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PATIENT CHARACTERISTICS, PATIENT EXPERIENCE FROM PSYCHOTHERAPY, AND PSYCHOTHERAPY EFFECTIVENESS

In the presented research, questions were asked concerning the associations (1) between patients' characteristics and their experiences from psychotherapy as well as (2) between experiences from psychotherapy and the patients' assessment of its effectiveness. The variables were measured using a catamnestic survey, which was sent to 1,210 former patients of a psychotherapy center. We received answers from 276 people (55% women and 45% men), most of them aged under 30. Data were analyzed by means of structural models and correspondence analysis. The results indicate that: (1) variables group around good and bad psychotherapeutic relationship; two models were built – one for a good relationship and the other for a bad relationship with the psychotherapist; (2) the subgroups of patients reporting improvement, deterioration, and no change differ in terms of characteristics before psychotherapy and in terms of experiences from psychotherapy.

Keywords: psychotherapy effectiveness; patient expectations regarding psychotherapy; therapeutic relationship; number of sessions; duration of psychotherapy.

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Introduction

In the fifth point of the section devoted to general principles, *the Code of Professional Ethics for the Psychologist* presented by the Polish Psychological Association (2016) states that the psychologist "will be critical of his own achievements . . ." With regard to psychotherapy, which is a type of the clinical psychologist's practical activity, this may mean the duty of controlling the course and effects of this activity and the duty of conducting research on psychotherapy.

Since the beginning of the 1990s, research on psychotherapy has been conducted in the Academic Center for Psychotherapy (AOP) established in 1978 at the Faculty of Psychology of the University of Warsaw (e.g., Fila, 1993; Lenkiewicz, 1992; Grzesiuk, 2006). The catamnestic survey developed for research purposes, which we used in the present study, constituted the main source of information about the four groups of variables: the patient's characteristics, his or her experience from psychotherapy, as well as direct and delayed effectiveness of psychotherapy.

The research presented in this report provides answers to two questions concerning the relationships (1) between patient characteristics and experience from psychotherapy and (2) between the variables related to the course of psychotherapy and its direct effectiveness. In our research, we used structural equation modeling and correspondence analysis, which enabled more in-depth exploration of the investigated phenomena.

We assumed that it is important in analyzing the process of psychotherapy to take into account **the patient's perspective** – the patient's perception of his or her own attributes and behaviors as well as the patient's evaluation of the therapist's method of work and the effectiveness of psychotherapy (Mander et al., 2014; Ward, Wood, & Awal, 2013). The advocates of this view point out that it is the patient's experience that should be the object of analysis in psychotherapy; his or her opinion concerning the process of psychotherapy and its effectiveness is of special importance. Even though the patient's perspective is treated as more valid than the objective assessment of the therapist, few studies are conducted that focus on the patients' subjective perception of psychotherapy (Lutz et al., 2006). This usually stems from the fear that the patient's evaluation may be a result of his or her dissimulation, simulation, or striving to satisfy his or her own neurotic needs (Aleksandrowicz & Sobański, 2004). Still, the main source of information about the patient's experience is the patient's own opinion expressed in response to the items of the catamnestic survey.

Patient characteristics and experience from psychotherapy

The patient's characteristics are commonly regarded as important predictors of his or her experience in the process of psychotherapy; this refers especially to characteristics such as: age, sex, reported problems, ailments, inhibitions or other difficulties in contacts with people, learning difficulties, as well as temperament and personality traits (Aleksandrowicz & Sobański, 2004; Cosden, Patz, & Smith, 2009; Constantino, Penek, Berncker, & Overtree, 2014; Grzesiuk, 2006; Kuutmann & Hilsenroth, 2012).

One of the patient's important characteristics is the attitude towards psychotherapy. In the study by Constantino and colleagues (2014), the assessment of the patient's attitude to therapy using the Credibility/Expectancy Questionnaire covered both patient expectations and patient-perceived credibility of psychotherapy. The hypothesized construct of "attitude towards psychotherapy" comprised both expectations and motivations, the type of desires that therapy is to satisfy, as well as the patient's confidence in psychotherapy and its effectiveness.

Patient attitudes towards psychotherapy are described in terms of expectations regarding therapy, such as: (1) the desire to eliminate the symptoms of disease, (2) motivation to change oneself – to cope better in life, to get to know and understand oneself, to change one's own characteristics, experience, and behavior, as well as (3) the desire to receive support (Czabała, 2006; Grzesiuk, 2005; Grzesiuk & Suszek, 2011; Miller, 2009; Rakowska, 2005; Timmer, Bleichhardt, & Rief, 2006). The expectation of support means hope that psychotherapy (the therapist, cotherapists, other patients from the therapeutic group) will satisfy current needs, remedy problems and difficulties, provide help in a difficult life situation, and make it possible to obtain care and support from the psychotherapist. In that case, the relationship with the therapist – a substitute of a close person who is supposed to satisfy the patient's needs – becomes more important than internal change in the patient that would allow him or her to satisfy needs outside therapy.

