tbody>
</table>

a Items "spouse" and "children" were removed from scale due to large amounts of missing data, n increased to 51
The major hypotheses of the study were tested by examining the correlations of the dependent variables (client outcome, therapist outcome, and client satisfaction) with measures of: non-specific factors, characteristics of therapy, client level of functioning, social desirability response set, and demographic variables. The presentation of the results is divided into two sections: therapeutic outcome and client satisfaction.

Table 3 reports the relationships between measures of: non-specific factors, characteristics of therapy, client level of functioning, social desirability, demographic variables, and the dependent variables.
Table 3
Correlations with outcome measures

<table>
<thead>
<tr>
<th>Non-specific factors</th>
<th>Client Satisfaction</th>
<th>Client Outcome</th>
<th>Therapist Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regard</td>
<td>.64***</td>
<td>.53***</td>
<td>.40***</td>
</tr>
<tr>
<td>Empathy</td>
<td>.76***</td>
<td>.53***</td>
<td>.26</td>
</tr>
<tr>
<td>Unconditionality</td>
<td>.44***</td>
<td>.28*</td>
<td>.21</td>
</tr>
<tr>
<td>Congruence</td>
<td>.68***</td>
<td>.46***</td>
<td>.27</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Characteristics of therapy</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Number of sessions</td>
<td>.28*</td>
<td>.01</td>
<td>.08</td>
</tr>
<tr>
<td>Time since last session</td>
<td>.26*</td>
<td>.07</td>
<td>-.04</td>
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<table>
<thead>
<tr>
<th>Level of functioning</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Life Satisfaction</td>
<td>.17</td>
<td>.33*</td>
<td>.12</td>
</tr>
<tr>
<td>Life Adjustment Rating</td>
<td>.20</td>
<td>.29</td>
<td>.25</td>
</tr>
<tr>
<td>General Health Q</td>
<td>-.23</td>
<td>-.31*</td>
<td>-.13</td>
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</table>

<table>
<thead>
<tr>
<th>Social desirability</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Marlowe-Crowne SDS</td>
<td>.18</td>
<td>.24</td>
<td>-.02</td>
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<table>
<thead>
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<th>Demographic variables</th>
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<tr>
<td>Age</td>
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<td>.21</td>
<td>.18</td>
</tr>
<tr>
<td>Education level</td>
<td>.04</td>
<td>.08</td>
<td>-.05</td>
</tr>
</tbody>
</table>

* p < .05.
** p < .01.
*** p < .001.

Client satisfaction was significantly related to all four non-specific factors, the characteristics of therapy and age of the client.

Client outcome correlated significantly with all non-specific factors, Overall Life Feeling and GHQ score.

Therapist rated outcome was significantly related only to the non-specific factor Regard.

Variables found to be significant in the correlation analyses mentioned above were entered into a stepwise regression\(^1\) to assess their independent contributions to the dependent variables. The results of these analyses are shown in Table 4.

---

\(^1\) The F-to-enter and F-to-remove were set to give probabilities of 0.05 and 0.10, respectively (Norusis & SPSS, 1988a, p. C-132)
Table 4
Regression analyses

<table>
<thead>
<tr>
<th></th>
<th>Client Satisfaction</th>
<th>Client Outcome</th>
<th>Therapist Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>r</td>
<td>Beta</td>
<td>r</td>
</tr>
<tr>
<td><strong>Non-specific factors</strong></td>
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<tr>
<td>Regard</td>
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<td>Empathy</td>
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<td>.62***</td>
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<td>Unconditionality</td>
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<td>.24</td>
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<tr>
<td>Congruence</td>
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</tr>
<tr>
<td><strong>Characteristics of therapy</strong></td>
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<td></td>
</tr>
<tr>
<td>Number of sessions</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Time since last session</td>
<td>.26</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Level of functioning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Life Satisfaction</td>
<td>.31</td>
<td>.22*</td>
<td></td>
</tr>
<tr>
<td>General Health Q</td>
<td>-.28</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Client outcome</td>
<td>.40</td>
<td>.27**</td>
<td>.25</td>
</tr>
<tr>
<td>Therapist outcome</td>
<td>.24</td>
<td>.25</td>
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<tr>
<td>Client satisfaction</td>
<td>.57</td>
<td>.53***</td>
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<td>Multiple R</td>
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<tr>
<td>Adjusted R2</td>
<td>.63</td>
<td>.35</td>
<td>.11</td>
</tr>
</tbody>
</table>

* p < .05.
** p < .01.
*** p < .001.

Note. Some correlation coefficients differ from those in Table 3, these coefficients are based on only those subjects with complete data.
The major variables that contributed to client satisfaction were the non-specific factor Empathy and client outcome. The other non-specific factors, the characteristics of therapy, therapist rated outcome and age of the client did not have independent contributions to the variance in client satisfaction, once the effects of Empathy and client outcome were discounted.

Client outcome was predicted by Overall Life Feeling and client satisfaction. The non-specific factors, the GHQ score, and therapist outcome had no independent effects.

Therapist outcome was predicted by client satisfaction. The non-specific factor Regard had no independent effect.

Intercorrelations among the measurement scales was examined to allow appropriate interpretation of their relations to the dependent variables. These correlations are presented in Table 5.
<table>
<thead>
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<td>.35*</td>
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<td>.40*</td>
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<td>-.23</td>
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<tr>
<td>6</td>
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<td>.40*</td>
<td>.64**</td>
<td>-.19</td>
<td>.14</td>
<td>.80**</td>
<td></td>
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<td>7</td>
<td>.53**</td>
<td>.26</td>
<td>.76**</td>
<td>-.25*</td>
<td>.04</td>
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<td>.80**</td>
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<td></td>
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</tr>
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<td>8</td>
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<td>.21</td>
<td>.44**</td>
<td>-.10</td>
<td>.01</td>
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<tr>
<td>9</td>
<td>.46**</td>
<td>.27</td>
<td>.68**</td>
<td>-.14</td>
<td>.05</td>
<td>.78**</td>
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<td>-.54**</td>
<td>.43*</td>
<td>.16</td>
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<td>-.02</td>
<td>.15</td>
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<tr>
<td>11</td>
<td>.33*</td>
<td>.12</td>
<td>.17</td>
<td>-.59**</td>
<td>.23</td>
<td>.13</td>
<td>.17</td>
<td>.04</td>
<td>.01</td>
<td>.70**</td>
<td></td>
</tr>
</tbody>
</table>

* $p < 0.05$

** $p < 0.01$
High levels of client outcome were associated with high therapist rated outcome, high reported client satisfaction, low GHQ pathology scores, high levels on all four non-specific factors, and high Overall Life Feeling.

Therapist outcome ratings were related to high client outcome, high client satisfaction and high levels of the non-specific factor Regard.

High reported client satisfaction was associated with both high client and therapist outcomes, and high levels of all four non-specific factors.

Low levels of GHQ pathology were related to high levels of: client rated outcome, Empathy, life adjustment and Overall Life Feeling.

High social desirability was associated with high levels of reported life adjustment.

The non-specific factor Regard was related to high levels of: client and therapist outcome, client satisfaction, and the other non-specific factors (i.e., Empathy, Unconditionality, and Congruence).

