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A STUDY OF COUNSELING AT
REED COLLEGE

by

MARTIN SHAWN FISHER

MARK MASTERSON

A practicum submitted in partial fulfillment
of the requirements for the degree of

MASTER of SOCIAL WORK

Portland State University
1976

TO THE OFFICE OF GRADUATE STUDIES AND RESEARCH:

The advisor approves the practicum of Martin Shawn Fisher and Mark Masterson presented May 14, 1976.

Nancy Koroloff, MSW, Advisor

ACKNOWLEDGEMENTS

In the Spring of 1975 we were invited to develop a study of the services provided by the Reed College Counseling Service. The invitation was from Jim Allred, one of the two psychiatric social workers who compose the staff of the Reed College Counseling Service. He suggested that a study might accomplish two things. First, he thought that a study could provide the counselors with information which would be useful in their practice. Second, he saw the possibility of a study of the Reed College Counseling Service as a method of fulfilling the practicum requirement for the Master of Social Work degree which both authors sought. In addition, his invitation conveyed an openness on the part of the counselors to explore whatever avenues of evaluation we chose.

The invitation was viewed by the authors as both an opportunity to explore their common interest in evaluating the effectiveness of individual counseling and as a way of developing an understanding of how to conduct research in a functioning treatment setting. Because the invitation was proffered with a firm commitment of cooperation, we also felt challenged to help develop information which could aid the counselors in their work.

The following study represents the work which grew from the invitation. While the authors are responsible for the design and content of the study, their work would not have been possible without the faithful collaboration of Jim Allred and Eunice Watson of the Reed College Counseling Service. In addition we wish to acknowledge the gracious cooperation of Juana Ukolov and Helen Ellis who aided our study through their services in the Reed College Deans' Offices. We also appreciate the cooperation from the students of Reed College who through their responses to our questions showed themselves to be helpful as well as bright. Finally, we gratefully acknowledge the support and competance of our advisor Nancy Koroloff who helped us "each step of the way."

Mark Masterson

Martin Shawn Fisher
May, 1976

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CHAPTER I

INTRODUCTION

Description of Reed College

Reed College is a small coeducational liberal arts college located in a residential section of South East Portland. The college has approximately eleven hundred and thirty undergraduates and a Masters Program with about forty students. The undergraduate population is about sixty percent male and forty percent female with most students being between the ages of eighteen and twenty-two. The student-faculty ratio of the undergraduate college is twelve to one.

The cost of undergraduate tuition and fees, exclusive of room and board charges, is three thousand seven hundred and forty dollars. The total cost of an academic year including charges for campus room and board is about five thousand dollars. As regards educational financing almost one-half of the student body receives some form of financial assistance from the college.

The most distinctive feature of the college is its continuing tradition of academic excellence. Reed College enjoys a national reputation as an outstanding undergraduate school. Eighty-eight percent of its students come from

states other than Oregon, with over half being from east of the Mississippi River. Three-fourths of its student body ranked in the top fifth of their graduating class in high school and ninety percent of the student body had Standard Aptitude Test scores, upon entrance to the college, of over five hundred. More impressive is the fact that Reed has more Rhodes Scholars in relation to enrollment than any other college or university in the United States. In addition, only one other college in the United States has a higher proportion of students who go on to achieve Ph. D. degrees. Facts like these have helped establish Reed College as one of the United States' leading undergraduate colleges.

The Reed campus environment is in contrast with the rigorous academic demands made of its inhabitants. The one-half of the student body that lives on campus enjoys a relatively undemanding "rule free" existence. The college administration has only minimal codes about campus behavior, although it does make clear that students who live on campus are subject to the laws of Oregon. In place of extensive campus regulations the "Honor Principle" is subscribed to by most campus dwellers. In essence the Honor Principle permits any behavior which does not cause "unnecessary embarrassment, discomfort or injury" to others in the Reed community. Observation seems to indicate that the paradox of stringent academic demands on the one hand, and a relatively rule free campus life on the other,

may foster serious conflicts in the lives of Reed students. This observation takes into account two important dynamics of Reed life which should be considered when thinking about student life at Reed College.

Description of the Reed College Counseling Service

The Reed College Counseling Service provides both free and fee based services to the student body of Reed College. The services include consultation, individual and group counseling, a couples group and training for improving study skills. The services are principally delivered by two counselors who have Master of Social Work degrees. In addition a school psychiatrist is available for consultation and direct service to students with severe emotional problems. The two counselors currently divide the responsibilities for consultation, two weekly counseling groups and a study skills group. In addition each sees approximately twenty students a week in individual counseling.

The Reed College Counseling Service is under the direction of the Deans' Offices. The Deans' Offices serve as a kind of campus center for student welfare. The two Deans help students with a variety of situations including academic, legal, financial, social and emotional ones. In their efforts the Deans often collaborate with the two counselors in addressing the emotional needs of the

students.

Arrangements to use the counseling services are made through the Deans' Offices. Appointments to see the counselors are made with the Deans' secretaries who also arrange the counselors' daily schedules. Physically, the Deans' Offices are across a small hall from the two counselors' offices. Most one to one counseling occurs in the counselors' offices following a check in at the Deans' Office. Groups are often held in one of the two Deans' private offices because of their size.

While the counseling service is only part of the available services in the Deans' Office its impact in the Reed community is substantial. For the academic year 1974-75, nearly a quarter of the Reed student body used at least one of the counseling services. Students typically bring academic problems or problems centering on their personal relationships to the counselors.

The Purposes of the Study

The main purpose of the study was to develop information which would be useful to the counselors of the Reed College Counseling Service in their practice. Specifically, information was sought on the outcomes of one to one counseling sessions. The aim of the inquiry was to determine some of the dynamics and results of individual counseling with Reed students. The goal was to discover

information about successful and unsuccessful counseling sessions which would benefit the counselors in the provision of their services.

A review of the literature on outcome research in psychotherapy suggested that focusing the study on the treatment of a single problem would yield the most useful information. In this light the literature seemed to point to the necessity of limiting the scope of research in studies of psychotherapy outcomes because of the complexity of psychotherapy. The development of the research design was guided by these insights. This study focuses on the dynamics and results of the treatment of a single problem: homesickness.

Homesickness was chosen as a problem whose treatment would be studied for two reasons. First, it was selected because the counselors suggested it as a problem whose treatment they would be willing to explore. Secondly, homesickness was chosen because of the feasibility of conducting a study of it. According to the counselors homesickness has been a frequently occurring problem in the Reed student populace. In the past the severity of homesickness symptoms has led many students each year to seek help at the counseling service. Homesickness was therefore feasible as a problem for study because it appeared to be a problem frequently encountered in counseling sessions. In addition the time of the greatest

incidence of homesickness problems, the fall term, coincided with the most convenient time for research data collection. Thus, the treatment of homesickness became the focus of the study's efforts to develop information which would be useful to the counselors. Given this focus it was hypothesized that homesick students receiving counseling would evidence improvement as defined by the dimensions of measurement used in this study.

A secondary purpose of the study was to develop an understanding of how to conduct research in a functioning treatment setting. Although more diffuse than the first purpose of the study the second nevertheless instilled much of the work of the study with a certain attitude. The attitude was one of trying to maximize the potential learning experiences possible in the study.

CHAPTER II

REVIEW OF THE LITERATURE

The purpose of this review is to provide the reader with an overview of outcome research in individual psychotherapy. Outcome research refers to studies that attempt to determine the effects of individual psychotherapy, on feelings, behaviors and attitudes of the client. Outcome research studies are being reviewed because the present research project is a study of individual therapeutic outcomes. This review of the literature therefore, will be useful in understanding and assessing the present research project.

In preparing this review, other reviews of the literature have been consulted extensively, although not exclusively [i.e. Eysenck (1952), Bergin (1966), Kellner (1967), Strupp and Bergin (1969), Luborsky et al. (1971), Meltzoff and Kornreich (1971), Malan (1973)]. In other words this review can be considered a review of reviews. This approach was chosen because it seems to provide the most comprehensive overview of research studies and because it identifies the prominent issues.

This review is organized into four sections. The first section highlights some major issues in outcome re-

search from a historical perspective. It will include a discussion of Hans Eysenck's 1952 review of the research literature and explain the issues of spontaneous remission, deterioration rate and control groups. In providing a historical perspective, the first section will also mention the establishment of five major sources of research in psychotherapy and briefly describe the focus of their studies.

The second section summarizes some of the major findings of outcome research in individual psychotherapy. This section will identify some of the variables in the therapeutic situation which have been empirically associated with positive outcomes.

Obstacles to conducting research in psychotherapy are discussed in the third section. The fourth section will summarize the efforts of this review. Finally, the last section will provide a rationale for this study's research design.

I. Historical Highlights of Outcome Research in Psychotherapy

For more than fifty years, researchers in psychotherapy have invested a great deal of time, money and effort in attempting to answer the question, "Is psychotherapy effective?" The results of these efforts have generated a great many more questions and controversies than

clear cut conclusions. In this section, some of these questions and controversies will be discussed from a historical perspective. Specifically, this section will focus on the following issues: the effects of therapy, spontaneous remission, deterioration rates. These issues will be developed historically by examining reviews by Eysenck (1953), Cartwright (1956) and Bergin (1971a).

Eysenck: Null Effects of Therapy, Spontaneous Remission

The first comprehensive review of outcome studies was Hans Eysenck's 1952 article, "The Effects of Psychotherapy, An Evaluation." This article was the first attempt to make some sense out of the confusing and conflicting results of outcome research studies at that time. Eysenck reviewed approximately twenty-four outcome studies that compared treatment groups with control groups. Eysenck found no measurable difference in outcome between treated and untreated patients from the studies he reviewed.

Eysenck formulated two major conclusions based on his review. First, he argued that there was no evidence that "Psychotherapy, Freudian or otherwise, facilitates the recovery of the neurotic patient" (p. 322). Secondly, Eysenck claimed that roughly two-thirds of all neurotic patients improve even in the absence of treatment (Malan, 1973, p.719). This phenomena of the patient's condition improving without treatment is known as spontaneous re-

mission. In essence, Eysenck concluded that psychotherapy is no more effective than normal living without treatment.

Cartwright: Deleterious Effects of Therapy

Eysenck's review generated a great deal of controversy because his conclusions clearly questioned the value of psychotherapy. There were numerous responses and critiques to Eysenck's contention that psychotherapy is no more effective than no treatment at all (Malan, 1973, p. 719).

One of the most enlightening reviews of Eysenck's work was Desmond Cartwright's (1956) article, "Note on 'Changes in Psychoneurotic Patients With and Without Psychotherapy'". In examining the studies Eysenck reviewed, Cartwright pointed out that there was significantly more variation in personality change indices for those patients who received psychotherapy. In other words, although the average outcomes were the same for treated and untreated groups, there was a much wider range of outcomes in the treated patients. Among the treated patients, Cartwright discovered that some had improved considerably while other patients became more maladjusted as a result of therapy. On the basis of this observation, Cartwright concluded that "psychotherapy may cause people to become better or worse adjusted than comparable people who do not receive

such treatment" (pp. 403-404). This observation was a milestone in outcome research. It provided one of the most credible explanations for Eysenck's finding that psychotherapy, on the average, is no more effective than normal living without treatment.

Bergin: Ambiguous Results, Control Groups, Spontaneous Remission

Eysenck's 1952 article, in which he questioned the effectiveness of psychotherapy, has had an enduring impact on psychotherapeutic literature. This is clearly evidenced by the fact that Allen G. Bergin, a prominent writer in the research of psychotherapy, deemed it necessary to respond to Eysenck's article nineteen years later (Bergin, 1971a).

In his 1971 article, Bergin reexamined the original studies which Eysenck reviewed in his controversial 1952 article. Bergin's "careful and dispassionate" reexamination of the evidence revealed the subjectivity inherent in interpreting divergent studies such as those referred to in Eysenck's review (Malan, 1973, p. 722). Bergin found that the studies Eysenck reviewed were ambiguous enough to allow for considerable individual bias in interpreting the results. For example, because of the different measuring indices of therapeutic outcomes employed in the studies, Eysenck was forced to arbitrarily determine the criteria for successful therapy. Bergin notes that Eysenck

counted premature dropouts as failures in therapy. Bergin however contends that "individuals drop out for numerous reasons, some of which have nothing to do with therapy" (p. 223). Clearly the determination of such criteria are very much a matter of personal opinion. Because of the great amount of ambiguity present in the studies Eysenck reviewed, Bergin maintains that Eysenck's conclusions are subjective. This means that the data are open to other equally valid interpretations.

Bergin also challenged Eysenck's claims that two-thirds of all neurotics improved with or without treatment. Bergin contends that this notion is invalid on two accounts. First, it is virtually impossible to set up a true untreated group. This is true because individuals in distress frequently receive help from nonprofessional therapists (i.e. friends, clergy, teachers). Secondly, in reviewing several recent outcome studies, Bergin found a substantial amount of evidence that the "so called spontaneous remissions rates vary greatly across different types of neuroses" (p. 236).

Furthermore, Bergin developed his own estimate of spontaneous remission rates from a review of fourteen studies. These studies yielded an average spontaneous rate of about thirty per cent. In summing up his reexamination of Eysenck's review, Bergin concludes, "not only is the spontaneous remission rate lower than expected but also

that it is probably caused to a considerable degree by actual therapy or therapy like procedures" (p. 246).

Thus far, this brief historical perspective has been selective in focusing primarily on Eysenck's 1952 review and the issues of null effects, spontaneous remission, deterioration rates and control groups. The significance of Eysenck's article was noted along with a description of how the issues have been clarified by subsequent reviews by Cartwright and Bergin. Obviously, there are a great many more personalities and issues in outcome research and some of them will appear in other sections of this review. For the moment, however, a broader historical perspective will be developed by describing the five major sources of outcome research.

