THE PROBLEM OF PSYCHOTHERAPEUTIC EFFECTIVENESS

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ABSTRACT

Hundreds of evaluative studies of psychotherapy still leave the issue unsettled. This paper argues that such studies have ignored the major determinant of therapeutic effectiveness, the role of a patient's belief in the successful outcome in therapy. It makes little sense to claim that a certain therapy is effective or ineffective in itself; rather, there is a relation of mutual interaction among three terms: a patient's ability to learn in a psychological context, a therapist's ability to teach, and the capacity of an approach to therapy to engender in the patient the necessary belief in its effectiveness.

"Many thanks for your...excellent paper. It is one of the best, if not the best, that I have read on this subject." – Thomas Szasz, Professor of Psychiatry Emeritus, Health Science Center, State University of New York, Syracuse (letter to the author, November 15, 1990)

"I find myself in substantial agreement with your major points which are well stated." – Hans H. Strupp, Distinguished Professor of Psychology, Vanderbilt University (letter to the author, November 14, 1990)

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§ *1. Introduction*

Evaluative studies of the many alternative approaches to psychotherapy, inclusive here of psychoanalysis, now number many hundreds. More than 500 evaluative studies were made, for example, during the period 1916-1967 alone.[1] In spite of their multitude, the studies have been inconclusive: It has not been possible to establish, with any consensus or assurance, the effectiveness of psychotherapeutic approaches. The evaluation of behavioral therapies, which we do not consider here, has been more favorable, but on the whole, psychotherapeutic effectiveness has been elusive. In contrast to these studies, which have generally been empirical and statistical in nature, unfortunately sparse attention has been given to more fundamental methodological or epistemological issues of therapeutic evaluation. A great mass of empirical data has been stockpiled, and yet we have made small progress toward answering the question, Is psychotherapy really effective? A careful retrospective analysis of the many studies cannot be accomplished in a single article. Instead, this paper tries to place evaluative research in perspective both to show why the problem of psychotherapeutic effectiveness has been so refractory, and to suggest a more promising direction for future research.

[1] See Allen E. Bergin, "The Evaluation of Therapeutic Outcomes," in Allen E. Bergin and Sol L. Garfield, (Eds.), *Handbook of Psychotherapy and Behavior Change: An Empirical Analysis*, New York: John Wiley, pp. 217-270, cf. p. 228, 1971.

§ 2. The present situation

One of the most systematic and comprehensive reviews of empirical evaluations of psychotherapeutic effectiveness was made by Allen E.Bergin.[2] In the course of a long comparative study, he makes such meta-comments as these: Referring to psychotherapy, he says "[i]t is time . . . that this field provide publicly verifiable evidence that its costly treatments have effects" (p. 228); and about analytical approaches, he claims "there is no valid way to assess the effects of psychoanalysis from the information available" (p. 225). He concludes that

> the process of therapeutic change in patients is multifactorial . . . divergent processes are occurring in therapeutic change . . . people themselves embody divergent dimensions or phenomena . . . divergent methods of criterion measurement must be used to match the divergency in human beings and in the change processes that occur within them. (p. 256)

In other words, research ought properly to be directed toward answering "*what* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances."[3] The need for differential diagnosis of this kind has so far largely been neglected, even though researchers appear to be in agreement that work in this area is fundamental and important. Hans Strupp was one of the first to call for a study of the "amenability of the individual patient" to specific forms of treatment.[4] James Prochaska later echoed Strupp's call: "Seeking to match symptoms with systems, or personalities with psychotherapies is truly an important task of our times."[5]

Psychologist Daniel N. Wiener noted, "So far, unfortunately, professional researchers and practitioners cannot definitely tell you which therapist or way of doing therapy will yield the best results with your problems."[6] Referring to the more limited domain of relaxation therapies, psychologist Jerrold Greenberg complained: "we still have no system to recommend

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[2] See note 1.