High levels of Empathy were associated with high levels of: client outcome, client satisfaction, the other three non-specific factors (Regard, Unconditionality, and Congruence), and low levels of GHQ pathology.

Unconditionality was significantly related to high client outcome, client satisfaction, and the other non-specific factors.

High levels of Congruence were related to high levels of: client outcome, client satisfaction, and the other three non-specific factors.

Low life adjustment was associated with high levels of GHQ pathology and low levels of social desirability and Overall Life Feeling.

High Overall Life Feeling was related to high: client outcome and life adjustment, and low GHQ pathology.
Therapeutic Outcome

Client
Table 3 and Table 5 illustrate the variables that correlated with client outcome. The significant variables included: all 4 of the non-specific factors, Overall Life Feeling, GHQ score, client satisfaction and therapist outcome.

The variables which were significantly related to client outcome in the correlation analyses were entered into a stepwise regression analysis to assess their independent contributions to client outcome. The results are summarised in Table 4, which indicates that client satisfaction and overall life feeling were the strongest predictors of client outcome.

To determine which variables separated clients with good from those with bad outcome (as rated by the client), a stepwise discriminant function analysis was used. Using the variable that minimises the overall Wilk's lambda as the criterion for item entry into stepwise selection, a 6-variable function was derived that was statistically significant for the sample [Wilks lambda = 0.53, Chi-squared (6) = 28.5, p < .0001], and had a canonical correlation of 0.68. The probability of correct classification by using the discriminant function was 0.90 and the function accounted for about 47% of the variance. The standardised coefficients of the items in the function are reported in Table 6. The coefficients reflect the relative contribution of the individual variable to the discriminatory power of the total function. The univariate F values reflect the discriminatory power of the variable when examined alone, instead of in combination with the other variables in the discriminant function.
Table 6
Items and standard discriminant function coefficients for client outcome (split at median) (n=50)

<table>
<thead>
<tr>
<th>Items included</th>
<th>Coefficient</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-specific factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congruence</td>
<td>.35</td>
<td>3.16</td>
</tr>
<tr>
<td>Unconditionality</td>
<td>-1.00</td>
<td>.27</td>
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<tr>
<td>Level of functioning</td>
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<td></td>
</tr>
<tr>
<td>General Health Q</td>
<td>-.45</td>
<td>9.03**</td>
</tr>
<tr>
<td>Outcome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Satisfaction Q</td>
<td>.70</td>
<td>14.66***</td>
</tr>
<tr>
<td>Social Desirability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marlowe-Crowne SDS</td>
<td>.28</td>
<td>4.80*</td>
</tr>
<tr>
<td>Demographic variables</td>
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<td></td>
</tr>
<tr>
<td>Age</td>
<td>.42</td>
<td>2.74</td>
</tr>
</tbody>
</table>

* p < .05.
** p < .01.
*** p < .001.

The univariate F ratio is a test of the discriminatory power of each variable taken individually; df=1,36.

As Table 6 indicates the strongest loadings on the function were: Unconditionality, Congruence, GHQ, client satisfaction, M-C SDS and age. However, when the variables were considered separately (the univariate F values) Congruence, Unconditionality and age were not statistically significant.
Therapist

The variables that correlated with therapist rated outcome are summarised in Table 3 and Table 5. As can be seen the only variables with significant correlations were the non-specific factor Regard, client satisfaction and client outcome.

When these three variables were entered into a stepwise regression to assess their independent contributions to therapist outcome, the results indicate that client satisfaction was the strongest predictor of therapist outcome (See Table 4).

In order to determine which variables separated clients with good from clients with bad outcome (as rated by the therapist), a stepwise discriminant function analysis was employed. Using the variable that minimises the overall Wilk's lambda as the criterion for item entry into stepwise selection, a 5-variable function was derived that was statistically significant for the sample [Wilks lambda = 0.74, Chi-squared (5) = 13.8, p < .017], and had a canonical correlation of 0.51. The probability of correct classification by using the discriminant function was 0.72 and the function accounted for about 26% of the variance. Table 7 contains the standardised coefficients of the items in the function.
Table 7
Items and standard discriminant function coefficients for therapist outcome (split at median) (n=50)

<table>
<thead>
<tr>
<th>Items included</th>
<th>Coefficient</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics of therapy</td>
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<tr>
<td>Number of sessions</td>
<td>.67</td>
<td>2.69</td>
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<td>Level of functioning</td>
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<tr>
<td>Overall Life Satisfaction</td>
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<td>1.56</td>
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<td>Social Desirability</td>
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<td>Marlowe-Crowne SDS</td>
<td>.45</td>
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<td>Age</td>
<td>.72</td>
<td>3.82</td>
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<tr>
<td>Education level</td>
<td>.47</td>
<td>.39</td>
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</tbody>
</table>

* p < .05.
** p < .01.
*** p < .001.

The univariate F ratio is a test of the discriminatory power of each variable taken individually; df=1,36.

As Table 7 indicates all of the variables entered had strong loadings on the function. These were: number of therapy sessions, Overall Life Feeling, M-C SDS, age and education level. However, when the variables were considered separately (the univariate F values) none were statistically significant.

Specific hypotheses:
(1) Non-specific factors and outcome
Hypothesis 1 states that the greater the level of the non-specific factors (i.e., Congruence, Empathy, Regard, Unconditionality) the better the level of outcome (rated by both client and therapist).

Results indicate that this hypothesis is fully supported for client outcome, but only partially for therapist outcome. Table 3 shows that all of the non-specific factors are highly correlated with client outcome, and therapist outcome correlated significantly with Regard only. However, when assessing their independent contribution to the measures of outcome in combination with other variables (Table 4),

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2 Note that hypotheses 3, 6 and 8 do not relate to therapeutic outcome and are discussed in Client Satisfaction section.
none are significant. The discriminant function analysis (Table 6) indicates that Congruence and Unconditionality differentiate those clients who report good from those who report bad outcome. Non-specific factors, however, did not differentiate between good and bad outcome as rated by therapists (Table 7).

(2) Relationship between measures of client and therapist outcome
Hypothesis 2 predicts a positive relationship between client and therapist ratings of outcome.

Evidence supports this hypothesis. Although a significant correlation of 0.35 was found between the two measures of outcome (See Table 5), they were not assessing the same construct as different variables were found to predict each outcome measure (See Table 4, Table 6 and Table 7). For further explanation see Client Satisfaction section (Hypothesis 3).

(4) Level of client functioning and outcome
Hypothesis 4 indicates that the level of client functioning will be positively associated with measures of outcome.

This hypothesis was supported for client outcome. Significant correlations were found between client level of functioning variables and client outcome (Table 3). One of these variables (Overall Life Feeling) contributed significantly to predict client outcome (Table 4). When distinguishing between clients with good and bad levels of client rated outcome the GHQ score was significant (Table 6).

The relationships between therapist rated outcome and level of client functioning were much weaker. The only significant relationship evident was that Overall Life Feeling discriminated between good and bad outcome as rated by the therapist (Table 7).

(5) Social desirability and outcome
Hypothesis 5 states that the greater the level of the attribute social desirability the better the rating of outcome.
Overall the results did not support this hypothesis. The variable social desirability, however, did distinguish between clients who reported good from those who reported bad levels of outcome (for both client and therapist ratings) (See Table 6 and Table 7).