Sources of Outcome Research in Psychotherapy

Much of the outcome research in psychotherapy has been carried out by five major sources of research. All of the following sources came into existence in the late 1950's. Each of these five sources has made a substantial contribution to the research literature. One of the oldest sources of research in psychotherapy has been the Psychotherapy Research Project of the Menniger Foundation. This project has attempted a "statistical and clinical study of psychoanalysis and psychoanalytic based psychotherapy" (Malan, 1973, p. 721).

Another source has been the work of Carl Rogers and the client centered school of psychotherapy. Rogers and his colleagues have conducted research aimed at specifying the characteristics of effective therapists.

A third major branch of research in this area has been Jerome Frank's studies of dynamic psychotherapy at the Phipps Clinic. Frank devoted his studies to determining the common curative elements of psychotherapy.

Behavior therapy represents another source of outcome research in psychotherapy. Researchers from this school (Wolpe, Paul, Lazerus, etc.) have developed specific, objective outcome criteria and have demonstrated empirically the effectiveness of several behavior techniques.

The fifth major source of outcome research has been a series of conferences on Research in Psychotherapy. The purpose of these conferences has been to provide a forum for sharing and integrating the results of various research projects across the country. At the conclusion of the third conference in 1966, Hans Strupp and Allen Bergin were directed to prepare a comprehensive review of the literature in this field. Their efforts resulted in an important paper published in 1969, entitled, "Some Empirical and Conceptual Bases For Coordinated Research In Psychotherapy."

Because of their significances, these five major sources of research will be referred to in other sections

of this review. Having concluded this historical perspective of outcome research in psychotherapy, the next section will summarize some of the important findings of research in the field.

II. Variables Related to Outcome in Psychotherapy

In this section, some of the significant findings of outcome research will be reviewed. This section will focus on the variables in the client, the therapist, the method of treatment and the duration of treatment, which have been correlated with positive outcomes in psychotherapy. Before proceeding two important facts merit recognition. First of all, in examining outcome studies, it is essential to note some of the problems encountered in outcome research. These problems concern the variations among outcome studies in the following areas; outcome criteria, type of treatment offered, training and competence of therapist, type of client, and duration of treatment.

Because of these differences, it is difficult to make valid generalizations and comparisons across studies. Similarly, studies which fail to specify the different variables involved in the therapeutic encounter, make it difficult to determine how to account for successful outcomes.

Secondly, it should be noted that the majority of outcome studies have focused on the relationship of a

specific variable to positive outcomes in psychotherapy. For the purposes of clarity and convenience, therefore, this section has categorized the studies into the four major treatment variables; the client, the therapist, the method of treatment and the duration of treatment. In concentrating on specific variables, there exists the danger of overlooking the significance of how these factors interact and influence treatment outcomes. As Sol Garfield has pointed out, "Clearly, there is an interaction between the client (or client variables) and the therapist (or therapist variables) that has to be studied and understood if we are to fully comprehend the psychotherapeutic endeavor" (Garfield, 1971, p. 291). With an appreciation of these considerations, significant findings of outcome studies will be reviewed.

Client Variables Related to Outcome

There have been a great many research attempts to identify client variables associated with psychotherapy outcomes. In their 1971 review of 160 outcome studies, Lester Luborsky et al., found that by far, the greatest number of factors which have been associated with positive outcomes are found in the client's personality. According to these researchers,

> Patient factors which were most significantly associated with improvement are psychological health or adequacy of personality functioning, absence of schizoid trends, motivation, intelligence, anxiety,

education and social assets (p. 145).

The research on client variables, however, is by no means conclusive and there are a number of contradictory findings. Nevertheless, there are a number of specific studies that deserve mention.

Level of Adjustment and Therapy Outcomes

Some studies have attempted to identify successful clients by their responses to psychological tests. Most of these studies have referred to a client's level of adjustment as a significant indicator of amenability to treatment. In a 1954 study by Rosenberg, the Rorschach the Wechsler-Bellevue and a sentence completion test were administered to 40 male white patients, 20-35 years of age at a Veterans Administration Mental Hygiene Clinic. All of the patients had received psychotherapy for nine months and were rated as "improved" or "unimproved" by their respective therapists. On the basis of the study, Rosenburg concluded that the successful patient has superior intelligence, has the ability to produce associations easily, is not rigid, has a wide range of interest, is sensitive to his environment, feels deeply, exhibits a high level of energy, and is relatively free from somatic symptoms.

Two other studies utilized psychological tests to determine significant variables among clients in pre-

dicting successful outcomes and emphasized the importance of the degree of impairment on outcome. Barron's 1953 study used the Rorschach, the Wechsler-Bellevue and the MMPI to distinguish between patients rated as "improved" and "unimproved." "Unimproved" patients scored higher on the Paranoid and Schizophrenic Scale of the MMPI. This led Barron to conclude that: "The patients who are most likely to improve are not very sick in the first place" (p. 240).

Sullivan, in his 1958 study of 268 Veteran outpatients reached similar conclusions. Sullivan found that those patients who were rated as less pathological by MMPI scores, showed the greatest improvement in therapy.

In addition, Luborsky, Auerbach, Chandler, Cohen and Bachrach (1971) in their extensive reviews of outcome studies make the following observation,

> ...of the 28 studies, that fall within this category, (Adequacy of General Personality Functioning), 15 show a significant relationship between the level of initial personality functioning and outcome of treatment; of these 14 are in the positive direction. They indicate that the healthier the patient is to begin with, the better the outcome--or the converse--the sicker he is to begin with, the poorer the outcome (pp. 147-48).

Truax and Carkhuff have discovered a slightly different relationship between personality adjustment and success in psychotherapy. In a 1964 study, they found that patients with the greatest internal disturbance, as indicated by MMPI and Q-Sort measures, and the lowest external

or behavioral disturbance, as indicated by the Wittenborn Psychiatric Rater Scales, showed the greatest improvement in psychotherapy. Additional studies by Truax and Carkhuff (1967, pp. 169-174), confirmed these findings. They explain their understanding of the relationship between the client's level of adjustment and therapy outcomes as follows:

> ...it seems likely that a high level of "Felt" disturbances (as measured by self-report questionnaires of felt anxiety, etc.) and a low level of overt or behavioral disturbances (as measured by ward behavior ratings length of institutionalization, current college grades, etc.) are most predictive of outcome (p. 174).

Thus, there is considerable evidence that high levels of personality functioning as measured by various psychological tests are correlated with positive outcomes in psychotherapy. It seems reasonable to conclude that in the past, psychotherapy has been most successful with those clients who are least disturbed or, as some authors have noted, in the least need of treatment (Garfield, 1971, p. 294). Although there are some inconsistencies between studies, there appears to be a growing amount of evidence in favor of this conclusion.

Client Expectancies and Therapy Outcomes

There have been a number of researchers who have explored the influences of a client's expectancies on treatment outcomes. Lipkin (1954) has examined client attitudes in relation to therapeutic outcomes in client cen-

tered therapy. He employed various pre-treatment and post therapy measures to determine personality change as well as the client's orientation to treatment. On the basis of his study, Lipkin concluded that,

> the client who is positively oriented toward the counselor and the counseling experience and who anticipates that his experience in counseling will be a successful and gratifying one, undergoes more change in personality structure than does the client who has reservations about the counseling experience (p.26).

A great deal of the research on the role of expectancies in psychotherapy has been completed by Arnold Goldstein. In a 1960 study, Goldstein found a significant correlation between patients' expected and perceived improvement in treatment.

Another study by Goldstein and Shipman (1961) found a positive but curvilinear relationship between expectancy and perceived symptom reduction in treatment. In other words, Goldstein's studies have revealed that those clients who go into psychotherapy with a moderate expectation of improvement are most likely to improve. On the other hand, clients with very high or very low expectations of therapy are less likely to benefit from treatment. In explaining the implications of his research, Goldstein (1962) notes, "it would follow that professional mental health groups who represent or sell psychotherapy to the public should place added emphasis on a realistic picture of therapeutic goals"(p.121).

Relationship Variables and Therapy Outcomes

There are a number of client variables which center around the client's ability to sustain a meaningful relationship with a therapist. Strupp and Bergin in their comprehensive 1969 review of outcome research have identified a number of these client-relationship variables which they consider "presently most valid." According to these authors, patient relatability, patient attractiveness, openness to influence and patient-therapist similarity are all significant client variables which appear related to positive outcomes.

"Openness to therapeutic influence" as defined by Strupp and Bergin (1969), refers to a multitude of client attitudes and behaviors. Such client characteristics as a willingness to express feelings, having and experiencing strong dependency needs, experiencing guilt and anxiety, sensing personal responsibility for problems, wanting help and avoiding a physiological focus on problems, constitute the openness to influence variable. There have been a number of studies which have measured these client characteristics during the initial interview by various scoring schemes such as the Depth of Self-Exploration scale developed by Truax (Truax, 1962; Truax and Carkhuff, 1967). These studies have demonstrated a positive correlation between a client's "openness to therapeutic influence" and improvement in psychotherapy.

Another important client variable cited in Strupp and Bergin's 1969 review is patient relatability. This variable refers to the client's ability to sustain a therapeutic relationship. It is obviously related to the "openness to influence" variable cited above. Researchers have yet to determine how these two client variables interact. Nevertheless, it is apparent from studies by Isaacs and Haggard (1966) that clients who score high on "relatability" as assessed by TAT scores, evidence greater improvement in client-centered therapy.

Finally, there are two additional client variables which also pertain to the therapeutic relationship. First, there is some research evidence according to Strupp and Bergin (1969), which indicates that those patients who are considered more "attractive" to the therapist are more likely to experience improvement in psychotherapy (p. 43).

Secondly, there are other studies which show that "patient-therapist similarity" may be an important factor in determining therapy outcome. Culter (1958) found that therapists who worked with client conflicts similar to their own, were judged less adequate than therapists who were paired with a client who had conflicts different from his own.

Bandura's 1960 study confirmed these findings. He found that therapists who were rated as having hostility conflicts were more likely to avoid hostility related

topics than those therapists who were not rated as having hostility conflicts. There is insufficient data at this time to permit a definitive conclusion regarding the effects of patient-therapist similarity on therapeutic outcomes. However, Strupp and Bergin in referring to patient-therapist similarity note that "this variable is generally of sufficient apparent importance to warrant more vigorous study" (Bergin and Strupp, 1972, p. 44).

Socioeconomic Class and Therapy Outcomes

Socioeconomic class has been identified by a number of investigators as having profound repercussions regarding continuation and success in psychotherapy. Much of the research on this variable has been conducted in response to the problems encountered by practitioners in working with low income clients. Hollingshead and Redlick (1958), Strupp and Williams (1960) and Auld and Myers (1960) have elaborated on some of the problems when the client and the therapist are of a different socioeconomic class.

In his review of client variables related to improvement, Sol Garfield has concluded, "...it seems rather clear that the more conventional dynamic, long term orientations in psychotherapy are not effective with a large number of clients of low socioeconomic status." Some authorities contend that the reason for the lack of success with low income clients is that such clients are less

likely to possess the characteristics of a "good client." For example, low income clients are considered likely to have different expectations of treatment and are more likely to experience difficulty in relating to professional therapists than are their middle class counterparts.

On the other hand, Barbara Lerner in her study of Therapy in the Ghetto, has argued that the lack of success with low income clients can be attributed to the fact that "very few highly trained and motivated professionals work extensively and by choice with severely disturbed lower class individuals" (p. 11).

Summary

There are a multitude of client variables which have been associated with improvement in psychotherapy. Although the client characteristics cited above are by no means an exhaustive or inclusive review of the voluminous research, some of the most prominent variables have been identified. There is a definite profile of the so-called "good client" or client most likely to succeed which emerges from the research studies cited. Clients who are most likely to experience improvement in psychotherapy are young, educated, intelligent and have an adequate personality adjustment. They are motivated, have a high level of "felt" anxiety and have realistic positive expectations of treatment. In addition, successful clients

are "likeable" and able to express their emotions. They are likely to have interests, values and attitudes in common with their therapists. Finally, all of the preceeding characteristics are less likely to be found among low income clients. In reviewing client characteristics it is apparent that many client variables, such as relatability and therapist-patient similarity, are somewhat dependent on the personality and skill of the therapist. It is now time to examine the outcome studies which address the characteristics of the successful therapist.

Therapist Variables Related to Outcome

There are two major areas of outcome research which focus on the therapist as a factor in successful therapy. One group of studies has attempted to determine the effect of the professional qualifications of the therapist on treatment outcomes. Another major research effort has been to assess the impact of the therapist's personality on the results of treatment. These two groups of studies which differentiate the successful therapist by professional qualifications and personality traits will now be reviewed.

Therapist Qualifications Related to Outcome

Perhaps it is indicative of the uncertainty in the field of psychotherapy, that some researchers have studied

the effects of training and experience on therapeutic effectiveness. In most other professions, the assumption that the better trained and more experienced professional is the most effective, is rarely questioned or deemed worthy of research. Researchers in psychotherapy however, have examined the therapy outcomes of therapists with varying amounts of experience, different types of training and from various professional disciplines. These studies have attempted to determine if therapists with a certain type of qualification are more effective than other therapists.