[3] G.L. Paul, "Strategy of Outcome Research in Psychotherapy," *Journal of Consulting Psychology*, Vol. 31, p. 111, 1967.

[4] Hans H. Strupp, Ronald E. Fox, and Ken Lessler, *Patients View Their Psychotherapy*, Baltimore: Johns Hopkins Press, 1969.

[5] James O. Prochaska, *Systems of Psychotherapy: A Transtheoretical Analysis*, Homewood, Illinois: Dorsey Press, 1979.

[6] *A Practical Guide to Psychotherapy*, New York: Harper & Row, p. xv, 1968

particular relaxation techniques for particular people."[7] Lewis R. Wolberg makes the same general point in these words:

What is challenging for a therapist is discerning the form of learning that each patient can best utilize and then working to adopt techniques that are best suited for the patient . . . An important area of research is a way of detecting in a patient his optimal modes of learning. If we can pinpoint these, we can then more precisely determine the best means of therapeutic operaction.[8]

In spite of these hopeful pleas for relevant studies, researchers in general have simply not attempted to develop diagnostic algorithms to match presenting problems and the individual characteristics of the patient with most promising therapies.[9] The situation facing psychotherapy and psychoanalysis at the present time is one of scientific embarrassment in which the diagnostic matching process is ignored or conducted in little more than a random manner.

It is important to realize at the outset, then, that our diagnostic knowledge in the field is extremely poor. When we cannot systematically match symptoms, patient profiles, and therapies, it is not likely that we will find impressive evidence for the effectiveness of psychotherapeutic treatment.

§ 3. Studies of the effectiveness of psychotherapy

To gain perspective, it may be helpful to identify some of the main landmarks in the history of psychotherapeutic evaluation.

C.A. Landis appears to have been the first writer to argue that there is a significant rate of spontaneous recovery from mental disturbances.[10] He argued that for any therapeutic approach to be judged effective, its success rate must exceed the spontaneous recovery base line by some significant amount. He found, for example, that the discharge rate for neurotics from hospitals in New York State from 1917 to 1934 was 72 percent. In contrast, he observed that major approaches to psychotherapy, as evidenced by their published rates of improvement, were ineffective according to his criterion. The doubt Landis cast has prevailed for a long time. In 1966, Hans Eysenck published a survey that continued to place psychotherapy in an adverse

[7] *Comprehensive Stress Management*, Dubuque, Iowa: William C. Brown, p. 132, 1983.
[8] *The Technique of Psychotherapy*, New York: Grune and Stratton, vol. I, p. 271, 1977.
[9] A first step toward a diagnostic algorithm of this kind is presented in Steven J. Bartlett, *When You Don't Know Where to Turn: A Self-Diagnosing Guide to Counseling and Therapy*, New York: Contemporary Books, 1987.
[10] "A Statistical Evaluation of Psychotherapeutic Methods," in L.E. Hinsie, (Ed.) *Concepts and Problems of Psychotherapy*, New York: Columbia University Press, pp. 155-165, 1937.

light: on its basis, he concluded, for example, that the favorableness of results of evaluative studies appeared to be inversely proportional to the adequacy of their methodologies, and that the évidence appeared to show that psychotherapy is no more effective than no treatment at all.[11]

Following in the shadow of Eysenck's 1966 study, Bergin's comparative study was only modestly favorable toward psychotherapy: He found reason to believe that psychotherapy exerts a "moderately positive, average therapeutic effect."[12] To give one example, in an analysis of 52 studies, 22 received positive ratings under his criteria, 15 were doubtful, and 15 suggested negative evidence of therapeutic effectiveness.

Bergin expressed the belief that groups of "untreated neurotics," who serve as controls in many of the studies and who were found to improve "spontaneously," in fact benefitted from varieties of "informal therapy" – talk with spouses, friends, ministers, etc. In other words, Bergin hypothesized that spontaneous remission is not really spontaneous, but is frequently due to the effects of such "informal therapies." By inference, this gave him hope that professional therapy is itself modestly effective. Yet, it is clear that the hypothesis he makes begs the question.