(7) Relationships between characteristics of therapy and outcome
Hypothesis 7 states that the longer the treatment period the more favourable the reported outcome.

Generally the results did not support this hypothesis. However, number of sessions was found to distinguish between groups with good and bad outcome as rated by the therapist (Table 7).
Client Satisfaction

Table 3 and Table 5 contain the correlations between predictor variables and client satisfaction. The significant variables included: the four non-specific factors, characteristics of therapy, age of the client, and client and therapist outcome.

The variables which were significantly related to client satisfaction were entered into a stepwise regression analysis to assess their independent contributions to client satisfaction. The results are summarised in Table 4, indicating that the non-specific factor Empathy and client outcome were the strongest predictors of client satisfaction.

To determine which variables separated those with high from those with low reported client satisfaction, a stepwise discriminant function analysis was used. Using the variable that minimises the overall Wilk's lambda as the criterion for item entry into stepwise selection, a 9-variable function was derived that was statistically significant for the sample [Wilks lambda = 0.22, Chi-squared (9) = 47.7, p < .00001], and had a canonical correlation of 0.88. The probability of correct classification by using the discriminant function was 0.93 and the function accounted for about 88% of the variance. The standardised coefficients of the items in the function are reported in Table 8.
Table 8
Items and standard discriminant function coefficients for client satisfaction (split at median) (n=38)

<table>
<thead>
<tr>
<th>Items included</th>
<th>Coefficient</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-specific factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empathy</td>
<td>1.43</td>
<td>34.99***</td>
</tr>
<tr>
<td>Regard</td>
<td>-1.09</td>
<td>10.57***</td>
</tr>
<tr>
<td><strong>Characteristics of therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of sessions</td>
<td>.42</td>
<td>3.57</td>
</tr>
<tr>
<td><strong>Level of functioning</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Life Satisfaction</td>
<td>.86</td>
<td>14.50***</td>
</tr>
<tr>
<td>General Health Q</td>
<td>.54</td>
<td>1.96</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist outcome</td>
<td>.51</td>
<td>3.30</td>
</tr>
<tr>
<td><strong>Social Desirability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marlowe-Crowne SDS</td>
<td>.57</td>
<td>3.20</td>
</tr>
<tr>
<td><strong>Demographic variables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>.33</td>
<td>5.10*</td>
</tr>
<tr>
<td>Education level</td>
<td>.37</td>
<td>1.20</td>
</tr>
</tbody>
</table>

* p < .05.  
** p < .01.  
*** p < .001.

The univariate F ratio is a test of the discriminatory power of each variable taken individually; df=1,36.

As indicated in Table 8 all of the variables entered had strong loadings on the function. However, when the variables were considered separately (the univariate F values) only Empathy, Regard, Overall Life Feeling and age were statistically significant.
**Specific hypotheses**: 

1. **Non-specific factors and client satisfaction**
   Hypothesis 1 states that the greater the level of the non-specific factors (i.e., Congruence, Empathy, Regard, Unconditionality) the greater the level of client satisfaction.

The results support this hypothesis. High significant correlations were evident between client satisfaction and all four of the non-specific variables (Table 3). When assessing each variable's independent contribution to client satisfaction only the variable Empathy was significant (Table 4). The variables Empathy and Regard were found to distinguish between high and low groups of reported client satisfaction (Table 8).

3. **Relationship between measures of outcome (both client and therapist) and client satisfaction**
   Hypothesis 3 suggests that a significant positive relationship will exist between all three dependent measures.

The results support this hypothesis. All three dependent variables were significantly intercorrelated (Table 5). The regression analyses (Table 4) illustrate that when assessing the determinants of client satisfaction client outcome is significant; client satisfaction was significant when assessing both client and therapist outcome. Discriminant function analyses indicated that when distinguishing between high and low client satisfaction groups, therapist outcome was found to be significant (Table 8); level of client satisfaction was found to distinguish between good and bad client outcome groups (Table 6). These results indicate that the three measures are interrelated.

---

3 Note that hypotheses 2 and 7 do not relate to client satisfaction, and have been discussed in the Therapeutic Outcome section.
(4) *Level of client functioning and client satisfaction*
Hypothesis 4 suggests that the level of client functioning will be positively associated with measures of client satisfaction.

Generally this hypothesis was not supported. The only statistically significant relationship evident was in distinguishing between groups with high and low client satisfaction, where both Overall Life Feeling and GHQ score were significant (Table 8).

(5) *Social desirability and client satisfaction*
This hypothesis states that the greater the level of the attribute social desirability the higher the rating of client satisfaction.

This hypothesis was not generally supported. The only statistically significant evidence was in distinguishing between groups of clients who reported high and low levels of client satisfaction where M-C SDS significantly separated the groups (Table 8).

(6) *Relationships between demographic variables and client satisfaction*
This hypothesis states that several client demographic variables will be related to client satisfaction. Specifically: females will report greater levels of satisfaction than males, older people will report higher levels of satisfaction, and less educated clients will report lower levels of satisfaction.

This hypothesis was not supported. One-way ANOVA's were performed on the above variables and no statistically significant results obtained.
(8) Relationships between characteristics of therapy and client satisfaction

The hypothesis states that the greater the number of treatment sessions the higher the reported level of client satisfaction.

The results support this hypothesis. A significant correlation was found between client satisfaction and number of therapy sessions (Table 3). The number of sessions was also found to distinguish between high and low client satisfaction groups (Table 8).
CHAPTER 4
Discussion

This study primarily examined the relationship between non-specific factors and therapeutic outcome. Relationships between a number of associated variables were also assessed.

Table 9 summarises the hypotheses of this study and the pertinent results in relation to therapeutic outcome, and Table 10 those for client satisfaction.

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Non-specific factors (Congruence, Empathy, Regard, Unconditionality) will have a positive relationship to outcome.</td>
<td>Fully supported for client outcome, partially supported for therapist outcome (Regard only).</td>
</tr>
<tr>
<td>4. Present level of client functioning will be positively associated with outcome.</td>
<td>Fully supported for client outcome, partially supported for therapist outcome (no direct correlations, but distinguished between groups of good and bad outcome).</td>
</tr>
<tr>
<td>5. The higher the client's level of social desirability the better the rating of outcome.</td>
<td>Partial support for both client and therapist outcome (no direct correlations but distinguished between groups of good and bad outcome).</td>
</tr>
<tr>
<td>7. The longer the treatment period the more favourable the outcome.</td>
<td>No support for client outcome, partial support for therapist outcome (no direct correlations, but distinguished between groups of good and bad outcome).</td>
</tr>
</tbody>
</table>
### Table 10
**Summary of hypotheses and results for client satisfaction**
(Only hypotheses related to client satisfaction)

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Non-specific factors (Congruence, Empathy, Unconditionality, Regard) will have a positive relationship to client satisfaction.</td>
<td>Supported.</td>
</tr>
<tr>
<td>3. Significant positive relationship between the two outcome measures (client and therapist) and client satisfaction.</td>
<td>Supported.</td>
</tr>
<tr>
<td>4. Present level of client functioning will be positively associated with client satisfaction.</td>
<td>Partially supported (no direct correlations but distinguished between groups of high and low client satisfaction).</td>
</tr>
<tr>
<td>5. The higher the client's level of social desirability better the rating of client satisfaction.</td>
<td>Partially support (no direct correlations but distinguished between groups of high and low client satisfaction).</td>
</tr>
<tr>
<td>6. Relationships between demographic variables and client satisfaction. Specifically, sex, age and education level.</td>
<td>No support for any.</td>
</tr>
<tr>
<td>8. The greater the number of treatment sessions the higher the level of client satisfaction.</td>
<td>Supported.</td>
</tr>
</tbody>
</table>

**Non-Specific Factors**

Hypothesis 1 predicted that the four non-specific factors measured (i.e., Congruence, Empathy, Regard and Unconditionality) would be positively related to therapeutic outcome (both client and therapist) and client satisfaction. The results obtained fully support this hypothesis for client outcome and client satisfaction. However, the data for therapist outcome only partially supported the hypothesis.