Experience

There are four significant research studies which explore the effect of the therapist's experience on therapy outcomes (Meltzoff and Kornreich, 1971, pp. 268-273). One of the earliest of these studies was Myer and Auld's 1955 study at the out-patient clinic at Yale University. This study compared the treatment outcomes of patients treated by experienced staff psychiatrists with those patients seen by relatively inexperienced psychiatric residents. Based on an examination of 63 case records, patients were rated on a four point scale at termination. The patients were rated as follows: 1) patient quit therapy, 2) therapist discharged patient as unimproved, 3) therapist discharged patient as improved, and 4) therapy continued

elsewhere. Comparison of the 63 cases utilizing this termination scale yielded two major findings. It was discovered that therapist experience was not related to outcome in cases with less than 10 sessions. In cases with more than 10 sessions, however, the more experienced staff psychiatrists tended to have more successful terminations and fewer failures. Of those patients considered improved, 64% were treated by staff psychiatrists and 32% by psychiatric residents. With some qualifications, the study supported the notion that the experienced therapist is more effective (Meltzoff and Kornreich, 1971, p. 268).

Another study which relates therapist experience with outcome is Cartwright's and Vogel's 1960 study conducted at the University of Chicago Counseling Center. This study compared the outcomes of 22 clients seen by 19 therapists. The 19 therapists were divided into two groups. One group had 10 experienced therapists, while the other had inexperienced therapists. The 10 experienced therapists were those who had treated 6 or more cases with a mean of 25.8 cases. Therapists who had treated 5 cases or less were classified as inexperienced. Outcomes were measured by repeated application of the Butler-Haigh Q-Sorts and a mental health rating scale derived from the TAT. The results of the study clearly favored the experienced therapists. The authors found that not only were the experienced therapists more effective in

improving patients' adjustments, but the inexperienced therapists were associated with bringing about a decrease in adjustment with some patients. Meltzoff and Kornreich (1971) have noted an apparent weakness in Cartwright and Vogel's study (p. 270). This weakness concerns the classification of therapists as experienced if they had seen 6 patients. This criterion appears to be a questionable definition of an "experienced therapist."

Two additional studies provide information about experienced therapists as a secondary issue. McNair, Larr and Callahan's 1963 study of terminators and remainders in therapy, differentiates the experienced and inexperienced therapist. These authors discovered that therapists with more than four years of experience held 72% of their patients in treatment, while those with less than 4 years held 60 per cent (Meltzoff and Kornreich, 1971, p. 271). It should be noted that remaining in therapy is not necessarily an indication of improvement.

Experienced therapists have also been shown to like their patients more than relatively inexperienced therapists. This was the finding of Ehrlich and Bauer's 1967 study of psychiatric residents at Ohio State University Hospital. Although there is no conclusive evidence on the outcome effects of therapists liking their patients, it could be hypothesized that therapists will work harder and be more motivated with those patients they find

attractive.

In summary, limited research evidence seems to indicate that the experienced therapist is indeed more successful than the inexperienced one. Meltzoff and Kornreich cautiously reach this conclusion on the basis of their extensive 1971 review of available outcome studies. In pointing out limitations in the studies to date, Meltzoff and Kornreich note,

> As the studies were generally not specifically designed to answer the question, experience levels were not always sharply delineated nor were other relevant variables enough controlled for us to say with confidence that obtained differences were due to experience alone. The preponderance of evidence, nonetheless, is that experience does seem to make a difference. A lower drop-out rate appears to be a consistent result of experience (p. 272).

Training

Closely related to the issue of experience is the question of the impact of training on therapeutic outcomes. It would appear reasonable to assume that therapists with extensive training would be more likely to affect positive therapeutic outcomes than therapists without extensive training. However, as will be revealed below, many nonprofessional therapists have achieved results equal to those of highly trained therapists.

One study has suggested that training does not increase client satisfaction. Grigg's 1961 study at the University of Texas Counseling Center compared the treat-

ment outcomes of 219 clients. The clients were treated by three groups of therapists with varying amounts of training. The therapists were 6 experienced Ph. D's, 6 experienced trainees who had one year of counseling experience and 4 inexperienced trainees who had either not completed their internship or had no prior experience. Cases were routinely assigned and the median number of sessions was 4.2. A major limitation of this study was that the major outcome measure consisted of a client satisfaction scale. The clients judged whether counseling had been very, moderately or minimally helpful to them. Results showed that 80% of the clients seen by the Ph. D's reported that counseling had been moderately or considerably helpful. This was less than the 89% of the clients seen by the more advanced trainees and 85% of the clients seen by the inexperienced trainees who felt that counseling had been helpful. Grigg concluded on the basis of these results that client feelings about improvement are independent of a counselor's level of experience.

In reviewing Grigg's study, Meltzoff and Kornreich (1971) noted a number of significant limitations. First, they point out that clients were not assigned randomly to the three groups of therapists. Upon closer examination, they discovered that assigning cases routinely meant that the Ph. D's unlike the other therapists, received more

cases involving personal rather than vocational problems. Other weaknesses in Grigg's study cited by Meltzoff and Kornreich are the lack of indication of the severity of the client's disturbance, and the sole reliance on client satisfaction questions as outcome measures (p. 272).

Arnold Goldstein (1972) has noted that there is an increasing amount of research evidence which indicates that nonprofessional therapists are effective in achieving positive therapeutic outcomes (p. 115). Goldstein has cited studies which demonstrate the psychotherapeutic potency of nurses (Ayllon and Michael, 1959; Daniels, 1966), aides (Ayllon and Haughton, 1964; Carkhuff and Truax, 1965), patients' parents (Allen and Harris, 1966; Guerney, 1964; Straughan, 1964), college undergraduates (Poser, 1967; Schwitzgehel and Kolb, 1964), psychological technicians (Cattell and Shotwell, 1954; Poser, 1966), convicts (Benjamin, Freedman, and Lynton, 1966), housewives (Rioch, 1966; Magoon, 1968), auxiliary counselors (Costin, 1966; Harvey, 1964), human service aides (Maclennon, 1966), and foster grandparents (Johnston, 1967).

Bech, Kantor and Gelineau's 1963 study provides an illustration of research which has suggested that therapists without extensive training can bring about positive changes in clients. This study involved assessing the effectiveness of volunteer undergraduate students treating 120 hospitalized adult schizophrenics. The treat-

ment consisted of verbal interaction and activities and the volunteer therapist received an hour of supervision per week. Outcomes were determined by the number of treated patients discharged and a rating scale which categorized patients at termination as "sick as ever," "marginal adjusted," "considerably improved," and "appears well." The undergraduates were considered successful as the treated patients had a 31% discharge rate compared to the 3% discharge expectation. The 3% discharge expectation was based on a previous study in the literature and not from average discharge rates at the hospital.

This study typifies many of the studies cited above by Goldstein because there was an absence of any kind of control group. This limitation makes it impossible to determine if the treatment provided by the student therapists in this study was less, equally, or more effective than either no special treatment or highly specialized treatment given by professionals (Meltzoff and Kornreich, 1971, p. 276).

In one study which did utilize controls however, psychiatric aides were shown to be ineffective in improving the condition of adult female schizophrenics in a state hospital. This was Sines, Silner and Lucero's 1961 study in which patients were randomly assigned to an experimental or control group. The experimental patients received individual therapy from a psychiatric aide and

the controls received routine hospital care. The MMPI was used as an outcome measure to assess the personality change in 51 patients in the control group and 55 in the experimental individual therapy group. In examining the outcomes, there was no significant difference within the experimental group or between the experimental and control groups before and after therapy. This finding lead the authors to conclude that "beneficial results did not accrue from the random assignment of psychiatric aides to chronic psychiatric patients for the purpose of psychotherapy" (Meltzoff and Kornreich, 1971, p. 283).

In concluding this discussion on the comparative effectiveness of trained vs. nonprofessional therapists, several conclusions seem warranted. Most of the investigations in this area have concluded that various nonprofessional therapists are able to do as well or better than trained and experienced psychotherapists. However, this conclusion must be tempered by an awareness of the many limitations in experimental design which appear in studies of nonprofessional therapists. For example, many of the studies cited above employ unsatisfactory criteria of effectiveness, have inadequate or absent controls and reveal biases in sampling. Because of these shortcomings, Meltzoff and Kornreich (1971) in their review have concluded that "the point is not only unproved but essentially untestable. A good controlled comparison of the effective-

ness of the trained and untrained therapist has yet to be made"(p. 288). In other words, research evidence indicates that nonprofessional therapists can be effective but it is not yet apparent if they are more or less effective than trained professional therapists. Given this state of affairs, perhaps it is best to follow Meltzoff and Kornreich's advice and "continue to believe that training does not hamper therapeutic effectiveness even though we still can't be certain it does any good" (p. 288).

Personal Therapy and Professional Discipline

In considering the qualifications of the therapist, there are two additional aspects of a therapist's background which are of interest. The first of these concerns the common assumption that personal therapy for therapists increases therapeutic effectiveness. This assumption is based on the notion that the best adjusted therapist is the most effective. There is, however, a lack of research evidence proving that this is the case. There are, according to Meltzoff and Kornreich (1971, p. 265), Strupp and Bergin (1969) and other reviewers, no research studies which have demonstrated that therapists who have had personal therapy are more effective as a result of their therapy. There is, however, one study (McNain, Lorr, Young, Roth and Boyd, 1964) which provides some evidence that therapists who had been in therapy themselves, tended to hold patients in treatment for a longer period.

A second issue related to therapists' qualifications concerns the type of training or professional discipline of the therapist. There is a lack of studies which investigate the comparative effectiveness of therapists from different professional backgrounds. According to Meltzoff and Kornreich (1971), "there is no satisfactory evidence to indicate that one professional discipline is any more or less effective than any other"(p. 265).

Personality Characteristics and Attitudes of the Therapist

In recent years added attention has been given to the personality of the therapist as a significant variable in therapy outcomes. As Strupp and Bergin (1972) note in describing emerging trends in psychotherapy research, "the therapist..., is viewed more as a person exerting personal influence rather than simply an expert applying techniques" (p. 18). Similarly, Arnold Goldstein (1972) argues that,

> Less concern, it seems apparent need be given to training in specific psychotherapeutic techniques and greater attention need be given to personal and interpersonal qualities of the psychotherapist (p. 115).

Outcome research studies are partially responsible for the current emphasis on the therapeutic significance of the therapist's personality. These studies have attempted to isolate specific personality traits of effective therapists. A sampling of these research studies

which investigate the personalities of effective therapists will now be examined.

Sex of the Therapist

Because of the intimate nature of therapy, the sex of the therapist has often been mentioned as a variable that can affect the outcome of treatment (Meltzoff and Kornreich, 1971, p. 295). There are very few studies which directly examine the effect of the sex of the therapist on treatment outcomes. Cartwright and Lerner's 1963 study of empathy, explores the sex of the therapist as a secondary issue. The study revealed that therapists obtained higher empathy scores with patients of the opposite sex but the difference disappeared at the end of treatment. In addition, there was no difference in improvement rate among patients with the same sex therapist and those with therapists of the opposite sex.

Meltzoff and Kornreich in their 1971 review of outcome studies, found that "the very few studies available on patient improvement showed no difference between male and female therapist" (p. 299). In short, there is simply no research evidence that the sex of the therapist does in fact affect treatment outcomes.

Therapeutic Conditions

Researchers from the client-centered school of psychotherapy have conducted extensive research on the in-

fluence of the therapist's personality on changes in the client. Based on the theoretical work of Carl Rogers, these researchers have attempted to demonstrate that three major therapeutic attitudes of the therapist result in positive outcomes in therapy. These three attitudes or therapeutic conditions which are considered to originate in the therapist are warmth, empathetic understanding and genuineness. According to Rogerian theory, an effective therapist can be described as follows. He is nonphony, nondefensive and authentic in his therapeutic encounters. He is able to provide the client with a safe, trusting atmosphere through his acceptance, or nonpossessive warmth for the client. Finally an effective therapist is able to "grasp the meaning of" or have a high degree of accurate empathic understanding of the client on a moment by moment basis (Truax and Mitchell, 1971, p. 302).

One of the first studies to provide empirical support to the significance of these three therapeutic conditions was a 1954 study by Whitehorn and Betz. This well-known contribution was a retrospective study of 35 psychiatrists who treated schizophrenic patients. They found that the top 7 psychiatrists had an improvement rate of 75 percent while another group of 7 psychiatrists had an improvement rate of only 27 percent. In contrasting the style of these two groups of therapists, Whitehorn and Betz found that the successful therapists were "warm and attempted

to understand the patient in a personal, immediate and idiosyncratic way" (Truax and Mitchell, 1971, p. 302). The less successful therapists tended to relate to the patient in a more impersonal manner, remained aloof and passive, emphasized pathology and evidenced a more external kind of understanding (Reisman, 1971, p. 89).

Whitehorn and Betz attempted to develop a screening device that could reliably predict the performance of these two types of therapists. They classified therapists who were successful with schizophrenics as "A" therapists and those who were less successful as "B" therapists. They subsequently administered the Strong Vocational Interest Inventory and found that there were significant differences between the A and B therapists on this scale. They selected 23 items on the Strong which appeared to differentiate the A and B therapist. These items became the Whitehorn-Betz A-B scale and were the object of a considerable amount of research. Whitehorn and Betz successfully used the scale to predict success in therapy with schizophrenics (Swensen, 1971, p. 151).

Another study which suggests the importance of therapeutic conditions is Halkides (1958) dissertation. In this study three judges rated extracts from two interviews each of twenty cases. The judges rated the therapist for genuineness, empathetic understanding and warmth. Several changes and outcome measures were used to rate the clients

as more or less successful. Halkides found highly significant associations between warmth, empathetic understanding, genuineness and improvement in therapy (Meltzoff and Kornreich, 1971, p. 331).

Further evidence of the significance of warmth, empathy and genuineness was revealed in Charles Truax's 1966 study of four resident psychiatrists. These four therapists were randomly assigned 40 patients and were evaluated for levels of empathy, genuineness and warmth. Those therapists who were rated high on the three therapeutic conditions had 90 percent of their patients improve. This was a significantly higher percentage than the 50 percent improvement rate of those therapists who were judged to offer less empathy, warmth and genuineness.