There are research results that prove the association between patient characteristics and the expected effects of psychotherapy (Constantino et al., 2014). The patient's problems and complaints can determine his or her expectations regarding psychotherapy.

In research on patient experience in **the course of psychotherapy**, the following are taken into account: (1) the evaluation of the psychotherapist's work in terms of the form of therapy, the strategy, interventions aimed at focusing the

patient's attention on emotions, self-knowledge, self-understanding, and experience; (2) the evaluation of the therapist's work with resistance; (3) the psychotherapist's exploration of the patient's problems and experiences; (4) assistance in the processing of problems and in achieving an improvement of functioning (Elliot et al., 2009; Greenberg, 2002; Tryjarska, 2006; Ward et al., 2013). What is also important is (5) interventions connected with concluding the psychotherapy – summing up the experiences that occurred in its course and helping the patient consolidate the beneficial changes and use the abilities acquired in the future.

A group of variables that is important in research on the patient's experience in the course of psychotherapy is the variables concerning his or her relations with the psychotherapist and with other patients in the therapeutic group as well as the duration of psychotherapy, the number of sessions, and the way of ending the therapy (Elliot, Watson, Goldman, & Greenberg, 2009; Greenberg, 2002; Hill et al., 2011; Harnett, O'Donovan, & Lambert, 2010; Tryjarska, 2006).

The three-factor model of the relationship between the patient and the psychotherapist distinguishes three basic elements of that relationship: (1) psychotherapeutic alliance, (2) transference and countertransference, and (3) the actual relationship (Cierpiałkowska, 2008; Gelso & Hayes, 2004). Therapeutic alliance is associated with the effectiveness of psychotherapeutic interventions (Bachelor, 2013; Bottella et al., 2008; Czabała, 2006; Rakowska, 2005). As revealed by studies focused on the patient's perspective, it is also associated with the quality of therapeutic sessions and with the sufficiently long duration of psychotherapy (Saunders, Howard, & Orlinsky, 1989). Additionally, it has been found that patients who declared having achieved an improvement in therapy more often claimed that they had experienced equality and autonomy in the relationship with the psychotherapist (McElvaney & Timulok, 2013).

The findings of studies concerning the duration of psychotherapy are usually expressed in the form of the optimal number of sessions (Harnett et al., 2010; Hill et al., 2011). Among other reasons, this aspect of research is important due to the fact that the number of sessions is limited by institutions financing psychotherapeutic centers. Research on the patients' perspective reveals that patients see the number of therapeutic sessions as highly significant to achieving improvement (Weitz et al., 1975). Most patients believe there must be more than 20 sessions (Owen, Smith, & Rodolfa, 2009).

Research reveals that the characteristics the patient has when he or she starts psychotherapy influence the course of the psychotherapeutic process, especially at the beginning of therapy (Kuutmann & Hilsenroth, 2012). Therapists who deal

with patients suffering from more severe disorders or exhibiting disorders in interpersonal relations focus more strongly on the therapeutic relationship particularly at the beginning of psychotherapy.

The answer to the first research question – concerning the associations, outlined above, between two groups of variables – is supposed to lead to the construction of a model of associations between the patient's characteristics before psychotherapy and his or her experience from therapy.

Patient experience from psychotherapy and psychotherapy effectiveness

The results of research on the **effectiveness of psychotherapy** vary depending on the way of understanding this variable, which is not precisely defined in the literature (Jakubowska, 2006). The source of information about the effects of psychotherapy can be patients, psychotherapists, test results, etc. (Fila, 1993; Grzesiuk, 2006; Lutz et al., 2006). The criterion of therapy effectiveness can be, for instance, the reduction of pathological symptoms in the patient after psychotherapy compared to the time before its beginning or compared to healthy people's functioning (Prochaska & Norcross, 2006; Rakowska, 2006, 2015). Authors distinguish (1) direct effectiveness – relating to the effects found after the completion of psychotherapy, and (2) delayed effectiveness – relating to long-term effects (Rakowska, 2006). In research on psychotherapy, common factors – variables concerning the patient and the psychotherapist – are associated with the effects psychotherapy to a greater degree than specific psychotherapeutic methods (Czabała, 2006; Prochaska & Norcross, 2006; Rakowska, 2006, 2015).

The results of studies comparing the effectiveness of applied forms of psychotherapy – summed up in meta-analyses – lead to the conclusion that their average results are comparable (Rakowska, 2006). In meta-analyses, the generally distinguished approaches in psychotherapy have results indicating their effectiveness (Prochaska & Norcross, 2006). Some research results show a slight advantage of cognitive and behavioral interventions (methods) over psychodynamic and humanistic ones (Rakowska, 2006).