Many studies, both before and since Bergin's analysis, seem to show that attention-placebo controls yield improvement figures that resemble the figures for therapy groups. Patients who are placed in attention-placebo control groups receive attention from unskilled "therapists". When patients in such groups improve at rates similar to patients in professionally treated groups, this is of course construed to be prima facie evidence that professional therapy is ineffective. Some of the improvement figures cited by individual attention-placebo control studies are rather remarkable: improvement in patients in attention-placebo groups was judged to be 50%[13], 59%[14] and even 76%[15]. It became evident that mental hospital aides and

[11] *The Effects of Psychotherapy*, New York: International Science Publishers, 1966.
[12] *Ibid*, p. 229.
[13] G.L. Paul, *Effects of Insight, Desensitization, and Attention Placebo Treatment of Anxiety*, Standord, Calif.: Stanford University Press, 1966.
[14] S.D. Imber, E.H. Nash, A.R. Stone, and J.D. Frank: "A TenYear Follow-up Study of Treated Psychiatric Outpatients," in S. Lesse, (Ed.), *An Evaluation of the Results of the Psychotherapies*, New York: Charles C. Thomas, 1968.
[15] R. Koegler and Q. Brill, *Treatment of Psychiatric Outpatients*, New York: Appleton-Century-Crofts, 1967.

minimally trained student volunteers significantly influenced the recovery of many patients.[16]

In addition to the attention-placebo studies, there have also been a few highly negative reports which suggest that therapy can actually be *injurious* to some patients.[17] If this iatrogenic criticism is valid,[18] then therapy may not only be ineffective but at times harmful. Bergin, who, as we know, was inclined to be hopeful, suggested that

> [e]vidently there is something unique about psychotherapy which has the power to cause improvement beyond that occurring among controls, but equally evident is a contrary deteriorating impact that makes some cases worse than they were to begin with.[19]

During the past two decades, the frequently disparaging results of evaluative studies have congealed around a range of negative judgements:

> . . . [M]ost of the verbal psychotherapies have an effect size that is only marginally greater than the effect size for . . . a "placebo treatment."[20]

> Most writers . . . agree that the therapeutic claims made for psychotherapy range from the abysmally low to the astonishingly high and, furthermore, they would tend to agree that on the average psychotherapy appears to produce approximately the same amount of improvement as can be observed in patients who have not received this type of treatment.[21]

> Psychotherapy of any kind applies techniques that are based on certain theories, and these theories demand not only that there should be correlation between success and length of treatment, but also that the training and experience of the therapist should be extremely important. To find that neither of these corollaries is in fact borne out must be an absolute death blow to any claims to have demonstrated the effectiveness of psychotherapy.[22]

> I have always felt that it is completely unethical to subject neurotic patients to a treatment the efficacy of which has not been proven, and indeed, the efficacy of which is very much in doubt – so much so that there is no good evidence for it, in spite of hundreds of studies devoted to the question. Patients are asked to spend money and time they can ill afford, and subject themselves to a gruelling experience, to no good purpose at all; this surely cannot be right. At least there should be a statutory warning to the effect that the treatment they are proposing to enter has never been shown to be effective, is very lengthy and costly, and may indeed do harm to the patient.[23]

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[16] For example: R.R. Carkhuff and C.B. Truax, "Lay Mental Health Counseling: The Effects of Lay Group Counseling," *Journal of Consulting Psychology*, Vol. 29, pp. 426-431, 1965; E. Poser, "The Effect of Therapists' Training on Group Therapeutic Outcome," *Journal of Consulting Psychology*, Vol. 30, pp. 283-289, 1966; B.G. Guerney, (Ed.), *Psychotherapeutic Agents: New Roles for Nonprofessionals, Parents, and Teachers*, New York: Holt, Rinehart and Winston, 1969.