There exists a convergence of research evidence concerning the significance of warmth, empathy and genuineness. The research studies suggest a correlation between warmth, empathy and genuineness, as offered by the therapist, and successful therapeutic outcomes. This finding seems to hold across a wide variety of studies involving therapists with different training and theoretical orientations (Truax and Mitchell, 1971, p. 310). Likewise, the studies have been done with a wide array of clients, including psychoneurotic outpatients (Truax et al. 1966), hospitalized schizophrenics (Truax et al. 1965), institutionalized male and female juvenile delinquents (Truax,

1966; Truax, Wargo, Silker, 1966), and college underachievers (Meltzoff and Kornreich, 1971, p. 333). As a group, these diverse studies indicate that the qualities of warmth, empathy and genuineness exhibited by the therapists are significantly related to progress in therapy. Furthermore, the absence of these qualities can lead to deterioration in the client (Swensen, 1971, p. 155).

There is a lack of consensus, among researchers in psychotherapy about this apparent relationship between the three therapeutic conditions and improvement in therapy. Carl Rogers (1957) and other therapists from the client-centered school of psychotherapy, believe that the qualities of empathy, warmth and genuineness are the crucial ingredients of effective therapy. They contend that these traits are both necessary and sufficient for client growth. In contrast to this view, Strupp and Bergin (1972) in their review of the studies in this area, note that other therapist qualities besides empathy, warmth and genuineness may contribute equally to therapeutic outcomes. They conclude that, "In light of this evidence, empathy, acceptance and warmth are best viewed as necessary but <u>not</u> sufficient conditions..." to affect change in the client (p. 26).

A more critical interpretation of the research of the three therapeutic conditions is found in Meltzoff and Kornreich's (1971) review, <u>Research in Psychotherapy</u>.

These authors contend that the research on empathy, warmth and genuineness is inconclusive in that it is not clear if patients can evoke these responses from the therapist. They also maintain that it is not apparent how these traits are affected by experience and training. On the basis of these reservations, Meltzoff and Kornreich conclude that

> the Rogerian hypothesis that these traits of the therapist are necessary and sufficient for patient change has not been tested adequately. Obvious flaws in research design, hopeful rather than valid conclusions from the evidence and contradictory findings lead to a verdict of not proven (p. 335).

Thus, there is a growing body of outcome research studies which demonstrate that the qualities of empathy, warmth and genuiness in the therapist are associated with personality changes in the client. However, there is continued debate among therapists and researchers about whether or not these traits are sufficient in themselves for success in psychotherapy.

In concluding this section on personality traits of effective therapists, it is relevant to note the discrepancy between the number of traits listed in the psychotherapeutic literature and those validated by outcome research studies. There are extensive lists in the literature describing desirable traits of effective therapists (Reisman, 1971, p. 74). However, very few of these traits have been empirically related to improvement in therapy. As Meltzoff and Kornreich (1971) comment,

> We know little about the personality of successful psychotherapists. Most researchers have not studied experienced psychotherapists and the experience of the therapist subjects has usually been neither measured nor varied (p. 309).

Summary

In this section, outcomes studies which focus on the therapist as a significant factor in successful treatment have been reviewed. The available research evidence suggests that the effective therapist is experienced and possesses the traits of warmth, empathy and genuineness. In addition, outcome studies show that nonprofessional therapists are effective in achieving positive outcomes. The comparative effectiveness, however, of trained versus nonprofessional therapists has not yet been determined by outcome research studies. Currently, there is no evidence that the sex of the therapist affects treatment outcomes. Finally, there is no research evidence at present to substantiate the assumptions that better adjusted therapists or therapists from a particular professional discipline are more effective as a result.

Method of Treatment as an Outcome Variable

A third major variable in the therapeutic encounter is the method of treatment. There has been much discussion and debate about the relative effectiveness of various forms of treatment. Unfortunately there is very little

research evidence which supports the comparative effectiveness of a particular type of psychotherapy. Nevertheless, there have been a few studies which have addressed the issue of the method of treatment as an outcome variable. Some of these studies will now be reviewed.

An early investigation by Heine (1950) suggested that different forms of treatment yield similar outcomes. Heine found that reported changes did not differ among clients from nondirective, psychoanalytic and Adlerian therapists. However, when asked to report on the factors responsible for change, clients tended to refer to factors that authorities of each school consider important (Meltzoff and Kornreich, 1971, p. 189).

Most of the research concerning the outcomes of various types of treatment have been conducted by researchers from a behavior therapy background. Lazarus (1966) compared the effectiveness of three different treatment techniques: behavioral rehearsal, advice, and reflective interpretation. The 75 patients included in the study were divided into three groups of 25 each. Each patient had a specific social or interpersonal problem. Therapy was limited to four sessions of thirty minutes. Lazarus was the only therapist for all patients. Treatment was considered a failure if, following the application of a technique for a month, there was no evidence of change. The results clearly favored the behavioral rehearsal

approach as 92 percent of the clients treated in this group were considered improved. In comparison, only 44 percent of those patients who received advice improved and only 32 percent of those who received reflective interpretation were considered improved. A weakness of this study was the possible experimenter's bias, as Lazarus was the only therapist for all clients.

One exceptional study comparing different types of treatment was Gordon Paul's (1966) well designed study. This study is unique in that it specifies the variables in the treatment situation and utilizes adequate control groups. Because of its superior design, it is one of the few studies to date, which clearly demonstrates the effectiveness of a particular method of treatment in producing positive outcomes with a specific client problem.

Paul's study was designed to compare the effectiveness of insight therapy, attention placebo treatment and desensitization in reducing client fears of public speaking. Treatment was limited to five contact hours over a period of six weeks. The study consisted of four different groups of clients. One group received individual insight therapy from five highly trained neo-Freudian and Rogerian therapists. Another group received systematic desensitization and progressive relaxation training from a behavior therapist. A third group received attention and an inert drug to control for placebo effects.

A fourth group consisted of a group of individuals with public speaking anxiety who received no treatment whatsoever. The results of this study which used multiple measures of outcome, demonstrated that desensitization was the superior method of treatment in reducing public speaking anxiety. All of the clients who received desensitization treatment evidenced cognitive, physiological and motoric changes. This 100 percent success rate compared favorably to a 47 percent success rate achieved by insight therapy and the attention placebo treatment, and the 17 percent success rate for the nontreatment control group.

In summarizing the outcome research on the effectiveness of various methods of treatment there appear to be two legitimate conclusions.

First, as Strupp and Bergin (1972) note in their review, "There is currently no evidence that different types of patients or symptoms are differentially responsive to psychonanalytic, client-centered, or other common types of traditional therapy"(p. 41). There are simply very few studies which compare different types of treatment, and available studies are inadequately designed and lack the proper control groups necessary to permit valid conclusions in this area.

A second legitimate conclusion regarding the method of treatment and successful outcomes concerns recent re-

search evidence on the comparative effectiveness of behavior modification techniques. There is considerable research evidence that desensitization is more effective than traditional insight oriented therapy in treating clients suffering from conditional avoidance responses. It should be pointed out that the comparative superiority of behavior therapy techniques is limited to client problems involving specific phobias. There is no evidence that behavior therapy is more effective than insight oriented therapy in treating cases of generalized maladjustment (Meltzoff and Kornreich, 1971, p. 200).

Duration of Treatment as an Outcome Variable

A fourth major variable in psychotherapy is the amount of contact between the client and the therapist. Many therapists have assumed that those clients who remain in treatment the longest, will experience the greatest amount of improvement (Lorber and Statow, 1975, p. 308). The present research evidence, although somewhat inconsistent and limited by inadequate research designs, contradicts this assumption. The research evidence suggest that short term treatment (7 to 20 sessions) yields outcomes as good as those produced by long term, unlimited treatment contact.

A few research studies suggest a relationship between longer durations of treatment and positive therapy

outcomes. Imber, Frank, Nash, Stone and Gliedman (1957) studied the treatment outcomes of 54 psychiatric patients. The patients were rated by a psychologist-observer, a therapist, and a significant other, both prior to treatment and six months later. The findings showed that those patients who received the most therapeutic contact evidenced the most improvement.

Most outcome research studies concerning the duration of treatment refute the assumption that longer periods of treatment yield better therapy outcomes. Steiper and Wiener (1959), for example, found no relationship between improvement and duration of treatment.

Two follow-up studies, which are somewhat suspect because of their failure to specify significant treatment variables (client characteristics, degree of disturbance, etc.), provide additional evidence in favor of short term treatment (Reisman, 1971, p. 40). Mensh and Golden (1951) studied the duration of treatment for 352 veterans who were considered successful therapy cases. They found that about one-half of these patients were helped in less than five interviews.

In another similar study of 1,216 cases from a mental health clinic, Garfield and Kurz (1952) discovered that almost half of the patients who experienced improvement had less than ten treatment sessions.

A more elaborate study which indicates the effec-

tiveness of short term therapy is a 1962 study by Shlien, Mosak, and Dreikus. This study was designed to assess the influence of two treatment variables. Its primary purpose was to compare the outcomes of clients receiving Rogerian and Adlerian therapies. However, it also contrasted results from clients seen for an unlimited period of time with outcomes obtained from clients seen twice a week for twenty interviews. The outcome measure employed was a rating scale filled out by the client. The rating scale was designed to measure satisfaction with self. Not surprisingly, there was no difference in outcome between clients receiving Rogerian therapy and those treated by Adlerian therapists. It was also found that clients treated for an unlimited period of time averaging about 37 interviews did not evidence greater satisfaction with self than clients seen for only 20 interviews. Closer examination of the results indicated that clients in the time limited group progressed at an accelerated pace as they achieved their maximum level of satisfaction with self at the end of seven interviews (Reisman, 1971, p. 41).

Further evidence which refutes the assumed superiority of long term treatment is provided by contrasting improvement rates from short term treatment studies with rates from outcome studies of conventional treatment. There are the usual limitations in such comparisons in terms of different criteria for positive outcomes and the

variations in major treatment variables (clients, therapists and method of treatment). According to Reid and Shyne (1969), however, "the outcomes reported for conventional treatment in general are no better than, in fact tend to be inferior to, the reported results of short term treatment" (p. 190).

Summary

In summarizing the outcome research on duration of treatment, it is apparent that the question of long versus short term treatment has not been adequately studied to permit definitive conclusions. A properly designed outcome study, which effectively isolated the influence of time as a treatment variable, has not yet been published (Reid and Shyne, 1969, p. 191).

Based on the available evidence, however, there is considerable support for the following tentative conclusions.

Short term treatment (7-20 interviews) produces outcomes at least as good as, and possibly better than, open-ended treatment of longer duration (Reid and Shyne, 1969, p. 189). Furthermore, follow-up studies indicate that changes produced by short term treatment appear relatively durable (Reid and Shyne 1969, p. 191). These conclusions are encouraging as studies indicate that 85 percent to 91 percent of the clients who apply for therapeutic services have less than ten interviews (Mensh

and Golden, 1951; Garfield and Kurz, 1952).

III. Obstacles to Research in Psychotherapy

In reviewing the results and conclusions of outcome research studies, it is clear that there are numerous obstacles to overcome in conducting research in psychotherapy. This fact is evidenced by the paucity of high quality studies and the relatively few valid conclusions which have emerged from years of research efforts. In this section, factors which impede research in psychotherapy will be discussed. This section will focus on two major factors which are frequently cited as responsible for much of the difficulties in implementing research designs. These two significant obstacles to research in psychotherapy are the complex nature of psychotherapy and communication problems between researchers and practitioners.

The Complexity of Psychotherapy

Surely, the most obvious obstacle to research, stems from the complex nature of psychotherapy. As Hans Strupp (1972) observes, "the term psychotherapy has become increasingly fuzzy and more than ever defies precise definition" (p.435). Psychotherapy is concerned with all levels of human functioning (physiological, psychological, social and cultural) and the many subtleties contained in

the communication process. The range and complexity of these variables makes it difficult to define psychotherapy. The problem for researchers has been to develop a conceptualization of therapy which includes the significant variables and at the same time, is limited enough to be amenable to scientific research methods (Frank, 1974, p. 325).

There have been two major attempts to resolve this continuing research problem. One approach recognizes the complex variables involved in therapy but lacks the precision necessary for research purposes. Jerome Frank (1974) characterizes this approach by noting that:

> Some formulations try to encompass all its (psychotherapy's) aspects. Many of these have been immensely insightful and stimulating and have illuminated many fields of knowledge. To achieve all-inclusiveness, however, they have resorted to metaphor, have left major ambiguities unresolved, and have formulated their hypothesis in terms that cannot be subjected to experimental test (p. 327).

The opposite approach has been to formulate a precise definition of specific aspects of therapy at the expense of excluding some of the most significant variables. According to Frank, (1974) such an approach leads to "an inevitable tendancy to guide the choice of research problems more by the ease with which they can be investigated than by their importance" (p.333).

Another research problem which stems from the complexity of psychotherapy concerns the definition and

measurement of improvement. Researchers have struggled to develop measures which account for the diversity of client complaints and various types of changes which are often attributed to therapeutic intervention. The most promising approaches to resolving this research problem appear to be in administering multiple outcome measures or specifying treatment goals for each client (Bergin and Strupp, 1972, p. 19).

A more difficult aspect of the measurement problem is that of determining how much of the change was actually due to therapy. Frank (1974) points out that it is important to distinguish between influences that produce therapeutic benefit and those that maintain it (p. 334). According to Frank, researchers should focus on methods of treatment which produce change because factors which maintain the change are more than likely beyond the control of the therapist. The random assignments of clients to control and treatment groups can help determine how much change can be attributed to therapy.