*Client outcome* was significantly correlated with all four non-specific factors, however, when assessing the independent contribution of these variables to client outcome none were significant. This suggests that other variables are more potent in predicting client outcome. Two such variables evident in the present study were Overall Life Feeling and client satisfaction. When distinguishing between clients who report
good therapeutic outcome from those who report bad outcome, the non-specific factors Regard and Unconditionality differentiated the groups.

These results, using client's from an educational counselling setting, are consistent with the literature which most often uses clinical and general counselling populations. A relationship has been found between client perception of therapists possessing a wide range of non-specific factors and therapeutic outcome (e.g., Henry et al., 1986; Lambert, 1983; Luborsky et al., 1980; Orlinsky & Howard, 1978; Rogers, 1957; Strupp, 1980a, b, c, d; Truax & Mitchell, 1971). The relationship between outcome and the client's perception of those non-specific factors particularly assessed in the present study have been found by others (Barrett-Lennard, 1962; Rogers, 1957). Empathic understanding is the most commonly assessed non-specific factor and a number of studies support the relationship between this variable and therapeutic outcome (e.g., Lambert, 1983; Luborsky et al., 1980; Rush, 1985; Truax & Mitchell, 1971). It has been noted that the client's perception of the therapist possessing certain qualities is more important than whether they actually exist (Rogers, 1957; Truax & Carkhuff, 1967).

Of the four non-specific factors measured, Regard was the only one that correlated significantly with therapist outcome. When assessing its independent contribution to therapist rated outcome it was not significant, again indicating that other variables were more potent in predicting therapist outcome. In the present study client satisfaction was one such variable.

The weak association found between the client's rating of the therapist possessing non-specific factors and therapist rated outcome, indicates a degree of independence of these variables. This is contrary to previous findings in the literature, suggesting a reciprocal relationship between therapist and client behaviour (i.e., therapists tend to foster warm, mutually respectful relationships with clients who tended to achieve good outcome and behave in a reciprocal manner to negativistic, resistant clients)(Henry et al., 1986; Strupp, 1980a, b, c, d).

The relationships between non-specific factors and client satisfaction were similar to those with client outcome. Again, all four non-specific
factors were highly correlated with client satisfaction. Only Empathy was significant and made an independent contribution to client satisfaction. This variable also distinguished between groups of high and low client satisfaction.

There is support in the literature for the finding that client satisfaction is related to a therapeutic relationship consisting of mutual feelings of warmth, respect, caring, understanding and openness (Saltzman et al., 1976).

The strongest relationships are evident between non-specific factors and both client rated outcome and client satisfaction. Therapist rated outcome had noticeably weaker associations with non-specific factors.

The finding that non-specific factors are more strongly related to client outcome than therapist outcome is supported by findings in the literature that the client's contribution to and perception of therapeutic alliance is more important than the therapists, and also best predicts successful outcome (Gomes-Schwartz, 1978; Horowitz et al., 1984; Marziali et al., 1981). Specifically, it has been found that clients rated as making a strong positive contribution to the therapeutic alliance had good treatment outcome and those contributing negatively had poor treatment outcome (Marziali et al., 1981). Further support comes from Gomes-Schwartz (1978) who found that clients who established and maintained a positive attitude toward the therapist and the work of therapy achieved the greatest benefits.

**Relationships Between Dependent Measures**

Hypothesis 2 suggests that a positive relationship will exist between client rated and therapist rated outcome. This hypothesis was supported, as a significant correlation was found between the two measures of outcome.

Although the correlation between the two ratings of outcome was significant, it was relatively small in magnitude. This is consistent with the literature and supports the evidence that differences have been found between the perspectives of clients and therapists (Gomes-
Schwartz, 1978), and that therapist and client often disagree on the amount of progress made in therapy (Larsen et al., 1979; Strupp, 1969). This emphasises the importance of measuring different perspectives of therapy to comprehensively evaluate therapeutic outcome and eliminate any bias in the results, which has been noted by Strupp & Hadley (1977). Future research in this area would be wise to include evaluation also from the third perspective (i.e., independent observer) to ensure unbiased results.

Hypothesis 3 states that all three dependent measures (client and therapist outcome, and client satisfaction) will be positively related. Results obtained support this hypothesis as all three measures were significantly intercorrelated. Further support comes from the findings of both the regression analyses (assessing the independent contribution of the variables) and the discriminant analyses (distinguishing between high and low groups), where various interrelationships were evident. These included: client outcome contributed significantly to client satisfaction, client satisfaction was significant when assessing therapeutic outcome (both client and therapist). When distinguishing between high and low client satisfaction groups therapist outcome was significant, level of client satisfaction distinguished between good and bad client outcome groups.

Such results have been supported in the literature by the finding of significant relationships between client satisfaction and measures of outcome (Edwards et al., 1978; Greenfield, 1983; Larsen et al., 1979; Willer & Miller, 1978). These studies have included a mixture of client (Edwards et al., 1978; Larsen et al., 1979) and therapist (Edwards et al., 1978; Greenfield, 1983; Willer & Miller, 1978) rated outcome.

The present finding that client outcome and client satisfaction are related to a greater extent than therapist outcome and client satisfaction is not surprising, given that both were rated by the same source (i.e., the client).
Hypothesis 4 predicts that a positive relationship will exist between the level of client functioning and both measures of outcome and client satisfaction. The results fully supported this hypothesis for client rated outcome, but only partial support was found for therapist rated outcome and client satisfaction.

All three measures of the present level of client functioning (i.e., Overall Life Feeling, life adjustment, and GHQ scores) were significantly correlated with client outcome. When assessing each variable's independent contribution to client outcome, only the measure of Overall Life Feeling was significant. The GHQ score was significant in distinguishing between groups with good and bad client rated outcome.

Therapist outcome was not found to correlate significantly with any measures of client level of functioning. The only relationship evident was that Overall Life Feeling distinguished between groups of good and bad therapist rated outcome.

Previous research supports the relationship between outcome of therapy (rated by client and/or therapist) and pre-treatment level of client functioning (Eaton et al., 1988; Jones et al., 1988; Luborsky et al., 1980; Marziali, 1984; Moras & Strupp, 1982). These studies have used a wide variety of measures to assess level of functioning.

Client satisfaction had no significant correlations with the measures of client level of functioning. The only statistically significant relationship found was that both the GHQ score and Overall Life Feeling distinguished between groups of high and low client satisfaction.