Based on meta-analyses of research results, it is estimated that factors connected with the psychotherapeutic relationship are responsible for the variability – from a few to 30 per cent – of the effects of psychotherapy (Cooper, 2010). Psychotherapeutic alliance is the most often investigated variable associated with the effectiveness of psychotherapy, although little is known about its components

considered separately (Bachelor, 2013; Botella et al., 2008; Cierpiałkowska, 2014; Clemence et al., 2005; Dinger, Strack, Leichsenring, & Schauenburg, 2007; Patterson, Anderson, & Wei, 2014). A summary of research findings reveals that effective psychotherapy depends not only on the psychotherapist's actions but also on the experiences induced in the patient (Cierpiałkowska & Czabała, 2013). The effects of psychotherapy depend on the therapist's ability to build – by providing information – a relationship with the patients in which they play the role of partners (rather than objects of interventions). What is also treated as a condition of effective psychotherapy is the partners' mutual acceptance and the expression of positive emotions.

The answer to the second research question – concerning the relations between the two groups of variables described above – is supposed to result in building a model of relationships between patient experience from psychotherapy and psychotherapy effectiveness.

Method

Study design

The study had a naturalistic and correlational character (Jakubowska, 2006). The status of the variables mentioned in the first research question was as follows. The explanatory variables were (1) patient characteristics, such as (1.1) reasons for reporting for psychotherapy, that is, complaints, pathological symptoms, as well as the kind and intensity of problems; (1.2) expectations regarding psychotherapy – the type and intensity of motivation to begin therapy: the elimination of pathological symptoms, a desire to change oneself, motivation to obtain support. The explained variables were: (2) experience from psychotherapy – (2.1) psychotherapeutic interventions, (2.2) psychotherapeutic relationship, emotional attitudes between the psychotherapist and the patient: patient → therapist and therapist → patient, (2.3) the number of sessions and the duration of psychotherapy, (2.4) the patient's adaptation to therapy.

The status of the variables included in the second research question was the following: the explained variable was (3) global perceived effectiveness of psychotherapy directly after its completion, and the explanatory variables referred to (2) patient experience from psychotherapy (in the first research question they had the status of an explained variable).

The way of measuring the variables, sample, and research procedure

We measured the variables using a catamnestic survey, which consists of four parts corresponding to four groups of variables (Fila, 1993; Grzesiuk, 2006).

– Part I describes **patient characteristics** before entering psychotherapy.

– Part II concerns patient experience **from psychotherapy.**

– Part III measures **the effectiveness of psychotherapy directly** after its completion.

– Part IV contains an assessment of **the delayed effectiveness of psychotherapy** at the time when the survey was completed (the length of the period of catamnesis varied from 1 year to 12 years).

In the present study, we used the answers of the patients to selected items from Parts I, II, and III of the survey. The catamnestic survey is a measurement instrument based on varied scales, with quantitative, categorical, and qualitative response formats. It enables the use of a broad spectrum of statistical analyses – from complex models (e.g., the structural models used in the present study) to qualitative analyses.

The catamnestic survey was sent out from the 1990s until 2013 to a total of 1,120 former AOP patients. AOP is a center where individual and group psychotherapy is conducted mainly for students and employees of Warsaw's universities. We received responses from 276 people, which is ~23% of the number of surveys sent out. This relatively low percentage of respondents may stem from (1) the relatively long period of catamnesis in some cases (even 12 years) and from (2) a change of the place of residence, frequent among students/graduates. The respondents were women (55%) and men (45%), mostly below the age of 30 (min. 21-25 years [interval data]; max. over 40 years [interval data]; mean: 26 years; median: 28 years; standard deviation: 3.779 – all the values are presented for classified data). The age given in the catamnestic survey is the age at the time when the survey was completed.

Based on information from psychotherapists, we found that the AOP patients who were respondents more often were those who (1) had attended more therapeutic sessions, had undergone a longer psychotherapy, and did not abandon it, those who (2) reported greater benefits from the psychotherapy they had attended, and those whose (3) catamnestic period had been relatively short (Fila, 1993). By contrast, in the analyses of interviews with AOP patients carried out by Lenkiewicz (1992), no differences were found between (1) respondents and (2) nonrespondents in terms of patient characteristics as well as the course

and outcomes of psychotherapy. The discrepancy between the results of these two studies can be explained, for instance, by their different assessment perspectives – psychotherapist's and patient's.