Thus far, this discussion of obstacles to research in psychotherapy, has focused on the difficulties encountered in making therapy amenable to experimental study. A different perspective on research problems is provided by Bergin and Strupp. These authors suggest that investigation of psychotherapy has been restricted by an unwarranted overemphasis on methodology. Allen Bergin

(1972) reflects on outcome studies by noting:

> Most of the methodological sophistication I learned as a graduate student and postdoctoral fellow and which is constantly reinforced by the criteria of major journal editors is too precise, too demanding of controls, too far advanced for most studies of clinical intervention (p. 452).

The complexity of psychotherapy therefore results in three major problems for researchers. First, it is difficult to formulate a definition of therapy which encompasses all of the relevant processes yet has the specificity required for research purposes. Secondly, the changes produced by psychotherapy are difficult to define and measure and it is even more difficult to establish that the changes were caused by the therapeutic intervention. Finally, it has been suggested that the effort to make psychotherapy amenable to the scientific method may have resulted in an unnecessary overemphasis on methodology. This overemphasis may be restricting other methods of inquiry into the nature of psychotherapy and may be inappropriate considering the crude formulation of therapy presently available.

Communication and Cooperation between Researchers and Practitioners

There is a great deal of evidence indicating that differences between researchers and practitioners constitute one of the main obstacles to research in psychotherapy. In 1961, the Joint Commission on Mental Illness and Health noted that,

> Practitioners find that they cannot understand the research reports nor see their relevance to their daily problems. Research workers on the other hand..., cannot understand the resistance of the practitioner to such elementary and necessary principles of good research as experimental controls and adequate sampling procedures (p. 116).

Further evidence of the significance of differences between clinicians and researchers is cited by Arnold Goldstein. Goldstein (1972) has related differences between clinicians and researchers to the lack of impact research has had on therapeutic practice (p. 117).

There are three factors which have been identified by researchers, clinicians and interested observers as contributing to the disharmony between researchers and clinicians. These factors are the rigid attitudes of researchers, the resistive attitudes of the clinicians, and the different motivations of these two groups of professionals.

A number of attitudes and behaviors on the part of researchers have severely damaged their relationship with practitioners. Mitchell and Mudd (1957) have observed that the researcher

> often does little to resolve the problem of terminology or semantic differences between clinician and researcher. He is frequently hesitant to take time to acquaint the clinician with fundamental principles of his test questionnaires and statistical techniques.

In addition, researchers have been accused of being unconcerned about the implications of their findings and of devoting their efforts to studies which are high in precision but low in psychological significance (Goldstein, 1972, p. 117).

Differences in motivation between researchers and clinicians also inhibit their capacity to cooperate in conducting research in psychotherapy. According to Colby (1972) a basic difference is that "a clinician wants to help people and make money while a researcher wants to discover new knowledge" (p. 102). The clinician often feels that the researcher is exploiting his clients in subjecting them to the various experimental procedures. Another related concern of the clinician is that of client confidentiality. Clinicians often refuse to cooperate with researcher's suggestions because they believe research may violate a client's right to privacy. David Fanshel (1966) has suggested that the concern for client confidentiality needs to be balanced with a commitment to provide the client with the most effective treatment. Fanshel implies that there is an overemphasis on client confidentiality in research studies by stating:

> I wish that the eagerness to protect clients from the depredations of cavalier investigators were matched by an equal zeal for scientific verification of the procedures employed in meeting their problems (p. 360).

Finally, clinicians are often resistant to research projects for other reasons. First, many clinicians feel certain that their methods are effective and that research will merely confirm what they already know. As Shoben (1953) points out, "where certainty exists no matter how tenuously based, there is little motive for investigations."

Overconfidence on the part of clinicians is perceived by some authorities as one of the major problematic attitudes of clinicians with regard to research studies. According to Allen Bergin (1972),

> One of the greatest obstacles to progress in this area is the fairly prevalent illusion that we know more than we do, which may have the unfortunate consequence of stifling open inquiry with the concomitant tendancy to hide from ourselves the nature and extent of our ignorance (p. 448).

Brody (1957) has succinctly summarized other attitudes of clinicians which can interfere with a productive relationship with a researcher. He considers the following points as significant sources of the clinician's resistance to research:

> 1. Hostility against being forced into a new, unwanted role.
> 2. Guilt associated with using the patient for research as equivalent to serving the therapist's needs and not the patient's.
> 3. Hostility due to new status hierarchy problems in the research-clinical group.
> 4. Threatened loss of self esteem following the removal or lowering of accustomed defenses which operate when the therapist works in privacy (p. 101).

Considering this formidable list of conflicts between researchers and practitioners, it is hardly surprising that it has been difficult for them to establish productive relationships. However it is also clear that there is much to be gained from cooperation between researchers and clinicians. Researchers could benefit from more opportunities to explore psychotherapy, especially

with experienced therapists. Therapists in turn, could profit from being able to base their practice on substantive research findings rather than the "shaky foundation of clinical lore and intuition" (Goldstein, 1972, p. 118).

Summary

Two major obstacles to research in psychotherapy have been examined in this section. The range and variety of variables encountered in psychotherapy account for difficulties in conceptualizing therapy in terms useful for research purposes. Problems in communication and cooperation between researchers and practitioners represent the other major obstacle to research efforts. Researchers often appear unconcerned about the practicality of their findings and clinicians are often hesitant to go along with the necessary experimental procedures.

IV. Summary and Implications of the Review of the Literature

This final section of the review of the literature has two objectives. It will provide a rationale for the research design of the present study and summarize briefly the efforts of this review.

One of the purposes of reviewing past studies has been to determine a useful strategy for the research design of the present study of counseling outcomes at the

Reed College Counseling Service. The strategy suggested by this review of the literature is one of specifying the treatment variables. The major treatment variables are the client, the therapist, the method of treatment and the duration of treatment.

This strategy of specifying the variables which comprise psychotherapy has been recommended by a number of researchers. Volsky and Magoon (1965), in explaining the basic principles of outcome research designs note that there is a

> need when stating a hypothesis to specify the kinds of clients to whom the hypothesis applies, the relevant professional and personal characteristics of the counselors and the nature of the treatment to be administered during counseling or psychotherapy (p. 32).

Gordon Paul (1967), who is responsible for one of the best designed studies to date which compares the outcomes of different methods of treatment, has also stressed the importance of specifying treatment variables. Paul points out that "in order to meaningfully accumulate knowledge across studies, it is necessary to limit or describe the variables" (the client, therapist, method of treatment, duration of treatment) (p. 111).

Finally, the need to specify treatment variables is one of the major conclusions stated by Strupp and Bergin (1972). In their extensive review of outcome studies, these authors conclude that there is a

> need to avoid further classical therapy outcome studies of the type that compare changes due to a heterogeneous set of interventions called psychotherapy applied to a heterogeneous patient sample with changes in an equally diverse control group which exists under unknown psychological conditions (p. 434).

Strupp and Bergin recommend that future studies attempt greater precision in specifying the treatment variables and determining the most effective relationships between them. They encourage researchers and clinicians

> to devote considerable effort to discovering which therapist and techniques are the best facilitators of change, which clients benefit most readily, and which combinations of these optimize positive results (p. 8).

The present study represents an attempt to comply with these important recommendations. The study of counseling outcomes at the Reed College Counseling Service employs a research design which attempts to specify several factors in treatment. The design focuses on a specific client problem (homesickness) within a specific client population (the Reed College Student Body). The study addresses only short term treatment. In addition the study has included a counselor form as a means of specifying the counselor involved and the type of treatment administered. Thus, the review of the literature suggested an orientation or strategy for the research design of the present study.

Summary Statement

This review of the literature has presented three

major perspectives on outcome research in psychotherapy. The first section provided a historical perspective by tracing the development of some major issues. The issues of the null effects of therapy, spontaneous remission, control groups and deterioration rates were discussed in the context of sequential reviews by Eysenck (1952), Cartwright (1956) and Bergin (1971). In addition, a broader historical perspective was developed by describing five major sources of outcome research.

The second section attempted the ambitious task of summarizing some of the most significant findings of outcome research in psychotherapy. For purposes of clarity, the studies were categorized into four major treatment variables; the client, the therapist, the method of treatment and the duration of treatment. Client variables such as intelligence, level of personality adjustment, realistic expectations of improvement, and ability to express emotions have been correlated with success in psychotherapy. Other client related variables such as "openness to therapeutic influence," "client relatability," "similarity between therapist and client," were noted to be of sufficient importance to warrant further study.

Another group of studies reviewed were those which focused on the therapist as a significant factor in successful treatment. Therapists with more experience, who possess traits of empathy, warmth and genuineness are

more successful according to the available research evidence. The studies on therapist personality traits and professional qualifications also indicate that the sex of the therapist, the type and degree of training, and the level of personality adjustment of the therapist have not been empirically identified as responsible for greater therapeutic effectiveness.

The other two major groups of studies reviewed in the second section pertained to the method and duration of treatment. It was shown that there are no consistent research findings indicating the most effective method of traditional psychotherapy. The studies on method of treatment and treatment outcomes reveal however, that desensitization, a behavior therapy technique, is clearly the most effective method of treatment for clients suffering from specific phobias.

Studies which examine the effect of the duration of therapy and treatment outcomes were also reviewed in the second section. A tentative conclusion concerning the comparative effectiveness of long versus short term treatment was that short term treatment yields outcomes comparable or possibly superior to outcomes produced by open-ended treatment of longer duration.

In the third section of this review, some of the major obstacles to research in psychotherapy were explored. The complexity of psychotherapy and the lack of communica-

tion between researchers and clinicians were cited as two major difficulties in the effort to examine psychotherapy through the use of experimental methods.

Finally, this last section has developed a rationale for the research strategy used in the present study and has summarized the review of the literature.

CHAPTER III

METHODOLOGY

Introduction

The methodology is divided into four sections. The first three sections present an overview of the research design, a discussion of the populations of the study and an explanation of the instruments of the study and their administration. The fourth section focuses on two aspects of the implementation of the research design: the limitations of the design and procedural difficulties which arose through the process of its implementation.

Overview of the Study

The research design focuses on the outcome of individual counseling with Reed students diagnosed and treated as homesick by the two counselors of the Reed College Counseling Service. Because of this focus an initial and central consideration was to define homesickness. The two counselors were asked to jointly prepare a diagnostic profile of a homesick student so that their definition of homesickness could be clearly understood. The profile prepared by the two counselors may be found in Appendix A. For the purposes of this study the counselors' diagnosis

of homesickness, which is assumed to be based upon their diagnostic profile of a homesick student, shall be considered evidence of the presence of homesickness.

With this approach to defining homesickness the study attempts to answer two general questions. First, do students diagnosed as homesick, who receive counseling, experience improvement in relation to the outcome measures employed in this study? And, second, if homesick students who receive counseling improve, what did the counselors do that may have facilitated the improvement?

In order to answer the first question, a questionnaire was developed to measure homesickness symptoms. The questionnaire will be called the Homesickness Scale and can be found in Appendix B. The Homesickness Scale was given to two populations of students who received counseling both before and after their counseling. One of these treated populations was composed of students who were diagnosed and treated for homesickness. The scale was also administered to a third population which did not receive any counseling. The scale was employed to record movement in the degree of homesickness of the three populations. It was hoped that the scale would reveal improvement, if any, in the homesick population.

In the second area of the study's focus the question is asked: If homesick students who receive counseling improve, what did the counselors do that may have facili-

tated the improvement? This question was addressed in the study through the request that the two counselors complete a Counselor Form, (see Appendix B). Counselor Forms were to be completed on the students in the two counseled populations of the study. The form asks for information about the client and the counselor's relation to him or her. The purpose of this mode of inquiry was to determine as specifically as possible what a counselor did with students in the counseling sessions.

Finally, a third kind of information was sought in relation to the outcomes of the counseling. In the second follow-up questionnaire, filled out by the two populations of counseled students, four client satisfaction questions were asked, (see Appendix B). These questions were viewed as a potential supplement of information about the outcomes of counseling.

Summary of the Overview

The study was conducted from the beginning of Reed's fall semester in September of 1975, to the end of the fall semester in early December of 1975. Essentially the study centers on a problem, which particularly during the fall at Reed College, may often require brief but intense individual treatment. Often the problem of homesickness is addressed with only one or two individual counseling sessions. To summarize then, the above design is a study of

the short term treatment of a problem whose incidence may be directly related to the element of time.

Populations of the Study

Population I

The first population in the study is composed of students who have been diagnosed as homesick by one of the two counselors of the Reed College Counseling Service. A diagnosis was determined by the counselor interviewing the student and was based on the "Profile of a Homesick Student." The counselors agreed prior to the beginning of study to make diagnoses of homesickness, where appropriate, immediately following the initial interview. At which time, in addition, the counselors agreed to explain their diagnoses by completing a Counselor Form. Population I subjects began to be identified during the third week of the study. Because of a high attrition rate, Population I was composed of five students.

Population II

The second population was to be made up of every third nonhomesick student interviewed by each counselor. This random population of treated students was sought in order to develop an understanding of how students who received counseling, but were not homesick, compared with

students diagnosed as homesick. This population began to be identified at the beginning of the study. Like Population I, Population II had a high research mortality rate. Population II consisted of twelve students.

Population III

The third population was made up of twenty-three students in a predominately freshman dorm called Mckinley Dorm. The students agreed to be part of the study. Students in the dorm who indicated on their questionnaires that they had used the services of the Reed College Counseling Service were excluded from the study. Population III was then composed of students who did not receive individual counseling, but who lived in the same Reed environment as many of those students who did receive counseling.