[17] See, for example, Thomas J. Nardi, "Psychotherapy: Cui Bono?," in Jusuf Hariman, (Ed.), *Does Psychotherapy Really Help People?*, Springfield, Illinois: Charles C. Thomas, pp. 154-164, 1984.

[18] A disorder brought about by medical treatment is called an *iatrogenic disturbance*.

[19] Bergin, *op cit.*, p. 246.

[20] Edward Erwin, "Is Psychotherapy More Effective Than a Placebo?," in: *Does Psychotherapy Really Help People?*, p. 39.

[21] S. Rachman, *The Effects of Psychotherapy*, New York: Pergammon Press, p. 84, 1971.

[22] Hans J. Eysenck, "The Battle over Therapeutic Effectiveness," in J. Hariman, (Ed.), *Does Psychotherapy Really Help People?*, p. 57.

[23] *Ibid.*, p. 59.

§ 4. *The criticisms of psychotherapy*

Three main negative judgments, then, have been levelled against psychotherapy: (i) that many of the emotional or mental problems to which psychotherapy is applied would, in time, even if left untreated, remit or vanish of their own accord; (ii) that the effectiveness of psychotherapy is frequently on a par with that of attention-placebo treatment; and (iii) that psychotherapy may indeed be injurious to some. Psychotherapy's critics believe they are justified in concluding that psychotherapy is redundant in relation to natural restorative processes, that it is useless if attention-placebo treatments are equivalent in value, and that at times it is detrimental.

These appear to be strong and persuasive criticisms. Yet, they rest on a number of implicit assumptions that deserve our attention, for they influence the way in which we interpret the issues before us.

The first criticism can be interpreted in two different ways: It might be taken to mean (a) that a given patient who is treated with a particular therapy and who improves under specified criteria would have improved to the same, or much the same, extent had he not been treated at all. The counterfactual conditional raises its familiar ugly head here. The conditions that would have to be satisfied for (a) in principle to be meaningful are ruled out by the frame of reference in which (a) is proposed. As I have argued elsewhere, a conceptual mistake of a particular and pervasive kind is involved here.[24] Our frame of reference, in which a patient's improvement is associated with a specific treatment, allows us to make no potentially meaningful claims about that patient's putative condition had the treatment been withheld. It is for an essentially epistemological reason that control groups are used in empirical studies.

What most metaphysically disinclined scientists mean by (i) is not (a), but really (b) that improvement rates in individuals who have basically the same difficulties, some of whom are treated professionally and others not, will tend, when large populations are considered, to be nearly equivalent. As

[24] See, for example, Steven J. Bartlett, "Varieties of Self-Reference" in Steven J. Bartlett and Peter Suber, (Eds.), *Self-Reference: Reflections on Reflexivity*, Dordrecht (The Netherlands): Martinus Nijhoff, pp. 5-28, esp. p. 10, 1987; *Conceptual Therapy: An Introduction to Framework-Relative Epistemology*, St. Louis, Mo.: St. Louis University, Studies in Theory and Behavior, 1983; "Referential Consistency as a Criterion of Meaning," *Synthese*, Vol. 52, pp. 267-282, 1982.

justification for avoiding the unnecessary expense of psychotherapy, this sort of observation is nothing short of nearsighted, if not callous. For the purposes of argument, suppose that treated and untreated patients suffering from similar difficulties improve in equal or approximately equal periods of time. It does not follow from this that their suffering is equally tolerable for them to bear. If psychotherapy offers encouragement, comfort, and human contact during a period of demoralization, its value would be attested by patients themselves.[25] The criticism that many emotional or mental problems remit spontaneously, and that psychotherapy is therefore unnecessary, may be no less insensitive than withholding painkillers because they do not accelerate healing.