Data analysis method

Based on data from the literature concerning research on psychotherapy, it is difficult to build a model explaining the relationships between the variables involved in the psychotherapeutic process, since nearly all of these variables are interrelated. This leads to a methodological problem in the construction of the model (Jonkisz, 1998; Szymańska, in press). From the mathematical point of view, it is not advisable to build structural models in which variables are all reciprocally related[1] (Bartholomew, Steele, Moustaki, & Galbraith, 2008; Hair, Black, Babin, Anderson, & Tatham, 2006; Heck & Thomas, 2010). For this reason, in the present study we built a model of the investigated phenomenon using an exploratory method, which consists in laboriously freeing relations[2] between variables in order to end up with a model that includes only statistically significant relations and is fitted to the data (Hair et al., 2006).

In the case of exploratory models, however, there is a problem with generalizing the associations described by the model to the population (Gajda, 1992). Therefore, the model that will emerge from data analysis requires empirical verification in the future (Bartholomew et al., 2008; Hair et al., 2006; Heck & Thomas, 2009; Szymańska, in press). In other words, our solution should be tested on a different sample.

The set of data included a group of variables that could not be analyzed using structural equation models due to their qualitative character. Because they concerned important aspects of psychotherapy (such as attitude towards the therapist, therapy duration, the number of sessions, the ease of adapting to psychotherapy, and psychotherapy effectiveness), we used them to build models estimating the associations between qualitative variables. We wanted to check what levels of the psychotherapy effectiveness variable (expressed in answers: "improvement," "small improvement," "no change," and "deterioration") were associated with particular levels of the explanatory variables (e.g., for the number of sessions variable: "too many," "just enough," "too few"). What enabled us to do this in the case of qualitative variables was the nonparametric equivalent of factor anal-

[1] This is because such models do not explain anything.
[2] That is, excluding/removing statistically nonsignificant relations from the model.

ysis for qualitative variables – namely, correspondence analysis (Aranowska & Ciok, 1992; Bartholomew et al., 2008).

Results

Patient characteristics and experience from psychotherapy

The construction of the structural equation model reflecting the structure of relations between patient characteristics and the perceived course of psychotherapy had three stages. In the first stage we conducted an exploratory factor analysis in order to check which items of the scale constituted the factors. The following factors were extracted: (1) regarding **patient characteristics**: (1.1) inhibitions in contacts with people, (1.2) problems in contacts with people, (1.3) learning-related complaints, (1.4) patient-reported learning difficulties, (1.5) expectation of support from the therapist, and (1.6) other expected effects of psychotherapy, including: (1.6.1) getting rid of complaints, (1.6.2) achieving internal changes; (2) regarding **the course of psychotherapy**: (2.1) psychotherapist's focus on the transference relationship, (2.2) interpreting and informing the patient, (2.3) activating the patient, (2.4) the evaluation of the relationship with the psychotherapist as good, (2.5) the evaluation of the relationship with the psychotherapist as bad, (2.6) struggle with the psychotherapist.

In the second stage, the results of exploratory factor analysis were verified by means of a confirmatory factor analysis. After establishing that the solution yielded by the factor analysis was correct, in the third stage we built a structural model that used the factors distinguished in the factor analysis.

Because items in the catamnestic survey were described in terms of 0-1 and ordinal answer formats, in order to test the models we used the WLSMV[3] estimator, resistant to distributions diverging from normal. The results of analyses of structural equation models reveal that the theoretical model is well fitted to the obtained empirical data, as shown by the RMSEA statistic, whose value of .040 is lower than the .08 criterion, and by χ^2/df, whose value of 1.449 is lower than

[3] While Pearson's correlation coefficient estimates the linear relationship between two variables, the WLSMV estimator is used in investigating the association between multiple variables whose distributions diverge from normal.

the 2.5 criterion. The latent variables[4] also had sufficient reliability, which was indicated by the fact that their factor loadings (lambdas – λ) were relatively high.

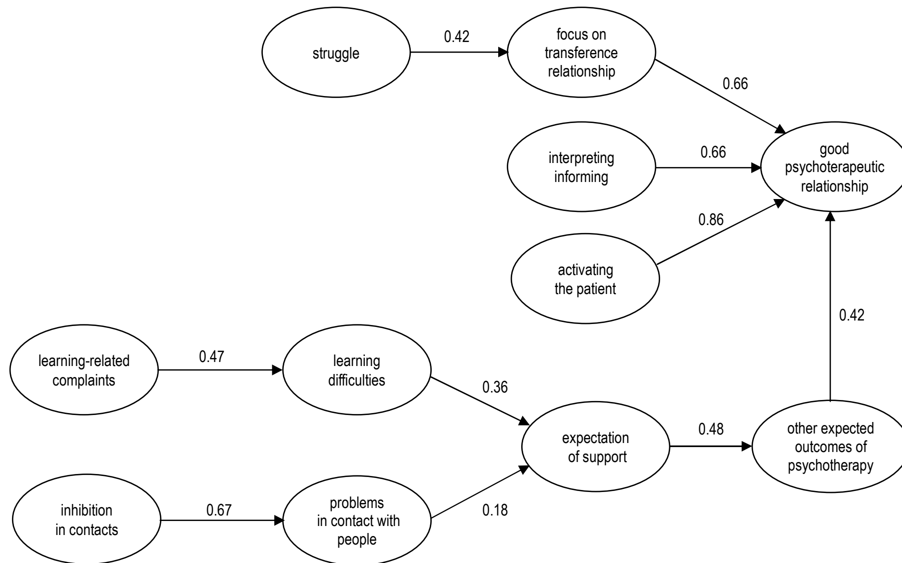
During the computing of structural models it turned out that all variables grouped around two: "good psychotherapeutic relationship" and "bad psychotherapeutic relationship." A good therapeutic relationship was characterized by the patients' impression that they had understood each other with the therapist, cooperated with him or her, wanted to be like the therapist, and wanted to meet him or her after the completion of psychotherapy. The patients describing their therapeutic relationship as bad had an impression that the psychotherapist had not understood them, had taken little care of them, and had not been interested in them.