Population III was predominately freshman. The class makeup of Population III was important because of the two counselors' belief that members of the freshman class are much more likely to be homesick than members of any other class. The Mckinley group was therefore a group of students with a projected high risk of homesickness. Another important feature of Population III was the living accomodations they experienced. Like a majority of Reed students, and like nearly all Reed freshmen, the Mckinley group lived in a dorm. A dorm living situation, like the fresh-

man class status, was also postulated by the counselors to be a contributing factor to homesickness. The purpose of administering the Homesickness Scale to this group of students was to determine the effects of time in the Reed environment on students' responses to the Homesickness Scale. Accordingly, the twenty-three students in Population III completed the Homesickness Scale on September 20 and one month later on October 22.

The Instruments of the Study and their Administration

The Homesickness Scale

The Homesickness Scale is composed of seven questions which were designed to measure some of the feelings, attitudes and behavior associated with homesickness. Four of the questions were posed as continuums that were aimed at determining student adjustment to life at Reed. Three other questions asked about the frequency of participation in certain activities which were hypothesized to be related to homesickness. All of these questions can be found in Appendix B. The seven items listed on the scale were considered to be significant aspects of the condition known as homesickness.

Administration of the Homesickness Scale to Populations I and II

The research design called for a Homesickness Scale and a short explanation to be given to each student who came to the Reed College Counseling Service seeking individual counseling. The initial explanation may be found in Appendix B. Along with giving each student a scale and the written explanation enclosed in an envelope, secretaries who made the appointments were to instruct each student to return the initial scale to their counselor at the time of the student's first interview. Questionnaires returned at the time of the first interview constituted the baseline measures for Populations I and II.

Students in both Populations I and II were sent a second Homesickness Scale following a two week interval after their last appointment or after terminating treatment. For the purposes of the study, counseling ended when a student did not have appointments for a period of two weeks or stated his or her intention not to continue in counseling. The follow-up Homesickness Scale with a second explanation of the study was mailed with a return addressed envelope through the campus mail to treated students. The follow-up questionnaires included both the Homesickness Scale and the four client satisfaction questions. If the first follow-up questionnaires were not

received within two weeks, another follow-up questionnaire was mailed in an attempt to secure a high return rate. The explanations accompanying the first and second follow-up questionnaires may be found in Appendix B. Responses to these mailings constituted post-treatment Homesickness Scales for Populations I and II.

Client Satisfaction Questions

Included in the follow-up questionnaires sent to Populations I and II were four client satisfaction questions. The purpose of these questions was to gain additional perspective on issues surrounding the students' counseling experiences. These questions may be found in Appendix B.

Administration of the Homesickness Scale to Population III

The choice of administering the Homesickness Scale to Population III on September 22, 1975, three weeks after the beginning of the fall semester, was determined by the proximity of the date to the first diagnosis of homesickness in a student seeking individual counseling at the Reed College Counseling Service. The administration of the Homesickness Scale at about the same time of the first homesickness diagnosis was important because it was thought by the counselors that the "newness" of the Reed environ-

ment for the predominantly freshman dorm might initially inhibit the development of homesickness symptoms. The first diagnosed case of homesickness was a kind of cue that other students, particularly in a largely freshman dorm, may be experiencing homesickness and therefore might be useful as a comparison group with the developing diagnosed homesick population. Student responses from the September 22 administration of the questionnaire represented the baseline measure for Population III.

The second administration of the questionnaire to Population III was on October 20, about a month after the initial baseline measure. Besides being a feasible day for the second administration of the questionnaire, the date was important because of the length of time that had elapsed since the first administration of the Homesickness Scale to Population III. It was speculated that the time between the first and second administrations of the Homesickness Scale, to Population III, about a month, roughly paralleled the time between the first and second administrations of the scale to students who were diagnosed and treated for homesickness. This time parallel in the administration of the Homesickness Scale was seen as an important factor because of the validity it seemed to give to the comparison of the two groups.

Responses from the October 20 administration of the Homesickness Scale to Population III constituted the fol-

low-up responses from Population III. It was not feasible to follow-up students who missed the second administration of the questionnaire.

The Counselor Forms and their Use in the Study

Each counselor was to fill out a single Counselor Form after the first counseling session with students in Populations I and II. If the student in Population I or II had more than one counseling session the counselors were instructed to complete a second form. The second form was to be completed after treatment had been formally terminated or after a two week period in which there was no actual or anticipated treatment contact.

The form focuses on questions surrounding homesickness. If the student interviewed was homesick counselors were to answer three questions verifying the diagnosis, explaining its most salient characteristic and indicating other accompanying problems. Next, the form asked the counselor to rate and explain the severity of the student's presenting problem.

The next section of the Counselor Form requires the counselor to indicate from a list of treatment techniques what was done with the student. Counselors were also asked to explain the uses of the techniques employed.

The remainder of the form represents a kind of rough counselor self assessment of the counseling. Counselors

were asked how they would characterize their relationships with the counselees. In addition they were asked if they thought they were helpful to the client and on what basis they reached their conclusion. These questions were aimed at developing an approximation of the outcome of the counseling. Finally, the last three questions about the outcome were aimed at determining if the counselors thought they were successful in their work.

Implementation of the Research Design

Limitations of the Design

Two important limitations of the design affected the answering of the study's first question. The question was, do students diagnosed as homesick, who receive counseling, experience improvement in relation to the outcome measures employed in this study? While the study can answer this question, the question itself assumes that the outcome measures of the study consistently measure certain outcomes. Because the Homesickness Scale was not tested for either reliability or validity it may not be a dependable instrument for evaluating outcomes. In this light the scores of treated homesick students may reflect differences in the direction of improvement without providing the certainty of outcome which a more proven instrument might have facilitated.

The second limitation concerns the approach to developing the Homesickness Scale. This approach was affected by a desire on the part of both the counselors and the researchers to protect the therapeutic setting of the Reed College Counseling Service. The construction of the Homesickness Scale was guided by a desire to minimize the impact of the survey on the counseling process. Toward this end both the number of questions and their relatively unobtrusive quality was based on a calculation that the scale was the least disrupting instrument that could be devised to measure homesickness outcomes. Perhaps, because of this relatively conservative approach in inquiry, the study's first question is not as thoroughly addressed as it might have been with a more extensive and sophisticated outcome measure.

Another important limitation of the research design affected the answering of the study's second question: If homesick students who receive counseling improve, what did the counselors do that may have facilitated the improvement? This question was addressed in the study through Counselor Forms which were designed to solicit information about the counseling process after it occurred. Included on the form was a question which asked the counselors to indicate, from a list of treatment techniques, the kind of treatment they gave along with an explanation of its application. Responses to this question were expected to gen-

erally explain a given student's treatment. However, it appears that this retrospective effort, with its general inquiry approach and global listing of treatment techniques, was not very effective in determining the nature of the treatment provided. This seems true because the results of the Counselor Forms only very partially explain what the counselors did in the counseling sessions. In general, as the results of these Counselor Forms demonstrate, and as many other studies show, retrospective accounts of counseling are very poor substitutes for direct observation in understanding the counseling process. Thus, the study's attempts to answer any questions about treatment, especially the study's second major question, is limited by the retrospective nature of the study's inquiry.

Two other factors which may have influenced the answering of the study's major questions should be noted. First, it is assumed in the research design that the counselors' diagnoses of homesickness are accurate. However, no tests were completed on the reliability of the counselors to diagnose homesickness. Because no tests were completed a measure of uncertainty about the counselors' accuracy in diagnosing homesickness must be acknowledged. Therefore conclusions about both the treatment and the improvement of the homesick population should be tempered with the understanding that some error may exist in the composition of the homesick group which was not compen-

sated for in the statistical results of the study.

The second factor which may have influenced the answering of the study's major questions is the testing process of the research design. The effect of the initial testing by means of the Homesickness Scale may have directly or indirectly affected student responses to follow-up questionnaires. It seems possible that just giving a student a questionnaire may have affected in some way the student's course of treatment. Giving a student who is seeking counseling a questionnaire might affect his treatment by focusing his or her concerns on the kinds of issues the Homesickness Scale raises. Similarly the students in Mckinley Dorm may have been stimulated by the questionnaire to confront or deny the kinds of issues the Homesickness Scale raises. Although the testing process is an influence with a vague character that may be nearly indiscernible, it nevertheless is acknowledged as a factor that may have affected the answering of the study's major questions.

Summary of the Limitations

The above limitations of the design and potential influences on the study's three populations were largely anticipated in the early stages of this research. However, their full impact on the execution and results of the study was not expected. No doubt some things would be done differently if the same task were approached again. Yet, as in this study, another study would again proceed

with limitations and influences indigenous to the study's origins.

Procedural Difficulties

Major procedural difficulties of the study centered in events which seriously affected the mortality rates of the study's three populations and the use of completed Counselor Forms. The most significant initial problem was in the distribution of the initial questionnaire to students seeking individual counseling at the Reed College Counseling Service. Because of the secretaries' work loads the initial Homesickness Scales were only sporadically distributed to students making initial appointments. Coupled with a low return rate of the initial questionnaire from treated students, the sporadic distribution precluded the adoption of different standards for the composition of Populations I and II. Population I was composed of five students. While a total of eight students had been diagnosed as homesick, only five completed both initial and follow-up Homesickness Scales. These five students were identified as Population I because they returned both initial and follow-up Scales. Population I was then made up of just over half of the diagnosed homesick students. Therefore, it seems possible that those students not included in the study may have provided responses that changed the data profile of homesick students. If

this possibility is seen as significant Population I may have a potential bias of responses because of its formation.

Population II was more seriously affected by distribution problems and return rates than Population I. Forty students would have constituted Population II if the random method devised to identify it had effectively been instituted. However only twenty-six students out of the one hundred and twenty-two counseled students who were not homesick returned initial Homesickness Scales. Because of the low return rate by potential subjects of Population II the random method of selection was dropped in favor of the decision to identify all of the twenty-six students as potential subjects of Population II. Of these students only twelve returned follow-up scales. These twelve students, less than fifty percent of the nonhomesick students potentially in Population II, were identified as Population II because they had completed both initial and follow-up scales. Population II was then probably biased because it was a nonrandom population. In addition, as in the case of Population I, it seems possible that students in Population II might somehow be different than either the many nonhomesick students who didn't turn in an initial scale or the fourteen in the group of twenty-six who did not return a follow-up scale.

Population III was affected by a similar failure of

potential subjects to complete both initial and follow-up Homesickness Scales. While forty different students completed scales, only twenty-three completed both the initial and follow-up Homesickness Scales. As in the case of Population I a potential bias exists with Population III because of the possibility that those students included in the study were significantly different than those who were not.

Difficulties similar to those which affected the study's three Populations were found in the inclusion process of Counselor Forms. A total of thirty-seven different counseled students had forms completed on their treatment. However only seventeen of these forms, five for Population I and twelve for Population II, were included in the study. As in the formation of the two counseled populations a number of students, fourteen in all, were excluded because they had not completed initial and follow-up Homesickness Scales. There were also four students, one in Population I and three in Population II, who had both initial and post-treatment Counselor Forms completed. However, their forms were excluded from the study because there were not enough students with initial and post-treatment Counselor Forms to establish meaningful comparisons among them. The seventeen Counselor Forms included in the study therefore reflected the same potential and real biases of the two treated populations they addressed.

CHAPTER IV

RESULTS

Population I: Homesick Clients

The major hypothesis of this study of counseling outcomes concerned the students diagnosed by the counselors as homesick. It was hypothesized that the students of Population I who were diagnosed and treated for homesickness, would experience improvement. For the purposes of this study, improvement has been defined as significant, favorable changes in the students' responses from their initial to their post-treatment Homesickness Scales. The results however, do not support this hypothesis. There was no significant difference at .05 level of probability between initial and post-treatment responses on any of the items on the Homesickness Scale for the five students diagnosed as homesick.*

The outcome measure employed in this study, the Homesickness Scale, was composed of seven items developed to measure significant aspects of homesickness. The first three questions on the scale were designed to measure the students' feelings and attitudes towards the Reed environ-

*All tests were conducted using a t test of the means.

ment and their academic performance. Responses to these first three questions are presented in Tables I, II and III. These tables show that there was very little difference between initial and post-treatment scores. The slight differences present are in a negative direction. This indicates that the students' conditions may have deteriorated slightly. A t test, however, revealed that these slight differences were not significant at a .05 level of probability.

TABLE I

How do you feel about being at Reed?

Student	Pre	Post	Difference
A	3	2	1
B	5	4	1
C	2	3	-1
D	5	5	0
Mean	4	3.6	

Scale: From 1-I don't feel comfortable at Reed, to 5-I feel at home at Reed.

TABLE II

How do you feel about people at Reed?

Student	Pre	Post	Difference
A	2	2	0
B	4	4	0
C	4	5	-1
D	5	4	1
E	4	4	0
Mean	3.6	3.8	

Scale: From 1-People at Reed are not very friendly, to 5-People at Reed are very friendly.

TABLE III

At this time, how satisfied are you with your performance in class?

Student	Pre	Post	Difference
A	2	1	1
B	3	2	1
C	1	3	-2
D	2	2	0
E	2	1	1
Mean	2	1.8	1

Scale: From 1-I am very unsatisfied, to 5-I am very satisfied.

The next two questions on the Homesickness Scale concerned aspects of students' behaviors believed to be related to homesickness. Students were asked to rate the frequency with which they participated in certain extracurric-

ular social activities. As shown in Tables IV and V most of the students diagnosed as homesick frequently participate in activities such as socials, movies and concerts. All of the students in Population I responded that they "almost never" participate in more organized activities like volunteer work and off campus employment. None of the five students diagnosed as homesick reported any change in the frequency of their participation in these activities as shown in their responses to the initial and post-treatment Homesickness Scales.