The second criticism, that psychotherapy and attention-placebo treatment may both result in improvement is not so easily countered, for it contains an element of truth, which we'll discuss in the next section.

The third criticism that psychotherapy may in some cases be iatrogenic does no more than to underscore an attendant danger when we do not know how to make individualized diagnoses. Only differential diagnosis can serve as a foundation for differential treatment, enabling practitioners to provide treatment selectively to patients on the basis of individual needs, and avoiding potentially injurious treatment. Certainly, there can be no doubt, for example, that "[p]sychotherapeutically derived self-insight and personality reconstruction do not necessarily alter the troublesome facts of existence and conceivably may even cause one to ruminate excessively over things better left alone."[26] It is evident that most treatments are potentially harmful under some conditions. We do not dismiss them for that reason.

§ 5. *Psychotherapy and the attribution of illness*

Evaluative studies of psychotherapy have relied heavily on a stock vocabulary of concepts. In particular, the notion that psychotherapy is engaged in the "treatment of illness" has played a central role in evaluative research, and so must concern us here.

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[25] Although most evaluative studies take patients' personal assessments into account, it is rare for an evaluation of psychotherapeutic effectiveness to use patients' reports as the main basis for judgment. One of the rare studies to focus on how patients regard their own experiences in therapy is Hans H. Strupp, Ronald E. Fox, and Ken Lessler, *op. cit.*.

[26] Bergin, *op. cit.*, p. 246.

It has been argued, for example, that the idea of illness, when it is applied to emotional or mental states, becomes simply metaphorical or analogical. Take, for instance, the distinction we draw between falling victim to an accident, in which a leg is broken, and falling victim to an illness, as when one becomes ill as a result of infection. In both injury and disease, we identify a physical cause that acts upon the bone's brittleness, or the immune system's vulnerability.

The situation with emotional or mental "illness" is, according to this criticism, fundamentally different. Thomas Szasz[27] has argued that in the majority of cases involving emotional or mental difficulties we are unable to identify a physical cause, or an underlying physical disorder. Certainly, some emotional or mental difficulties have been associated with an excess, or depletion, of known individual neurotransmitters and imbalances in the sustaining biochemistry, or from organic lesions. At the present stage of psychiatric knowledge, however, organically-based emotional disorders are the minority. What does it mean, in connection with emotional states that cannot be, or have not been, linked to underlying physical conditions, to say of them that they involve illness or disease?

Szasz replies that two things in fact are involved. They are: (i) an unwarranted, and hence purely metaphorical, extension of the use of 'sickness', 'illness', 'disease', and 'disorder' to apply to certain emotional and mental states; and (ii) a judgment by society against feelings and behavior that are not in its interest. Certain responses to the conditions of social life are, from this point of view, condemned as non-adaptive and dysfunctional. Szasz believes that the majority of emotional and mental 'disorders' or 'illnesses' are of this kind: they are judged to be undesirable conditions and carry stigmata principally in relation to values that society advocates. If mental or emotional 'illness' is, then, largely the result of unfounded metaphor, then psychotherapy, as long as it is construed as treatment of illness, is really a myth – for it is myth to treat a fiction.

Szasz's deft argument notwithstanding, there is clearly a sense in which many emotional or mental conditions stand in the way of their possessor's own desires and life goals. They are dysfunctional from the individual's *own*

[27] Thomas Stephen Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, New York: Harper & Row, 1974; first published, 1961; *The Myth of Psychotherapy: Mental Healing as Religion, Rhetoric, and Repression*, Garden City, NY: Anchor Press, 1978; and *Insanity: The Idea and its Consequences*, New York: Wiley, 1987.

point of view precisely because they are handicapping. Szasz prefers to call these conditions 'problems of living', as did Alfred Adler.[28] But as long as it is not possible to link such conditions to underlying physical disorders, Szasz refuses to call those who suffer from them 'sick'.