The grouping of variables ruled out introducing both of these variables into one model: two negatively correlated variables ("good psychotherapeutic relationship" and "bad psychotherapeutic relationship") must not be introduced into one model because this decreases the fit of models and their interpretative value (Figures 1 and 2). Figure 1 presents the first model for a good relationship with the psychotherapist, with associations between latent variables, and Figure 2 – the results of the second model for a bad relationship with the psychotherapist.

Both models show that an important variable mediating between patients' complaints and problems and the expected effects of psychotherapy (in the form of internal changes and gaining self-knowledge as well as the disappearance of symptoms and complaints) is the expectation of support (i.e., of rest as well as obtaining help and care from the therapist).

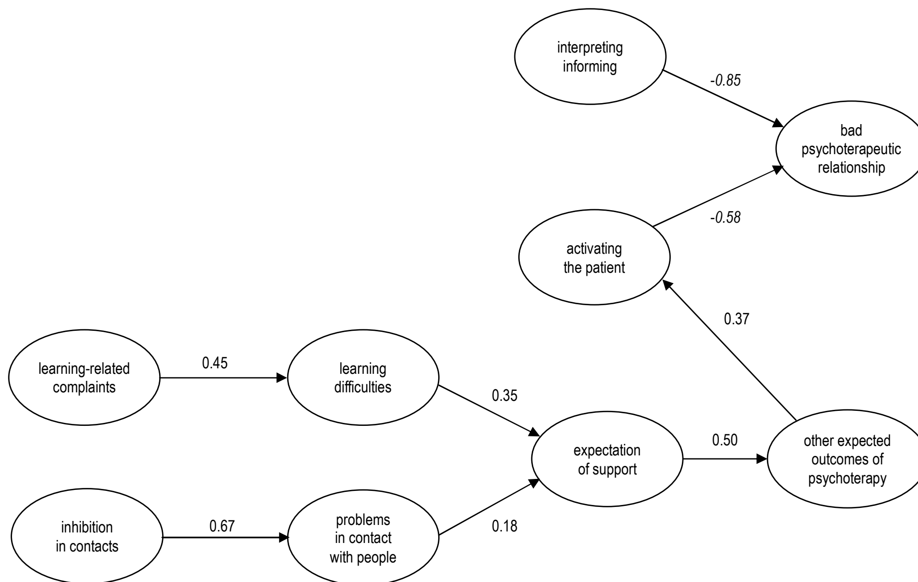
The good psychotherapeutic relationship model reveals that when patients evaluated their relationship with the psychotherapist as good they also reported that the therapist had activated them, interpreted and informed them, and focused on the transference relationship. These patients also claimed that in their relationship with the psychotherapist there had been an element of struggle connected with focusing on the transference relationship.

[4] These are variables that are not directly measurable; their variance is inferred based on the values of observable variables. An example of a latent variable can be *intelligence*, which it is impossible to observe directly and whose occurrence (or nonoccurrence) in a person is inferred based on the person's behavior.



χ^2 = 882.377, *df* = 609, CFI = .795, RMSEA = .040
The expected effects of psychotherapy are the removal of health problems and self-change. The 90% confidence interval for RMSEA is .034 – .046.

Figure 1. Model one – good psychotherapeutic relationship.



χ^2 = 608.246, *df* = 366, CFI = .817, RMSEA = .049; The 90% confidence interval for RMSEA is .042 – .056. Negative associations are italicized.

Figure 2. Model two – bad psychotherapeutic relationship.

In the second model – the one relating to bad psychotherapeutic relationship – there is neither the struggle component nor a focus on the transference relationship. Bad psychotherapeutic relationship is negatively associated with activating and interpreting the patient's experience and with informing the patient.