TABLE IV

How often do you go to extracurricular activities like socials, movies, concerts etc.?

Student	Pre	Post	Difference
A	2	2	0
B	1	1	0
C	5	5	0
D	1	1	0
E	2	2	0

Scale: 1. More than once a week. 2. Once a week. 3. Twice a week. 4. Once a month or less. 5. Almost never.

TABLE V

How often do you go to extracurricular activities, like OSPIRG, off campus employment, volunteer work, etc.?

Students	Pre	Post	Difference
A	5	5	0
B	5	5	0
C	5	5	0
D	5	5	0
E	5	5	0
Mean	5	5	

Scale: Same as Table IV. 5-Almost never.

Finally, the last two questions on the Homesickness Scale asked students to estimate their anticipated home visits for the first semester and to rate the degree that they missed persons whom they knew at home. Three of the five homesick students reported that they expected to visit home more than once during the first semester. In addition, three of the five homesick students reported that they missed people at home more after counseling than before treatment. However, like all other items on the Homesickness Scale, these differences were not significant at the .05 level of probability.

TABLE VI

Approximately how often do you think you will go home during the first semester including Christmas Vacation?

Student	Pre	Post	Difference
A	3	3	0
B	1	1	0
C	3	4	-1
D	2	2	0
E	1	1	0
Mean	2	2.2	

Scale: 1. Once.
2. Twice.
3. Three times.
4. More than three times.
5. Not at all.

TABLE VII

How much do you miss persons whom you knew at home?

Student	Pre	Post	Difference
A	4	4	0
B	1	2	-1
C	5	3	2
D	3	4	-1
E	1	2	-1
Mean	2.8	3.0	

Scale: From 1-Not at all, to 5-A great deal.

The data gathered on homesick students does not support the major hypothesis of this study. Students diagnosed and treated for homesickness did not evidence significant improvement as measured by the Homesickness Scale.

There are several factors which individually or in some corporate fashion may account for this finding.

First, it might be contended that, for whatever reason, the counseling did not improve the adjustment of some or all homesick students to the Reed environment. Such a contention might be accepted as a sole explanation for the study's findings if the study did not have important methodological limitations. However, because the study did have several significant limitations, the effectiveness of the counseling cannot be positively identified as the only factor, or even as one of several, which contributed to the study's nonsignificant results. The possibility that the counseling did not improve the adjustment of homesick students nevertheless should be considered as a potential explanation which either alone or with other factors may account for the findings.

Three major limitations of the study which may have affected the study's findings can be identified. Each of these factors complicate the relation of the study's results to the counseling provided. First, students may not have been accurately diagnosed as homesick. The study did not include a procedure for determining the reliability of the counselors' diagnoses. The dependability of the counselors' assessments was therefore never empirically established. Possibly some students diagnosed and treated for homesickness were not homesick at the time they entered

counseling. If this is true, the lack of overall improvement of the population may be due to the absense of the condition which was addressed in the counseling.

A second factor which may be related to the lack of improvement in the homesick population concerns the size of the sample. Given the small size of the homesick population, five students (5), it seems possible that the groups' responses were not as representative of diagnosed and treated homesick students as a larger population might have been. The smallness of the sample alone or in conjunction with other factors may then have distorted the profile of homesick students' responses and consequently prevented a more valid testing of the study's hypothesis.

Lastly, the Homesickness Scale itself may have contributed to the negative finding. The scale was never tested for either validity or reliability. Because of this, its dependability as an instrument of measurement for homesickness is questionable. Perhaps, the scale lacked the sophistication necessary to accurately record the changes produced by counseling students diagnosed as homesick.

Population II: Students Treated for Problems other than Homesickness

The Homesickness Scale was administered to a group of twelve students who received counseling but were not diagnosed as homesick. The responses of Population II to the

Homesickness Scale were compared with those of Population I. Of the seven items on the Homesickness Scale only two were found to elicit slightly different responses. As anticipated, homesick clients were less active in extracurricular work activities and less satisfied with their academic performance than students in Population II. However, these slight differences were not significant at the .05 level of probability. The lack of significant differences between the two groups is clear when their responses to the individual questions of the Homesickness Scale are compared.

The first two items of the Homesickness Scale drew slightly different responses from the two populations. However the differences were not in the expected direction. Contrary to the researchers' expectations, students diagnosed as homesick were more likely to report feeling comfortable about being at Reed and more likely to perceive persons at Reed as friendly than students in Population II.

TABLE VIII

How do you feel about being at Reed?

Sample		Pre (Mean)	Post (Mean)
Population I Homesick Students	5	4	3.6
Population II Nonhomesick Students	12	3.3	3.4

Scale: From 1-I don't feel comfortable at Reed, to 5-I feel at home at Reed.

TABLE IX

How do you feel about people at Reed?

Sample		Pre (Mean)	Post (Mean)
Population I Homesick Students	5	3.6	3.8
Population II Nonhomesick Students	12	3.2	3.5

Scale: From 1-People at Reed are not very friendly, to 5-People at Reed are very friendly.

The next item on the Homesickness Scale focused on students' satisfaction with their academic performance. As expected, students in Population I were less satisfied with their academic work than those in Population II. However, the slight difference between the populations on this question was not significant at the .05 level of probability. Both populations reported being less satisfied with their academic work following counseling.

TABLE X

At this time how satisfied are you with your performance in class?

Sample		Pre (Mean)	Post (Mean)
Population I Homesick Students	5	2	1.8
Population II Nonhomesick Students	12	2.8	2.6

Scale: From 1-I am very unsatisfied, to 5-I am very satisfied.

On the items relating to participation in extracurricular activities, students in Population I were slightly more active in social activities and were less active in work related activities. These differences were not significant at the .05 level.

TABLE XI

How often do you go to extracurricular activities like socials, movies, concerts etc.?

Sample		Pre (Mean)	Post (Mean)
Population I Homesick Students	5	2.2	2.2
Population II Nonhomesick Students	12	2.0	2.3

Scale: 1. More than once a week.
2. Once a month.
3. Twice a month.
4. Once a month or less.
5. Almost never.

TABLE XII

How often do you go to extracurricular activities like OSPIRG, off campus employment, volunteer work etc.?

Sample		Pre (Mean)	Post (Mean)
Population I Homesick Students	5	5	5
Population II Nonhomesick Students	12	4	3.2

Scale: Same as in Table XI above.

On the final two items of the Homesickness Scale there was no significant difference between the mean responses of the two populations. Homesick students reported anticipating slightly more home visits, although this difference was not significant at the .05 level of probability. Both populations scored similarly on the scale regarding feelings towards persons the students knew at home.

TABLE XIII

Anticipated home visits during first semester.

Sample		Pre (Mean)	Post (Mean)
Population I Homesick Students	5	2	2.2
Population II Nonhomesick	12	1.6	1.6

Scale: 1. Once.
2. Twice.
3. Three times.
4. More than three times.
5. Not at all.

TABLE XIV

How much do you miss persons who you knew at home?

Sample		Pre	Post
Population I Homesick Students	5	2.8	3.0
Population II Nonhomesick Students	12	2.8	2.4

Scale: From 1-Not at all, to 5-A great deal.

This comparison of means of the two populations' responses to the Homesickness Scale has revealed that there is no significant difference between the two populations on any of the seven items of the Homesickness Scale. Population I, as expected, was found to be less satisfied with their academic work. Population I also reported that they participated less frequently in work related extracurricular activities.

The differences between the two populations were not great enough to be significant at the .05 level of probability.

In understanding the lack of significant differences between the two groups' responses three limitations of the study should again be considered. These are the same three factors which could have been related to the finding that homesick students did not improve.

First, the research design did not include a procedure for determining the validity of the counselors' diag-

noses. Because of this limitation in the research design, the counselors' assessment of a student as homesick may have been unreliable. Thus, it seems possible that some or all of the students in Population I may not have been homesick. This possibility could explain the lack of difference between Population I and Population II by suggesting that the two populations were in fact similar.

Secondly, the size of the samples may have been too small to represent the assumed differences between homesick students and other counseled students. Conceivably, a larger number of students in Population I and Population II might have resulted in significant differences between the two groups' responses to the Homesickness Scale.

Thirdly, the lack of significant difference between the two populations' responses may have been the result of an inadequate measuring device. As pointed out above the Homesickness Scale was never established as a valid and reliable testing instrument. Possibly the similarity between the two groups' responses was due to the failure of the Homesickness Scale to assess significant differences.

In assessing the probable factors which may have lead to the lack of significant difference between Populations I and II another possibility must be acknowledged. It seems possible that two or more of the above factors somehow combined to produce the similar responses of Populations I and II. However, regardless of what the determin-

ing factors of the results were, it is beyond the scope of this study to do more than outline the possibilities.

Client Satisfaction

In addition to the Homesickness Scale, both populations of counseled students, responded to four client satisfaction questions as a part of the follow-up questionnaire. Most of the students responded favorably when asked about their feelings toward the services they received at the Reed College Counseling Service. The majority of students, sixty-five percent from the total population of counseled students, reported that they were at least somewhat satisfied that they had received the kind of services they wanted. Of this total, only one homesick student reported receiving the kind of services desired. Two students in Population I responded that they didn't know if they received the kind of services they wanted. Two other students in Population I responded that they did not get the kind of services they wanted.

TABLE XV

Did you get the kind of services you wanted?

	Definitely yes	Somewhat	I don't know	Not at all
Population I Homesick 5	1		2	2
Population II Nonhomesick 12	2	8		2
Totals (17)	3	8	2	4

The next client satisfaction question asked students to describe how they felt about their problem(s) at present. Approximately seventy-one percent of the students, from both populations combined, responded that they felt somewhat or a great deal better about their problems after counseling. Interestingly, there are again two students from the homesick population who reported feeling worse about their problems after counseling. These two students consistently reported being dissatisfied with the services they received from the Reed College Counseling Service.

TABLE XVI

Do you feel differently about your problem(s) now?

	A great deal better	Somewhat better	No change	Worse
Population I Homesick 5	1	2		2
Population II Nonhomesick 12	2	7	3	
Totals (17)	3	9	3	2

With two exceptions, all of the students in the two populations reported that at least part of their improvement was attributable to the counseling services. The two exceptions were homesick clients who reported that none of their different or changed feelings about their problem(s) was due to the services of the Reed College Counseling Service.

TABLE XVII

Was this due to the services you received at the Reed College Counseling Service?

	Yes, all of it.	Yes, most of it.	Yes, part of it.	No, none of it.
Population I Homesick 5		1	2	2
Population II Nonhomesick 12		8	4	
Totals (17)	0	9	6	2

The final client satisfaction question asked students if they would return to the Counseling Service if they were in need of help again. Only twenty-nine percent of the students from both populations reported that they definitely would return to the Reed College Counseling Service. Four students or twenty-three percent reported "Definitely not" when asked if they would return to the Counseling Service if they were in need of help again.

TABLE XVIII

If you were to seek help again would you come back to the Reed College Counseling Service?

	Definitely yes	Depends	I don't know	Definitely not
Population I Homesick 5	2		1	2
Population II Nonhomesick 12	3	6	1	2
Totals (17)	5	6	2	4

The client satisfaction questions seem to indicate that the majority of students were satisfied with the outcome of their counseling experiences. There are two students from Population I who evidently were dissatisfied with the services they received. They consistently responded negatively to the four client satisfaction questions.

Counselor Forms

The counselors were asked to complete a Counselor Form on every student in Populations I and II. This procedure was included as a method of determining the nature of the treatment provided to the counseled students.

The first item of the Counselor Form pertained to the residency of the client. As expected, all of the homesick clients lived in dorms. Six of the twelve students in Population II lived in an off campus living arrangement known as Reed House.

TABLE XIX

Residence of clients.

	Population I	Population II
Home		
Reed House		6
Dorm	5	5
Off Campus		1

The next items on the Counselor Form focused on students diagnosed as homesick. The counselors were asked to describe any symptoms of homesickness as they appeared in homesick students. The counselors cited the following behaviors and feelings as evidence of homesickness; "talked nostalgically about his family," "is depressed," "has not got hooked into Reed, particularly true of academic work

and friends." Generally the counselors cited depression, somatic complaints, lack of friends and poor academic performance as indications of homesickness.

The counselors were also required to rate the severity of a client's presenting problems. On the average, the clients in Population I were considered to have problems more disabling than students not diagnosed as homesick. From examining the counselors' explanations of their ratings, it appears that the counselors perceived homesickness as more disabling in terms of academic work and social relationships, than problems presented by students in Population II.

TABLE XX

Severity of presenting problem.

Sample	Mean
Population I Homesick Students 5	2.60
Population II Nonhomesick Students 12	3.5

Scale: 1-Severely disabling, to 5-Mildly disabling.

The counselors were asked to specify, from a list of counseling techniques, what they did with the client. As shown in Table XXI there does not appear to be any specific pattern which emerges from the counselors' responses to this question. In addition, there does not seem to be any

difference in the treatment provided clients in Populations I and II. As mentioned in the methodology, such a retrospective effort does not adequately explain the content of the counseling. In fact, it appears from the meager results of the Counselor Form that there is no substitute for direct observation in determining the elements of counseling.

TABLE XXI

What did you do with the client?*

Technique	Population I	Population II
Gave advice	2	2
Support	5	8
Interpretation	2	4
Environmental manipulation	3	3
Confrontation	3	2
Reflective discussion	0	5

*Multiple Responses--The counselors were instructed to check as many techniques as they used.

The counselors also rated their relationship with clients in both populations. On the average the counselors described their relationships with students as being between "fair" and "good" on a five point scale.

TABLE XXII

How would you characterize your working relationship with this client?