Aside from Szasz's more self-consciously strict use of language, the main purpose served by his argument, vigorously sustained by him now for more than thirty years, is to situate the locus of change within the patient. For, in those many cases where no underlying physical disorder is identifiable, change, if it is possible at all, requires the patient's own initiative, to replace unwanted feelings and behavior patterns with those that can better serve his needs. Psychotherapy, from this point of view, is engaged not in the treatment of illness, but in a form of epidictic interaction with the patient: its fundamental purpose is to persuade the patient to take on the often difficult task of self-transformation, and to persuade him that his faith in this process is warranted.

§ 6. Phenomenological psychiatry and therapeutic evaluation

One of the most sensitive approaches so far developed to represent the inner world of the patient in psychotherapy is J.H. van den Berg's phenomenological psychiatry.[29] Van den Berg and his American contemporary George Kelly[30] recognized that if a patient is to overcome the limitations defined by the world of his experience, he must participate actively in his therapy. In Kelly's view, in particular, successful therapy is largely a matter of the ability of patients to learn to experience reality differently, to develop new interpretations of events, and on this basis to establish new habits of feeling and behavior. This process is essentially one of education in which patients' individual, and unequal, abilities to learn in a psychological context are of paramount importance.

A phenomenological perspective helps to throw into relief the weakness of the many studies of therapeutic effectiveness: they have been looking for the key to successful therapy in the wrong place. It is not that a particular approach to psychotherapy is effective or ineffective in its own right, but rather there is a relationship of mutual interaction among three terms: a

[28] *Problems of Neurosis*, New York: Harper & Row, 1964.
[29] *The Phenomenological Approach to Psychiatry: An Introduction to Recent Phenomenological Psychopathology*, Springfield, Illinois: Charles C. Thomas, 1955.
[30] *The Psychology of Personal Constructs*, 2 vols., New York: Norton, 1955.

patient's ability to learn, a therapist's ability to teach, and the particular approach to therapy that provides a framework for exchanges between patient and therapist.

The fact that attention-placebo therapy is often effective does not of itself diminish professional therapy. The two may prove to co-exist on the same continuum. To date, to the author's knowledge, no studies have been made of the phenomenology of belief among patients in psychotherapy: no attempt has been made to correlate successful therapeutic outcomes with measures of the belief that individual patients invest in the likely success of their therapists and therapies. Nor have studies been made that rate the psychological learning abilities of the patients themselves, which would serve as indications of their probable success in therapies that match their individual needs.

It would follow, from the standpoint of approaches like van den Berg's or Kelly's, that these are two vital elements in successful therapy: the patient's belief in its potential effectiveness, and his capacity to initiate change in himself with the assistance either of a professional therapist, or of someone whom he at least imagines to have a therapist's abilities.

Conclusion

The many hundreds of studies of therapeutic effectiveness have been minimally instructive; there has been much waste of time and effort searching for indications of therapeutic effectiveness among therapies themselves. In this paper, we have made an effort to discuss the most damaging criticisms that have emerged from evaluations of psychotherapy. They point toward these plausible conclusions:

Studies of the effectiveness of alternative approaches to psychotherapy and of psychoanalysis have failed to take into account the need for evaluation of the psychological learning abilities of individual patients themselves. We live in a time when men prefer to critique methods, rather than the abilities of individuals to implement them.

Secondly, placebo studies have shown that therapy is frequently successful when a patient is able to invest belief in its effectiveness. The role of belief here is similar to the role of interest in intellectual learning; without it, learning is ineffective. Since individual approaches to therapy are usually not in and of themselves belief-engendering, the task of the professional

therapist, or of the untrained 'therapist' in placebo studies, is to establish with each patient a framework of rapport and expectancy of a favorable outcome. Many patients, we must grant, do not require professional therapists to elicit their belief in a positive outcome. Other patients, whose difficulties are perhaps more complex, or who are themselves more demanding of sophistication in their treatment, may require professional therapists in order for the essential constituent of successful treatment to be realized. This constituent is belief in their capacity to change, and in the likelihood that change of a certain kind will resolve many of the problems they face.