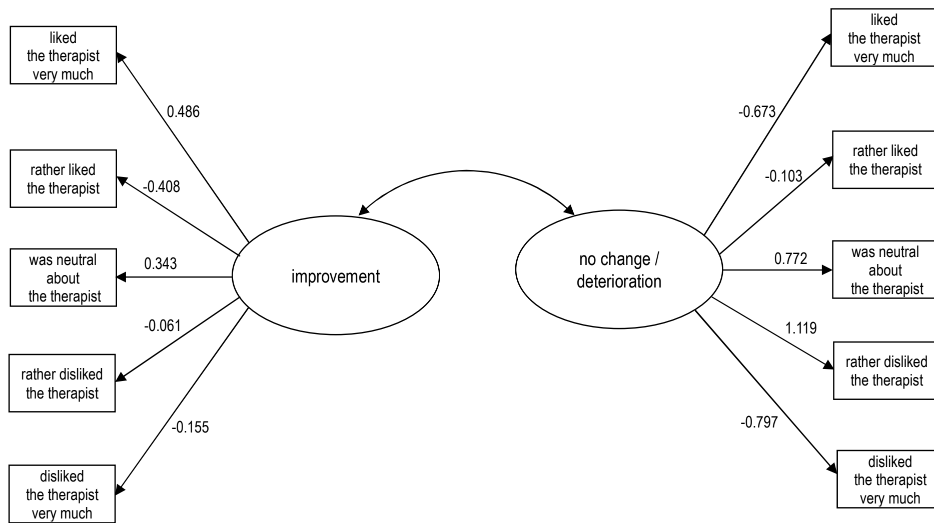
Patient experience from psychotherapy and psychotherapy effectiveness

With regard to the variables mentioned in the title, we applied **correspondence analysis**, which is an equivalent of factor analysis for qualitative variables (Aranowska & Ciok, 1992; Bartholomew et al., 2008).

In the present study, we distinguished four levels of the explained variable of *direct effectiveness of psychotherapy*: (1) **improvement** (indicated by two answers: *complete recovery* and *considerable improvement*) – found in 108 patients; (2) **small improvement** – found in 108 people; (3) **no change** – directly after the completion of psychotherapy – found in 35 people, and (4) **deterioration** – declared by 14 patients.

Correspondence analysis linked the four levels of the explained variable with the categories of explanatory variables. The variables that were predictors of direct effectiveness of psychotherapy concerned the following: psychotherapeutic interventions, the patient's emotional attitude towards the psychotherapist, the type of relationship (struggle, cooperation, agreement), the patient's adaptation to psychotherapy, the duration of psychotherapy, the number of psychotherapeutic sessions, and the way of ending the psychotherapy. Using these predictors, we built correspondence analysis models of which only four turned out to be statistically significant (Figures 3-6). For example, Figure 3 shows the relations between the levels of the variable of "attitude towards the psychotherapist" and three levels of the "psychotherapy effectiveness" variable, namely: (1) "improvement" as well as (2) "deterioration" and "no change." In the case of two levels of the psychotherapy effectiveness variable – *deterioration* and *no change* – we found the same associations with the levels of the explanatory variable. The absence of the "small improvement" level means that correspondence analysis revealed no significant associations between this variable and the levels of "attitude towards" the "psychotherapist."

The weights presented in the dimensions ("improvement" and "deterioration/no change") that were distinguished by correspondence analysis are non-standardized,[5] and so their values range from -∞ to +∞.

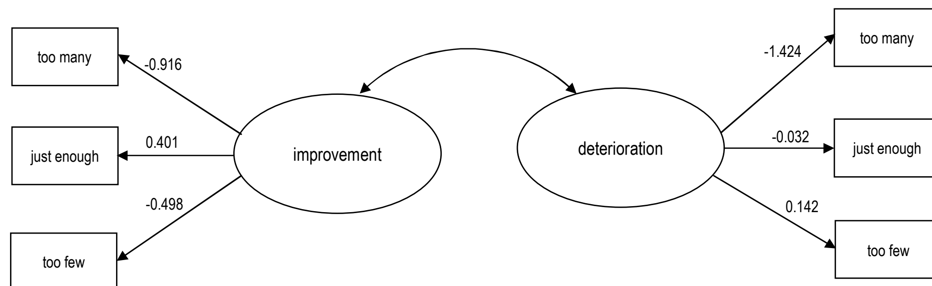


Correspondence analysis: $\chi^2 = 29.066$, $p = .004$.

Figure 3. Attitudes towards the psychotherapist and the effectiveness of psychotherapy.

As shown in Figure 3, **improvement** is the most clearly associated with a strong liking for the therapist or with a neutral attitude towards him or her. The weight of 0.343, referring to neutral attitude of this subgroup of patients towards the psychotherapist, was weaker than in the subgroup of people who reported having experienced a deterioration or no change, where the weight was 0.772. In the subgroup of patients who reported experiencing an improvement, we did not find strong weight for the "I strongly dislike the therapist response." **Deterioration** and **no change** are positively associated with a liking for or a neutral attitude towards the therapist and negatively associated with a liking or a strong dislike for the therapist. We found no associations between patient-assessed psychotherapist's attitudes towards the patient.