The literature supports findings of a relationship between client satisfaction and pre-therapy level of client functioning (Attkisson & Zwick, 1982; LeVois et al., 1981).
The existence of the above relationships is interesting as the present study measured the client's present level of functioning as opposed to the usual measurement of pre-treatment level of functioning. This may indicate that the client's general level of functioning does not significantly change from pre to post-therapy. The changes at post-therapy may be specifically related to the presenting problem symptoms rather than the client's general level of functioning.

**Social Desirability**

Hypothesis 5 suggests that the higher the clients level of social desirability the better the reported levels of outcome and client satisfaction. Partial support for this hypothesis was found for measures of client and therapist outcome, and client satisfaction.

The measure of social desirability was found to distinguish between groups of good and bad client outcome and also groups of high and low client satisfaction.

Previous research has found a variety of measures of the client's personality to be related to therapeutic outcome (Buckley et al., 1984; Luborsky et al., 1980). However, no study has specifically linked the client's level of social desirability to reporting of either outcome or client satisfaction. The rationale for the inclusion of social desirability in the present study is that the greater the client's level of social desirability response style the greater the likelihood of reporting positive outcome and high client satisfaction. In addition, a client who responds throughout therapy in a socially desirable manner will probably influence the therapist's outcome rating in a positive direction.

**Demographic Characteristics**

Hypothesis 6 suggests a number of associations between client satisfaction and certain demographic variables. The specific relationships predicted were that: females report greater levels of satisfaction than males, older people report a higher level of
satisfaction, and less educated clients tend to report lower levels of satisfaction.

The results of the present study did not support the above hypothesis, as no significant relationships were found between demographic variables and client satisfaction.

The negative findings in the present study between client satisfaction and age and education level have also been found by others (Larsen et al., 1979). However, the absence of a relationship between sex and client satisfaction is contrary to previous research where the relationship has been evident (Larsen et al., 1979; Ware, 1978).

The most likely explanation for this negative finding is the composition of the present sample which differed from those of the above studies (Larsen et al., 1979; Ware, 1978). Neither sample consisted primarily of students; Ware's (1978) sample was a random general community sample and Larsen et al.'s (1979) used outpatients who had received individual therapy as their sample. Other differences between samples were also evident. For example, Larsen et al.'s (1979) sample appeared to differ from the present sample on a number of variables: education level, number of sessions, sex distribution, marital status, and age distribution.

Characteristics Of Therapy

Hypothesis 7 predicts a relationship between the number of therapy sessions and outcome. Specifically, the longer the treatment period the more favourable therapeutic outcome. The results indicate no support for the above hypothesis in relation to client outcome and only partial support for therapist rated outcome.

The number of therapy sessions was found to distinguish significantly between groups of good and bad outcome as rated by therapist.

Present findings tend not to support previous research that has found a relationship between outcome and the number of therapy sessions (Gomes-Schwartz, 1978; Luborsky et al., 1980). This could be explained
by the fact that the presenting problems in the present study were not exclusively traditional clinical phenomena (e.g., depression, anxiety). In addition to clinical problems they consisted of a substantial number of career or study/educational issues (36%). These types of presenting issues (as opposed to many clinical problems) can often be resolved in a small number of treatment sessions, and may merely require information rather than traditional therapeutic intervention.

Hypothesis 8 states that a relationship is expected between the number of therapy sessions and client satisfaction. Specifically, the greater the number of treatment sessions the higher the reported level of client satisfaction. The results obtained support this hypothesis.

A significant correlation was found between number of sessions and client satisfaction. The number of sessions also distinguished between groups of high and low client satisfaction.

This linear relationship between client satisfaction and number of sessions has been supported by previous research (Attkisson & Zwick, 1982; Greenfield, 1983; McNeil et al., 1987) and makes intuitive sense. It would be expected that the greater the number of therapy sessions a client attends, the more likely the client is to get to know and like the therapist, and also gain positive outcome from therapy. Alternatively the less satisfied clients attend fewer sessions and drop out of treatment earlier. In support of the latter Larsen et al. (1979) found a relationship between satisfaction and the proportion of appointments missed.

Conclusion

Overall, the results of the present study suggest that non-specific factors do have an important role in determining therapeutic outcome. This supports previous research. The present study particularly emphasised the nature and content of the client-therapist relationship. In this relationship the therapist shows concern for the client's welfare, and encourages the client to develop a confiding, trusting emotional relationship between them (Frank, 1975).
Having established the link between non-specific factors and outcome, a future step would be to ascertain the relative importance of specific versus non-specific factors, including at what stage of therapy which group predominates. Non-specific factors are likely to be crucial during the initial stages of therapy. However, once the therapeutic relationship has been established, specific factors may then predominate. The literature contains conflicting evidence in this area and further investigation would be valuable. For instance, Parloff (1986a) suggests that early on in therapy the non-specific factors may be more salient than specific techniques. Their importance does not end there, as non-specific factors also act as catalytic agents during the entire course of therapy. Another area of contention is whether non-specific factors are necessary and/or sufficient to cause successful therapeutic change. Some believe them to be necessary but not sufficient (Frank, 1971; Parloff et al., 1978), whereas others feel they are both necessary and sufficient (Rogers, 1957; Truax & Carkhuff, 1967; Truax et al., 1966).

The separation of specific and non-specific factors may prove not to be the most useful research paradigm, as these factors are likely to be interactive. That is, "It is the technique in a certain context that seems to be the crucial thing" (p.149)(Frank, 1984). Additional support comes from others who believe that the interaction between client’s interpersonal style and the therapist's skill in managing that interpersonal style to be most important (Butler & Strupp, 1986). Although not directly tested, the results of the present study indicate support for the finding that client variables (e.g. level of symptomatology, personality variables, demographic factors) rather than therapist variables are the best predictors of outcome (Kolb et al., 1985; Luborsky et al., 1975). Future research should measure both therapist and client variables in order to compare their relative importance in predicting therapeutic outcome. Along a similar line some have found specifically that the client's contribution to and perception of the therapeutic relationship, more than the therapist's, best predicts successful outcome (Luborsky et al., 1983; Horowitz et al., 1984; Marziali et al., 1981).
The implications of the present study are potentially important for the training of therapists. Given the likelihood that non-specific factors are required to establish a satisfactory therapeutic relationship before any specific techniques can be successfully implemented. The training of therapists therefore, should not only include the learning of specific techniques but also emphasise the development of relationship skills. Truax and Carkhuff (1967) offer support to this idea and suggest that "...the hoped-for product of our training programs is not simply a technician skilled in the employment of a variety of techniques—although he certainly must be that. He is more, much more...an open and flexible person possessed with a great amount of self-awareness and self-knowledge, sensitive and attuned to receiving and communicating vital messages with other persons." (p.218) Although many theorists recognise the importance that a therapist learn effective interpersonal relationship skills, unfortunately, however, this is often not the focus of training (Truax & Carkhuff, 1967). "It may well be that the lack of efficacy of most counselling and psychotherapy training programs lies not in the method of training ... but in what is emphasized" (Truax & Carkhuff, 1967, p.223). Further support for the importance of relationship skills comes from the clients themselves who have reported that non-specific (relationship) factors are more useful than specific factors (techniques) (Llewelyn & Hume, 1979).