Sample	Mean
Population I Homesick Students 5	3.4
Population II Nonhomesick Students 12	3.5

Scale: Very Poor 1 Poor 2 Fair 3 Good 4 Excellent 5

The data from the Counselor Forms can be summarized as follows. As expected, all of the homesick clients resided in dorms on the Reed campus. The counselors cited depression, somatic complaints, lack of friends and poor academic performance as indicative of homesickness. In addition, the counselor rated homesick clients as having more severely disabling presenting problems than students treated for problems other than homesickness. The counselors reported that they had established "good" relationships with students in both populations. Finally, the Counselor Forms did not present any quantifiable data concerning the nature of the treatment provided to the students in these two populations.

Population III: Dorm Comparison Group

The Homesickness Scale was also administered to a group of twenty-three students who resided in McKinley

Dorm on the Reed campus. The scale was initially completed by this population on September 22. A second Homesickness Scale was distributed to this population about a month after the first one. This data from Population III was included in the study as a means of measuring the effects of time on the responses to the Homesickness Scale from a population with a high risk of homesickness.

The completed results from the two administrations of the Homesickness Scale to Population III are found in Appendix C. Of the seven items on Homesickness Scale only one was found to elicit significantly different responses on the first and second scales completed by this population. Students from Population III were shown to become significantly more dissatisfied with their academic performance, at the .05 level, after being at Reed for a period of one month. Students in Populations I and II also reported greater dissatisfaction with their academic performance on their follow-up Homesickness Scale. However, these differences were found not significant at the .05 level of probability. The significant increase in dissatisfaction with academic performance of Population III, is the only item on the Homesickness Scale to elicit significantly different responses from any of the populations in this study.

TABLE XXIII

How satisfied are you with your performance in class?

	Pre (Mean)	Post (Mean)
Population III Dorm Students 23	3.65	3.09

Scale: From 1-I am very unsatisfied, to 5-I am very satisfied.

Summary of Findings

The results of the study are summarized below.

1. The results of the study do not support the study's major hypothesis. Students diagnosed and treated as homesick did not evidence improvement as measured by their responses to the Homesickness Scale. Because of limitations in the research design however, it was not possible to reach a definitive conclusion concerning the effectiveness of the treatment provided to the students in Population I.

2. There were no significant differences between the initial responses of Populations I and II on any of the seven items on the Homesickness Scale.

3. The majority of clients reported being satisfied with the services they received from the Reed College Counseling Service.

4. The Counselor Forms did not provide adequate information to determine the nature of treatment given to stu-

dents in Populations I and II.

5. Students in Population III became significantly more dissatisfied with their academic performance after being at Reed for one month. This was the only significant difference in the initial and follow-up responses of any of the three populations.

CHAPTER V

SUMMARY

The study had two purposes. The first purpose was to develop information which would be useful to the counselors of the Reed College Counseling Service in their practice. The second purpose was to develop an understanding of how to conduct research in a functioning treatment setting. Both purposes were addressed throughout the study.

The focus of the first purpose was to determine the effectiveness of the treatment provided to those students diagnosed by the counselors as homesick. It was hypothesized that the students diagnosed as homesick would evidence improvement as defined by the dimensions of measurement used in this study. The hypothesis was not supported by the results of the study. The results showed that the five homesick students did not demonstrate any significant improvement from the outcome measures used in the study. However, because of suspected problems with the validity of the Homesickness Scale and other limitations of the research design, there is insufficient evidence to reach definitive conclusions about the effectiveness of the treatment provided to the homesick students.

The second purpose of the study proved more fruitful

than the first. The study facilitated a variety of learning experiences which enabled the researchers to develop knowledge about how to conduct research in a functioning treatment setting. Perhaps the single most important lesson shared by the researchers concerned the selection of the research topic.

It is the researchers' conclusion that students who are invited into an agency to conduct research can most effectively study areas of agency practice which are of significant concern to the practitioners whom the research is supposed to benefit. In this light, it seemed to the researchers that many of the study's shortcomings were less the product of technical error, than the result of not having more fully engaged the interest and energies of the practitioners in the pursuit of the research aims. While the researchers were encouraged by the cooperation and support of the two counselors of the Reed College Counseling Service, it nevertheless was evident in the execution of the study that a topic of research which was of more cogent concern to the two counselors' work should have been chosen. In retrospect, the researchers believe that the practitioners' efforts were circumscribed by the practical necessity of relegating the study to a low priority in relation to their professional duties. Thus, while the researchers acknowledge the cooperation of the two counselors, it is regretted that some other area of

research which was more central to the counselors' concerns was not pursued. As with the content of the previous pages, the researchers accept full responsibility for not determining areas of research which might have been more congruent with the counselors' interests and therefore might have held a higher degree of professional investment for the counselors. Be that as it may, the conduct of the present study allowed the researchers to gain many such insights about research in a functioning treatment setting which will help guide the authors' future research efforts.

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APPENDIX A

DIAGNOSTIC PROFILE OF A HOMESICK STUDENT

A diagnostic profile of the homesick student, while not a discrete or limiting category would include in various degrees a number of systematic behaviors in one or more of the following categories:

1. Dissatisfaction with the environmental milieu. This would include:

    a. negative projections about their specific housing situation, ie, too noisy, too crowded, haven't unpacked yet, vague plans about decorating or moving, food is unappealing.

    b. negative references that the community is unfriendly, roommate is distant and uninteresting, don't or have not made a close friend.

2. Personal physical complaints - ie., not able to establish sleeping pattern, loss of appetite, stomach or chest pains, without medical verification.

3. Negative feeling and attitude about the Educational Process. This category includes an expressed feeling that the institution misrepresented its educational offering together with expressions that it's not what "I want" anyway. Examples; specific complaints include the professors are too busy or awesome; conferences are dominated by more knowledgeable peers.

4. References to family and friends at home; these are positive and reflect the homesick individual's longingness for the comfort and ties to his imminent past. Often these feelings are not expressed until the second or third interview and follow the student's sense that it's

O.K. to have and express dependent or "weak" feelings. Denial of need for any dependence on family for moral or financial support.

APPENDIX B

HOMESICKNESS SCALE

1. Please scale how you fit on these three continuums about life at Reed.
   Circle the appropriate number.

   How do you feel about being at Reed?

   1 2 3 4 5

   I don't feel comfortable with Reed. — I feel at home at Reed.

   How do you feel about people at Reed?

   1 2 3 4 5

   People at Reed are not very friendly. — People at Reed are very friendly.

   At this time, how satisfied are you with your performance in class?

   1 2 3 4 5

   I am very unsatisfied. — I am very satisfied.

2. How often do you go to extracurricular activities like socials, movies, concerts etc.?

   ___More than once a week.
   ___Once a week.
   ___Twice a month.
   ___Once a month or less.
   ___Almost never.

3. How often do you go to extracurricular activities like OSPIRG, off campus employment, volunteer work etc.?

___More than once a week.
___Once a week.
___Twice a month.
___Once a month or less.
___Almost never.

4. Approximately how often do you think you will go home during the first semester including Christmas Vacation?

___Once.
___Twice.
___Three times.
___More than three times.
___Not at all.

5. How much do you miss persons who you knew at home?

1 2 3 4 5

Not at all. A great deal.

COUNSELOR FORM

Initial Form ____

Post-treatment Form ____

Counselor ________________________ Name of client _________

Residence of client.

___Home

___Reed House

___Dorm

___Off Campus

___Other. ________________

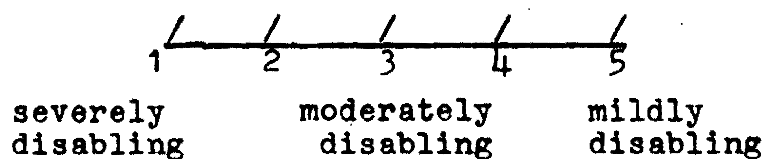
Was this client homesick? ___________

How did you know this person was homesick?
(describe attitudes, feelings, behavior)

What was the most salient characteristic of the client's homesickness? (what was the most significant symptom?)

If the client was homesick, what other problems were present?

How severe was the client's presenting problem?



Explain.____

What did you do with the client?

___ gave advice

___ support

___ interpretation

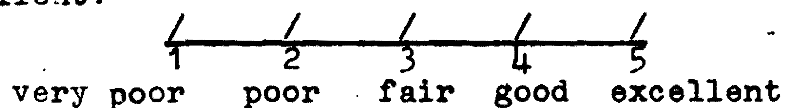
___ environmental manipulation

___ confrontation

___ reflective discussion

Explain.____

How would you characterize your working relationship with this client?



Do you think you were helpful to the client? How do you know?

In terms of outcome,

What is the most desired?

Least desired?

Expected outcome?

Date of initial interview. ________________

Do you expect to see this client again?

___ Yes
date of next appointment if scheduled. ________

___ No

___ Don't know

Dates of subsequent interviews. ____________________________

Please write in any additional comments on the back of this sheet.

CLIENT SATISFACTION QUESTIONS

The following group of questions concerns how you feel about the services you have received at the Reed College Counseling Service. Circle the appropriate answer.

1. Did you get the <u>kind of services</u> you wanted?

   Definitely yes   Somewhat   I don't know   Not at all

2. Do you <u>feel differently</u> about your problem(s) now?

   A great deal better   Somewhat better   No change   Worse

3. Was this due to the services you received at the Reed College Counseling Service?

   Yes, all of it   Yes, most of it   Yes, part of it   No, none of it

4. If you were to seek help again would you <u>come back</u> to the Reed College Counseling Service?

   Definitely, yes   Depends   I don't know   Definitely not

INITIAL EXPLANATION OF HOMESICKNESS SCALE GIVEN TO POPULATIONS I AND II

The attached survey was developed by graduate student researchers, Mark Masterson and Shawn Fisher, in cooperation with Jim Allred and Eunice Watson of the Reed College Counseling Service. The survey was designed to record some of the feelings, attitudes, and behavior of students as they begin adjusting to Reed life for a new school year. It is part of a study whose purpose is to develop a better understanding of how Reed Students make the transition from summer to life at Reed. All responses to the survey are confidential and will not be examined by the counselors. The responses will only be used for the general statistical purposes of the research. Please seal the survey in the envelope on which your appointment time is listed and bring it with you when you come for your appointment. In the near future a second short survey will be distributed through the campus mail.

Thank you for your cooperation.

Student's Name______________________________.

FIRST FOLLOW-UP QUESTIONNAIRE EXPLANATION

Dear

A few weeks ago, you filled out a short survey designed to record some of the feelings, attitudes and behaviors of students as they begin adjusting to Reed life for a new school year. The surveys are part of a study whose purpose is to develop a better understanding of how Reed students make the transition from summer to life at Reed. As you can see, the attached questionnaire is very similar to the one you responded to earlier. We would greatly appreciate your taking a few minutes to fill out this survey. Please return it to the Dean's Office personally or through the campus mail within one week. A return envelope has been enclosed for your convenience. As our sample is relatively small, it is important that as many people as possible return the form. All individual responses are confidential and will not be examined by the counselors at Reed. Thank you for your past cooperation in contributing to our study.

Sincerely,

Shawn Fisher
Mark Masterson
Graduate Student Researchers

SECOND FOLLOW-UP QUESTIONNAIRE EXPLANATION

Dear

We have not yet received your second and last survey. In case it has been lost in the mail or somehow misplaced, we have enclosed another survey to expedite your response.

We urge you to help us complete our study of Reed College Students by filling out the enclosed questionnaire and mailing it to the Dean's Office in the envelope we have provided. This survey will be used in anonymous comparison with the results of the first survey. As our sample is relatively small, it is important that as many people as possible return the form. However, if you choose not to complete the survey, please acknowledge that you have been contacted by returning the blank survey. All individual responses are confidential and will not be examined by the counselors at Reed. Thank you for your past cooperation in contributing to our study.

Sincerely,

Shawn Fisher
Mark Masterson
Graduate Student Researchers

APPENDIX C

POPULATION III RESPONSES TO HOMESICKNESS SCALE

TABLE I

How do you feel about being at Reed?

		Sept. 22 Mean	Oct. 20 Mean
Population III Dorm Students	23	4.35	4.17

Scale: From 1-I don't feel comfortable at Reed, to 5-I feel at home at Reed.

TABLE II

How do you feel about people at Reed?

		Sept. 22 Mean	Oct. 20 Mean
Population III Dorm Students	23	3.57	3.48

Scale: From 1-People at Reed are not very friendly, to 5-People at Reed are very friendly.

TABLE III

At this time, how satisfied are you with your performance in class?

		Sept. 22 Mean	Oct. 20 Mean
Population III Dorm Students	23	3.65	3.09

Scale: From 1-I am very unsatisfied, to 5-I am very satisfied.

TABLE IV

How often do you go to extracurricular activities like socials, movies, concerts etc.?

		Sept. 22 Mean	Oct. 20 Mean
Population III Dorm Students	23	2.0	1.96

Scale: 1-More than once a week, 2-Once a week, 3-Twice a month, 4-Once a month or less, 5-Almost never.

TABLE V

How often do you go to extracurricular activities like OSPIRG, off campus employment, volunteer work, etc.?

		Sept. 22 Mean	Oct. 20 Mean
Population III Dorm Students	23	3.96	4.22

Scale: Same as Table above.

TABLE VI

Approximately how often do you think you will go home during the first semester including Christmas Vacation?

		Sept. 22 Mean	Oct. 20 Mean
Population III Dorm Students	23	2.0	2.04

Scale: 1-Once, 2-Twice, 3-Three times, 4-More than three times, 5-Not at all.

TABLE VII

How much do you miss persons who you knew at home?

		Sept. 22 Mean	Oct. 20 Mean
Population III Dorm Students	23	3.22	3.0

Scale: From 1-Not at all, to 5-A great deal.