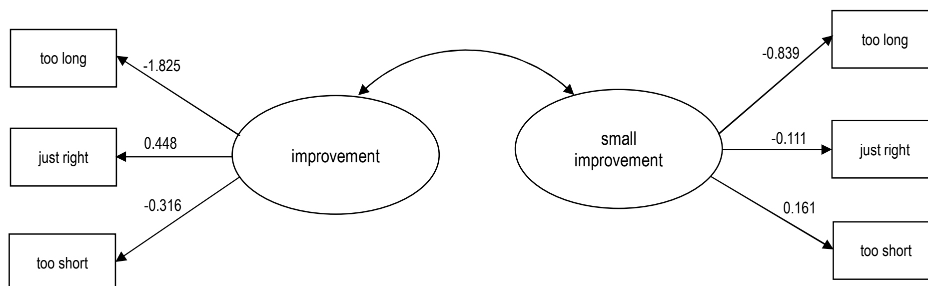
[5] Standardized data are values expressed on a standard scale, where the mean is 0 and scores range from -3 *z* to +3 *z*.



Correspondence analysis: $\chi^2 = 12.774$, $p = .04$.

Figure 4. The number of sessions and the effectiveness of psychotherapy.

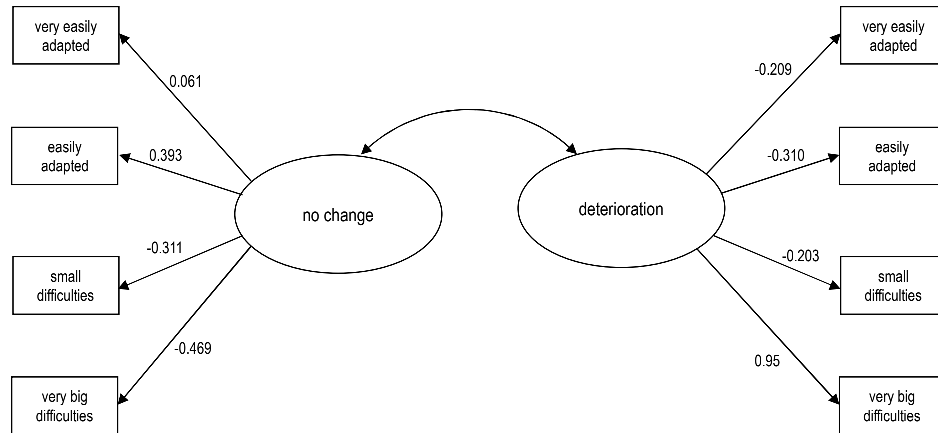
The model concerning the relationship between the number of sessions and the effectiveness of psychotherapy is presented in Figure 4. **Improvement** is associated with what the patient considers to be an appropriate number of sessions, and **deterioration** – with an insufficient number of session.



Correspondence analysis: $\chi^2 = 16.217$, $p = .013$.

Figure 5. The duration of psychotherapy and its effectiveness.

The model concerning the association of the duration of psychotherapy with its effectiveness is presented in Figure 5. **Improvement** is associated with what the patient regards as an appropriate duration of psychotherapy, and **small change** is associated with a too short duration.



Correspondence analysis: $\chi^2 = 19.371$, $p = .022$.

Figure 6. Adaptation to psychotherapy and psychotherapy effectiveness.

The model concerning the association between the ease of adaptation to psychotherapy and its effectiveness is presented in Figure 6. Figure 6 shows that **no change** is associated with easy or very easy adaptation to psychotherapy. **Deterioration** is associated with high difficulties in adaptation to therapy.

To sum up the results of correspondence analysis, **improvement** is associated with a liking for the psychotherapist or a neutral attitude towards him or her, as well as with the duration of psychotherapy and the number of sessions that the patient regards as appropriate. **Deterioration** and **no change** are associated with disliking the psychotherapist or with a neutral attitude towards him or her. As regards **deterioration** alone, it is associated with high difficulties in adapting to therapy and with a sense that the psychotherapy was too short.

Conclusion and discussion

The two methods of data analysis applied in the present study – structural models and correspondence analysis – revealed new, not previously described relationships (Fila, 1993; Grzesiuk, 2006) and, above all, made it possible to observe the complex structure of relations between the variables. While previous statistical analyses had been limited to revealing the relations between individual variables (Fila, 1993; Grzesiuk, 2006; Lenkiewicz, 1992), structural equation models made it possible to synthetically view the results in the form of two models presenting the variables in a network of interrelations. The variables in the

structural models grouped around good and bad psychotherapeutic relationships (Fila, 1993; Grzesiuk, 2006; Lenkiewicz, 1992).