The generalisability of the present findings may be limited for several reasons. Firstly, the response rate was low (26%). Although this is not atypical of mailed questionnaires, many researchers have supposed that the majority of non-responders are highly dissatisfied with services (Berger, 1983), resulting in a biased sample of responders. In addition, clients presenting at an educational counselling unit are likely to be different to clients seen in general community counselling settings. In educational settings a higher proportion of presenting problems related to study, career and vocational issues are likely to be seen than in other settings. Also the average number of therapy sessions is likely to differ between the two settings (i.e., educational and general), as career/vocational issues often require information as opposed to traditional therapeutic intervention.
The present study indicated a number of areas requiring further research. The validity of retrospective data must be assessed, which could be achieved by a comparison of retrospective reports with information given at a termination interview. Also other variables not measured in the present study must be important in predicting therapeutic outcome, given that the amount of variance accounted for in the analyses was relatively small. Future studies should measure other non-specific factors (e.g., presenting a new perspective and providing rationale for the client's problem) and other client variables (e.g., client expectations of therapy), in an attempt to discover more salient predictors of therapeutic outcome.

The debate over the importance of specific and non-specific factors will inevitably continue for some time. However, it is only through research, such as the present study, that eventually it will be resolved. The results indicated that non-specific factors are indeed important in determining therapeutic outcome. One of the major practical implications of these findings is in the training of therapists, where the emphasis should be on developing relationship skills rather than teaching specific therapeutic techniques.
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Ware, J. E., & Snyder, M. K. (1975). Dimensions of patient attitudes toward doctors and medical care services. *Medical Care, 13*, 669-682.


<table>
<thead>
<tr>
<th>APPENDIX</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPENDIX 1</td>
<td>The Questionnaire(^1)</td>
<td>87</td>
</tr>
<tr>
<td>APPENDIX 2</td>
<td>Covering Letter</td>
<td></td>
</tr>
<tr>
<td>APPENDIX 3</td>
<td>Follow-up Letter</td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) The names of the measurement instruments have been included for ease of presentation, these did not appear in the administered questionnaire
APPENDIX 1

BACKGROUND INFORMATION

. Sex [circle one number]

Female (1)
Male (2)

?. Age ..........years

}. Martial status [circle one number]

SINGLE
Never married (1)
Divorced (2)
Separated (3)
Widowed (4)
MARRIED
Married once (5)
More than once (6)
De facto (7)

1. Number of children......

5. What is your nationality? .................

5. How long have you lived in Australia? ......years

7. What is your highest education level? [circle one number]

less than year 9 (1)
Year 9 (2)
Year 10 (3)
Year 11 (4)
Year 12 (5)
Greater than year 12 (6) Specify:....................

3. About your mother.
(1) What is your mother's occupation?...................
(2) Her nationality?..................................
(3) Her education level?..............................

9. About your father.
(1) What is your father's occupation?...................
(2) His nationality?..................................
(3) His education level?..............................

10. Before going to the TAFE Counselling Unit had you previously ever sought counselling anywhere else? [circle one number]

Yes (1)
No (2)

11. Who referred you to the TAFE counselling unit? [circle one number]

Self (1)
Teacher (2)
Other client (3)
Other (4) Specify:.................................

12. a) Approximately how many sessions at the TAFE counselling unit have you attended?
 ..........sessions

b) Approximate date of last session ..../../19
13. At the time you were attending the TAFE counselling unit were you taking any drugs (either legal or illegal)? [circle one number]
Yes (1)
No (2)

14. If yes, please list the names of the drugs. (e.g. valium, stelazine, serapex, modecate.)
a) ...........................................................
b) ...........................................................
c) ...........................................................
d) ............................................................
e) ............................................................

15. List up to 3 main issues for which you sought counselling (be as specific as you can).
(1) ................................................................
(2) ................................................................
(3) ................................................................

16. Rate the severity of the issues listed in Question 15 on the following scale.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absent</td>
<td>Doubtful</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
</tr>
</tbody>
</table>

Before therapy
Issue 1 ..............
Issue 2 ..............
Issue 3 ..............

After therapy


17. Mark on the below scale the amount of change that occurred after having completed counselling for each issue identified in Question 15.

Issue 1

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very much worse</td>
<td>No change</td>
<td>Completely recovered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Issue 2

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very much worse</td>
<td>No change</td>
<td>Completely recovered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Issue 3

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very much worse</td>
<td>No change</td>
<td>Completely recovered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
18. Reason for terminating therapy [circle one number]

- Mutual decision  (1)
- Your decision  (2)
- Therapist's decision  (3)
- External factors  (4) Specify: .............

19. Presently how do you feel about your life as a whole?

1 2 3 4 5 6 7
Terrible Unhappy Mostly Mixed Mostly Pleased Delighted
dissatisfied satisfied

20. At the moment how do you feel about each of the following areas of your life?
I feel: (fill in the appropriate number of each item using the scale below)

1 2 3 4 5
Extremely Good Neutral Poor Extremely Good

a) Work ------(a)
b) Social life ------(b)
c) Spouse ------(c)
d) Relationships with children ------(d)
e) Physical problems ------(e)
f) Sexual functioning ------(f)
g) Overall feelings ------(g)
h) Overall handling of demands ------(h)
i) Overall symptoms ------(i)
The General Health Questionnaire

We would like to know if you have had any medical complaints, and how your health has been in general, over the past four weeks. Please answer ALL questions by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you have had in the past.

It is important that you try to answer ALL questions.