The analogy with education can be extended. We call those who learn well good students; they receive higher marks for their work. Frequently, although not always, their learning presupposes good teaching. But more important than teaching – and recognizing that good teaching can sometimes kindle it to some extent – is their personal interest in learning; it is an essential factor in their success.

Similarly, successful patients in psychotherapy are good students of another kind. Belief in the likelihood of a successful outcome of therapy is probably the crucial factor that sustains their abilities to learn in a psychological context. For some patients with certain difficulties, a good, i.e., professional, teacher may be unnecessary. For others, competent therapy appears to be indispensable to a favorable outcome. Only attention to individual differences will help us to know what is needed in specific cases.

Earlier in this paper, we mentioned the need for differential diagnosis and treatment – that is, the need to find the best match between the nature of an individual's difficulties, his type of personality, and his psychological learning abilities, on the one hand, and most promising approaches to psychotherapy, on the other. Desirable though this is, we have also suggested that the efficacy of any chosen approach to therapy will depend, in great measure, upon the degree to which the individual patient is able to believe that the process of therapy will, with time and his own effort, fulfill his needs. This difficult-to-quantify element of necessary belief is likely to remain one of the less tangible elements of effective therapy. It is perhaps best described as a mutually reinforcing interaction between the persuasive power of some therapists to summon in the patient's mind the faith that they

will be able to change, and the ability of some patients to develop and then to act upon that faith.

If this characterizes the essential dynamic of successful therapy, it becomes all the more understandable why the hundreds of studies of therapeutic effectiveness have failed to achieve less ambiguous results.

Evaluative research has been looking in the wrong place for evidence of therapeutic success, somewhat like the drunk who looks for his lost keys beneath a lamp post, simply because there is more light there. And placebo studies, far from casting doubt upon therapeutic effectiveness, in fact reveal the existence of its most basic human ingredient.

2014 AFTERWORD

In the years since I wrote this paper, my confidence in the view that it advocates has strengthened: It has become increasingly clear—I am tempted to say, abundantly evident—that the effectiveness of psychotherapy is a function of three main factors: the type of problem that brings a person to therapy; the individual nature of that person, including his or her own willingness, degree of motivation, as well as ability to learn new emotions, attitudes, and behavioral responses to life; and, finally, the degree of belief that the therapist and the approach used can elicit in the client, belief that predisposes the client to trust that the therapy offered will bring about desired change.

These three factors are seldom consciously recognized by most clinicians as forming an essentially interconnected group, and as a result the interrelations among the three factors do not play the leading role they should in self-critical clinical diagnosis and treatment. Instead, the *DSM* concentrates exclusively only on the first factor, the nature of the "presenting problem." This is both a conceptual and a practical/clinical mistake, and it is compounded by the unbridled appetite *DSM* proponents have acquired for uncritically inflating the number and kinds of so-called "mental disorders."

My book, *When You Don't Know Where to Turn: A Self-Diagnosing Guide to Counseling and Therapy* (Contemporary Books/McGraw-Hill), written for general readers, offered in 1987 the only existing algorithm to guide people toward approaches to therapy and counseling that are, based on studies of their effectiveness, most likely to benefit them. Fundamental to the approach advocated in this book was the above three-factor understanding of psychotherapeutic effectiveness. As far as I've been able to determine, *When You Don't Know Where to Turn* is still the only book to offer a person- and therapy-centered algorithm of this kind.

In *Normality Does Not Equal Mental Health: The Need to Look Elsewhere for Standards of Good Mental Health* (Praeger, 2011), I take clinical psychology and psychiatry to task for their unquestioned and unfounded presumption that psychological normality should serve as a baseline standard for good mental health. Psychologically normal people are known, under the right circumstances (which occur all-too-often) to be highly capable of pathological thinking and behavior, as examined in my book, *The Pathology of Man*. Psychological normality is about as appropriate a standard for good mental health as cancerous cells are a suitable standard for healthy tissue.