**HAVE YOU RECENTLY:**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>been able to concentrate on whatever you're doing?</td>
<td>Better than usual</td>
<td>Same as usual</td>
<td>Less than usual</td>
</tr>
<tr>
<td>2.</td>
<td>lost much sleep over worry?</td>
<td>Much more than usual</td>
<td>Rather more than usual</td>
<td>No more than usual</td>
</tr>
<tr>
<td>3.</td>
<td>felt that you are playing a useful part in things</td>
<td>Much less useful than usual</td>
<td>Less useful than usual</td>
<td>Same as usual</td>
</tr>
<tr>
<td>4.</td>
<td>felt capable of making decisions about things?</td>
<td>More so than usual</td>
<td>Same as usual</td>
<td>Less so than usual</td>
</tr>
<tr>
<td>5.</td>
<td>felt constantly under strain?</td>
<td>Much more than usual</td>
<td>Rather more than usual</td>
<td>No more than usual</td>
</tr>
<tr>
<td>6.</td>
<td>felt that you couldn't overcome your difficulties?</td>
<td>Much more than usual</td>
<td>Rather more than usual</td>
<td>No more than usual</td>
</tr>
<tr>
<td>7.</td>
<td>been able to enjoy your normal day-to-day activities?</td>
<td>Much less than usual</td>
<td>Less so than usual</td>
<td>Same as usual</td>
</tr>
<tr>
<td>8.</td>
<td>been able to face up to your problems?</td>
<td>More so than usual</td>
<td>Same as usual</td>
<td>Less able than usual</td>
</tr>
<tr>
<td></td>
<td>9. been feeling unhappy and depressed?</td>
<td>10. been losing confidence in yourself?</td>
<td>11. been thinking of yourself as a worthless person?</td>
<td>12. been feeling reasonably happy all things considered?</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------</td>
<td>---------------------------------------</td>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Much more than usual</td>
<td>Not at all</td>
<td>Not at all</td>
<td>Much less than usual</td>
</tr>
<tr>
<td></td>
<td>Rather more than usual</td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Less so than usual</td>
</tr>
<tr>
<td></td>
<td>No more than usual</td>
<td>Rather more than usual</td>
<td>Much more than usual</td>
<td>About same as usual</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
<td>Much more than usual</td>
<td></td>
<td>More so than usual</td>
</tr>
</tbody>
</table>
Below are listed a variety of ways that one person may feel or behave in relation to another person. Please consider each numbered statement with reference to your relationship with the counsellor you saw at the TAFE Counselling Unit. Mark each statement in the answer column on the right, according to how strongly you feel that it is true, or not true, in this relationship. Please be sure to mark every one. Write in +3, +2, +1, or -1, -2, -3, to stand for the following answers:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. She respects me as a person</td>
<td></td>
</tr>
<tr>
<td>2. She wants to understand how I see things</td>
<td></td>
</tr>
<tr>
<td>3. Her interest in me depends on the things I say or do</td>
<td></td>
</tr>
<tr>
<td>4. She is comfortable and at ease in our relationship</td>
<td></td>
</tr>
<tr>
<td>5. She feels a true liking for me</td>
<td></td>
</tr>
<tr>
<td>6. She may understand my words but she does not see the way I feel</td>
<td></td>
</tr>
<tr>
<td>7. Whether I am feeling happy or unhappy with myself makes no real difference to the way she feels about me</td>
<td></td>
</tr>
<tr>
<td>8. I feel that she puts on a role or front with me</td>
<td></td>
</tr>
<tr>
<td>9. She is impatient with me</td>
<td></td>
</tr>
<tr>
<td>10. She nearly always knows exactly what I mean</td>
<td></td>
</tr>
<tr>
<td>11. Depending on my behaviour, she has a better opinion of me sometimes than she has at other times</td>
<td></td>
</tr>
<tr>
<td>12. I feel that she is real and genuine with me</td>
<td></td>
</tr>
<tr>
<td>13. I feel appreciated by her</td>
<td></td>
</tr>
</tbody>
</table>

Barrett-Lennard Relationship Inventory
14. She looks at what I do from her own point of view.

15. Her feeling toward me doesn't depend on how I feel toward her.

16. It makes her uneasy when I ask or talk about certain things.

17. She is indifferent to me.

18. She usually senses or realises what I am feeling.

19. She wants me to be a particular kind of person.

20. I feel that what she says usually expresses exactly what she is feeling and thinking at that moment.

21. She finds me rather dull and uninteresting.

22. Her own attitudes toward some of the things I do or say prevent her from understanding me.

23. I can (or could) be openly critical or appreciative of her without really making her feel any differently about me.

24. She wants me to think that she likes me or understands me more than she really does.

25. She cares for me.

26. Sometimes she thinks that I feel a certain way, because that's the way she feels.

27. She likes certain things about me, and there are other things she does not like.

28. She does not avoid anything that is important for our relationship.

29. I feel that she disapproves of me.

30. She realises what I mean even when I have difficulty in saying it.

31. Her attitude toward me stays the same: she is not pleased with me sometimes and critical or disappointed at other times.

32. Sometimes she is not at all comfortable but we go on, outwardly ignoring it.

33. She just tolerates me.

34. She usually understands the whole of what I mean.
35. If I show that I am angry with her she becomes hurt or angry with me, too ..............................................
36. She expresses her true impressions and feelings with me .................................................................
37. She is friendly and warm with me .................................................................
38. She just takes no notice of some things that I think or feel ............................................................... 
39. How much she likes or dislikes me is not altered by anything that I tell her about myself ......................
40. At times I sense that she is not aware of what she is really feeling with me ........................................
41. I feel that she really values me .................................................................
42. She appreciates exactly how the things I experience feel to me ............................................................
43. She approves of some things I do, and plainly disapproves of others ....................................................
44. She is willing to express whatever is actually in her mind with me, including personal feelings about either of us .................................................................
45. She doesn't like me for myself .................................................................
46. At times she thinks that I feel a lot more strongly about a particular thing than I really do ........................
47. Whether I happen to be in good spirits or feeling upset does not make her feel any more or less appreciative of me .................................................................
48. She is openly herself in our relationship ..............................
49. I seem to irritate and bother her .................................................................
50. She does not realise how sensitive I am about some of the things we discuss ........................................
51. Whether the ideas and feelings I express are "good" or "bad" seems to make no difference to her feeling toward me .................................................................
52. There are times when I feel that her outward response to me is quite different from the way she feels underneath .................................................................
53. She feels contempt for me .................................................................
54. She understands me .................................................................
55. Sometimes I am more worthwhile in her eyes than I am at other times ............... 

56. She doesn't hide anything from herself that she feels with me ....................... 

57. She is truly interested in me ............... 

58. Her response to me is usually so fixed and automatic that I don't really get through to her ............... 

59. I don't think that anything I say or do really changes the way she feels toward me ............... 

60. What she says to me often gives a wrong impression of her total thought or feeling at the time ............... 

61. She feels deep affection for me ............... 

62. When I am hurt or upset she can recognise my feelings exactly, without becoming upset too ............... 

63. What other people think of me does (or would, if she knew) affect the way she feels toward me ............... 

64. I believe that she has feelings she does not tell me about that are causing difficulty in our relationship.
The Client Satisfaction Questionnaire (18-B)

We are very keen to improve our services. Please help us to do this by answering some questions about the services you have received at The Counselling Unit. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions.

CIRCLE YOUR ANSWERS

1. When you first came to our program, were you seen as promptly as you felt necessary?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, very promptly</td>
<td>Yes, promptly</td>
<td>No, there was some delay</td>
<td>No, it seemed to take forever</td>
</tr>
</tbody>
</table>

2. In general, how satisfied are you with the comfort and attractiveness of our facility?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
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</thead>
<tbody>
<tr>
<td>Quite dissatisfied</td>
<td>Indifferent or mildly dissatisfied</td>
<td>Mostly satisfied</td>
<td>Very satisfied</td>
</tr>
</tbody>
</table>

3. Did the characteristics of our building detract from the services you have received?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
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</thead>
<tbody>
<tr>
<td>Yes, they detracted very much</td>
<td>Yes, they detracted somewhat</td>
<td>No, they did not detract much</td>
<td>No, they did not detract at all</td>
</tr>
</tbody>
</table>

4. How satisfied are you with the amount of help you have received?

<table>
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<tr>
<th>1</th>
<th>2</th>
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<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quite dissatisfied</td>
<td>Indifferent or mildly dissatisfied</td>
<td>Mostly satisfied</td>
<td>Very satisfied</td>
</tr>
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</table>

5. Considering your particular needs, how appropriate are the services you have received?

<table>
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<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly appropriate</td>
<td>Generally appropriate</td>
<td>Generally inappropriate</td>
<td>Highly inappropriate</td>
</tr>
</tbody>
</table>

6. Have the services you received helped you to deal more effectively with your problems?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, they helped a great deal</td>
<td>Yes, they helped somewhat</td>
<td>No, they really didn't help</td>
<td>No, they seemed to make things worse</td>
</tr>
</tbody>
</table>