We need to look elsewhere to understand and appreciate what makes people mentally healthy and fully sane. As Abraham Maslow recognized, genuine mental health is found, not among the average and psychologically normal, but among relatively few people who are exceptional in various ways. The defining characteristics of good mental health include such characteristics as consciousness of higher values and dedication to ends that have intrinsic value, heightened perceptual abilities, creativity, aesthetic sensibility and greater responsiveness to beauty, resistance to enculturation and resulting conformity, and what I have elsewhere referred to as "moral intelligence"[1] (other mentally healthy capacities are described in *Normality Does Not Equal Mental Health*).

These are a few of the positive traits that *should* be used to measure good mental health, but they are unfortunately not the traits that clinicians do use to establish a baseline for good human mental health. The reason for this is, of course, that the positive traits I've listed are generally not found in great measure among the psychologically normal (and most clinicians belong to this group).

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[1] *The Pathology of Man: A Study of Human Evil* (Charles C. Thomas, 2005), pp. 279-280 and passim.

I have proposed that effective psychotherapy is a function of three interrelated factors: the psychological problem that brings the person to therapy, his or her motivation and ability to learn what the therapist has to offer, and the degree of belief the client has in the success of the therapy. Overlaid on these basic truths about effective therapy is a metatheoretical claim that good mental health is not to be equated with norms derived from the psychologically average population, which is predisposed to many varieties of pathology, but instead requires standards derived from individuals who genuinely are mentally healthy.

From this point of view, we should see that the effectiveness of psychotherapy has been deeply misunderstood: Its effectiveness depends not merely on the "presenting problem," but upon the personal incentive and the learning skills of the client, upon the client-therapy and client-therapist "fit" in terms of the degree to which trust in a successful therapeutic outcome is realized, and, last and most recently emphasized in some of my publications,[2] upon the firm dismissal of psychological normality as an appropriate standard of mental health.

In its place, we need to affirm what phenomenological psychiatrist J. H. van den Berg would perhaps have

2 See "From the Artist's Perspective: The Psychopathology of the Normal World," *The Humanistic Psychologist*, Vol. 37:3, July/September, 2009, pp. 235-256, as well as chapters in *Normality Does Not Equal Mental Health.*.

called "therapeutic tailoring" — an apt phrase for understanding that psychological problems are wholly relative to the client's interests, personality, and goals; that, as a consequence, the majority of today's non-organically-based "mental disorders" do not exist as disease entities in their own right; and that successful therapy is above all a matter of helping the client to adjust to his or her own self, interpersonal and physical environment, goals, and needs. Such a tailored approach to individual therapy clearly does not seek to "adjust the patient" to social needs and requirements. It only serves the needs, goals, and individuality of the person, as it should.

Such a person-relative understanding of psychological problems obviously does not lend itself to the wish of the majority population of professionals with vested interests in being able to specify diagnostic codes authoritatively drawn from a progressively thickening manual that lists and classifies the authorized universe of "mental disorders." That professionally authorized manual is, as one should expect, given very high credence, for it claims that such "mental disorders" are real dysfunctions, although they are liberally created, most often without any evidence of an underlying organic basis, through the consensus of appointed committees whose members' financial and professional self-interests are at stake.

In such a context, the repudiation of psychological normality as a standard for good mental health is not something that is likely to happen any time soon—least of all will it paradoxically be advocated by the psychologically normal majority.

But until this happens, our understanding of psychotherapeutic effectiveness will continue totally to miss its mark.[3]

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[3] For more detailed discussion and support of the observations and claims made here, see Chapters 1-3 in my *Normality Does Not Equal Mental Health*.