7. When you talked to the person with whom you have worked most closely, how closely did he or she listen to you?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all closely</td>
<td>Not too closely</td>
<td>Fairly closely</td>
<td>Very closely</td>
</tr>
</tbody>
</table>
8. Did you get the kind of service you wanted?
   1. No, definitely not
   2. No, not really
   3. Yes, generally
   4. Yes, definitely

9. Are there other services you need but have not received?
   1. Yes, there definitely were
   2. Yes, I think there were
   3. No, I don't think there were
   4. No, there definitely were not

10. How clearly did the person with whom you worked most closely understand your problem and how you felt about it?
    4. Very clearly
    3. Clearly
    2. Somewhat unclearly
    1. Very unclearly

11. How competent and knowledgeable was the person with whom you have worked closely?
    1. Poor abilities at best
    2. Only of average ability
    3. Competent and knowledgeable
    4. Highly competent and knowledgeable

12. How would you rate the quality of the service you have received?
    4. Excellent
    3. Good
    2. Fair
    1. Poor

13. In an overall, general sense, how satisfied are you with the service you have received?
    4. Very satisfied
    3. Mostly satisfied
    2. Indifferent or mildly dissatisfied
    1. Quite dissatisfied

14. If a friend were in need of similar help, would you recommend our program to him or her?
    1. No, definitely not
    2. No, I don't think so
    3. Yes, I think so
    4. Yes, definitely

15. Have the people in our program generally understood the kind of help you wanted?
    1. No, they misunderstood almost completely
    2. No, they seemed to misunderstand
    3. Yes, they seemed to generally understand
    4. Yes, they understood almost perfectly
16. To what extent has our program met your needs?

<table>
<thead>
<tr>
<th>Choices</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost all of my needs have been met</td>
<td>4</td>
</tr>
<tr>
<td>Most of my needs have been met</td>
<td>3</td>
</tr>
<tr>
<td>Only a few of my needs have been met</td>
<td>2</td>
</tr>
<tr>
<td>None of my needs have been met</td>
<td>1</td>
</tr>
</tbody>
</table>

17. Have your rights as an individual been respected?

<table>
<thead>
<tr>
<th>Choices</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, almost never respected</td>
<td>1</td>
</tr>
<tr>
<td>No, sometimes not respected</td>
<td>2</td>
</tr>
<tr>
<td>Yes, generally respected</td>
<td>3</td>
</tr>
<tr>
<td>Yes, almost always respected</td>
<td>4</td>
</tr>
</tbody>
</table>

18. If you were to seek help again, would you come back to our program?

<table>
<thead>
<tr>
<th>Choices</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, definitely not</td>
<td>1</td>
</tr>
<tr>
<td>No, I don't think so</td>
<td>2</td>
</tr>
<tr>
<td>Yes, I think so</td>
<td>3</td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>4</td>
</tr>
</tbody>
</table>
Listed below are a number of statements concerning personal attitudes and traits. Read each item and tick whether the statement is true or false as it applies to you personally.

1. Before voting I thoroughly investigate the qualifications of all the candidates.
2. I never hesitate to go out of my way to help someone in trouble.
3. It is sometimes hard for me to go on with my work if I am not encouraged.
4. I have never intensely disliked anyone.
5. On occasion I have had doubts about my ability to succeed in life.
6. I sometimes feel resentful when I don't get my way.
7. I am always careful about my manner of dress.
8. My table manners at home are as good as when I eat out in a restaurant.
9. If I could get into a movie without paying and be sure I was not seen I would probably do it.
10. On a few occasions, I have given up doing something because I thought too little of my ability.
11. I like to gossip at times.
12. There have been times when I felt like rebelling against people in authority even though I knew they were right.
13. No matter who I'm talking to, I'm always a good listener.
14. I can remember "playing sick" to get out of something.
15. There have been occasions when I took advantage of someone.
16. I'm always willing to admit it when I make a mistake.
17. I always try to practice what I preach.
18. I don't find it particularly difficult to get along with loud mouthed, obnoxious people.
19. I sometimes try to get even rather than forgive and forget. ___ ✔

20. When I don't know something I don't at all mind admitting it. ___ ✔

21. I am always courteous, even to people who are disagreeable. ___ ✔

22. At times I have really insisted on having things my own way. ___ ✔

23. There have been occasions when I felt like smashing things. ___ ✔

24. I would never think of letting someone else be punished for my wrongdoings. ___ ✔

25. I never resent being asked to return a favour. ___ ✔

26. I have never been irked when people expressed ideas very different from my own. ___ ✔

27. I never make a long trip without checking the safety of my car. ___ ✔

28. There have been times when I was quite jealous of the good fortune of others. ___ ✔

29. I have almost never felt the urge to tell someone off. ___ ✔

30. I am sometimes irritated by people who ask favours of me. ___ ✔

31. I have never felt that I was punished without cause. ___ ✔

32. I sometimes think when people have a misfortune they only got what they deserved. ___ ✔

33. I have never deliberately said something that hurt someone's feelings. ___ ✔

** Honestly would you have completed the questionnaire if the incentive of a raffle had not been included? [circle one number]

Yes (1)
No (2)
Dear client,

SURVEY OF ALL USERS OF THE COUNSELLING UNIT 1989-1990

We are eager to identify more precisely the characteristics of our clients and particularly to get feedback about our services. This information will assist us to identify areas of need and if necessary to provide a better service in the future. The proposed quality assurance evaluation is being undertaken by a postgraduate member of the Psychology Department at the Australian National University.

The attached survey is for general research purposes only and the information you provide will be treated as confidential. Your responses will be aggregated for reporting purposes so it will not be possible to identify responses of individuals.

I would be grateful if you would fill in the questionnaire and return it in the enclosed free post addressed envelope, for which no postage stamp is required. Please be absolutely frank and give your honest opinion. It would be appreciated if your completed questionnaire could be posted back by Monday 6th August 1990.

In appreciation for taking part in this evaluation we have enclosed a raffle ticket. To ensure that you are included in the draw to win $50.00 you must return half of the ticket (along with the questionnaire) with your phone number written on it. The winning ticket number will appear in the Public Notices section of the Canberra Times on Saturday 11th August 1990. In order to claim the prize you must retain the matching half of the ticket.

Thankyou in advance for your assistance, which will help us in our quest for continuous improvement in the quality of the services provided by the Counselling Unit.

Yours sincerely,

Don Clare
B.A. M.A.Ps.S.
(Manager Counselling Services)
Dear client,

SURVEY OF ALL USERS OF THE COUNSELLING UNIT 1989-1990

You may recall receiving a questionnaire from us a couple of weeks ago. We realise that questionnaires can be somewhat of a nuisance but would really appreciate you putting in the time and effort to complete this one. Your feedback on our services is very important and of great value to us. The information you provide will help us to identify areas of need, which will assist us if necessary in providing a better service in the future.

In appreciation for taking part in this evaluation we enclosed a raffle ticket with the questionnaire. If we receive your questionnaire by Monday 6th August 1990, you will be included in the draw TO WIN $50.00. Please do not hesitate to contact us if you require another questionnaire.

Thank you for your assistance, which will help us in our quest for continuous improvement in the quality of the services provided by the Counselling Unit.

Yours sincerely,

[Signature]

Don Clare
B.A. M.A.Ps.S.
(Manager Counselling Services)