In both models, in which the variables grouped around good and bad psychotherapeutic relationships, the study revealed the existence of associations between the expectation of (1) support and (2) effects of psychotherapy in the form of internal changes and the disappearance of symptoms. The *obtained support* variable seems to mediate the relationship between patient characteristics and other investigated expectations regarding psychotherapy. Perhaps patients begin psychotherapy with receiving support as the prevalent motivation. Subsequently, psychotherapeutic work on this kind of motivation may lead to the appearance of motivations to obtain the remaining two outcomes of psychotherapy – namely: better self-knowledge and a change of one's own behavior (Grzesiuk, 2005).

What is also worth noting is the association revealed by the model whose variables grouped around good therapeutic relations; it concerns the struggle with the psychotherapist as well as work on transference and on the evaluation of the psychotherapeutic relationship as good (Figure 1). This result reveals that in the group that perceived the therapeutic relationship as good the work during therapy concerned the transference relationship. No such association was detected in the second model, whose variables grouped around the bad therapeutic relationship. This may mean that the groups of people who evaluated the psychotherapeutic relationship as good and those who evaluated it as bad differ not only in terms of the therapist's interventions but also in terms of the aim of work. It is characteristic that the patients evaluating the therapeutic relationship as good pointed out that the relationship involved an element of struggle with and work on transference, which is treated as indispensable particularly in psychoanalysis (Sokolik, 2005).

The remaining results we obtained are consistent with the findings of studies analyzing the patients' perspective in terms of their evaluation of psychotherapy (Owen et al., 2009; Saunders et al., 1989; Weitz et al., 1975). Our study reveals the existence of a positive association between therapeutic interventions and a good psychotherapeutic relationship, which is consistent with the findings reported by Saunders and colleagues (1989). Their research also revealed that the better the patients evaluated their relationship with the psychotherapist, the better they evaluated the quality of sessions. Our results confirmed that these associations are not only significant but also strong. Moreover, the second model showed that the same principle operates in the reverse direction too. Namely, the worse the patients evaluated the psychotherapeutic relationship, the worse

they also evaluated the methods and interventions applied by the therapist. In other words, the patients perceived the therapeutic relationship as good (e.g., involving a sense of cooperation with and being understood by the therapist and a sense of identification with him or her) when the therapist activated, interpreted, and informed them as well as made them focus on the transference relationship. By contrast, they perceived the psychotherapeutic relationship as bad (e.g., when they had a sense of no understanding, interest, or care on the therapist's part) when the psychotherapist interpreted, informed, and activated them to a small degree.

In the part of the study aimed at finding the answer to the second research question, using correspondence analysis, we were able to identify the factors that determine the "psychotherapy effectiveness" variable (improvement, small improvement, no change, deterioration), such as: attitude towards the psychotherapist (liking/neutral attitude/disliking), the formal aspects of psychotherapy (duration, the number of sessions), or the patient's adaptation to psychotherapy.

The results of correspondence analysis show that improvement directly after the completion of psychotherapy is related to the patient's liking for the psychotherapist, an appropriate duration of the therapy, and an appropriate number of sessions. Deterioration and no change are related to disliking the psychotherapist or having a neutral attitude towards him or her. Deterioration is associated with considerable difficulties in getting used to psychotherapy and with the sense that it has been too short. These results are consistent with reports stating that, to be evaluated as effective, a psychotherapeutic intervention cannot be too short (Harnett et al., 2010; Hill et al., 2011). This is because patients who have difficulties in getting used to the conditions of psychotherapy usually need more sessions to go deeper into the therapeutic process, which the results of interactions reveal (Szymańska, Dobrenko, & Grzesiuk, 2014). Furthermore, many studies show that the quality of the psychotherapeutic relationship is associated with the effects of therapy (Clemence et al., 2005; Cooper, 2010; Dinger et al., 2007; Howgego, Yellowless, Owen, Meldrum, & Dark, 2003; Patterson et al., 2014).

What is characteristic about the obtained results is that no statistically significant effect was detected when it comes to the association between psychotherapy effectiveness and the way patients perceived the therapist's attitude towards them (in terms of "liking – neutral attitude – disliking"). Statistically significant associations concerned only the patient's attitudes towards the psychotherapist. In other words, the patient's attitudes towards the psychotherapist turned out to be more important to psychotherapy effectiveness than the attitudes attributed to the psychotherapist. Perhaps patients' answers regarding the psychotherapist's

attitudes could have been less unambiguous and less homogeneous as well, which is why the results turned out not to be statistically significant.

At the same time, the problem under discussion reveals the limitations of the analyses presented in the report. The use of a catamnestic survey – even though that instrument measures the patient's experience reliably – implies limitations connected with the objective measurement of actual events, the actual assessment of reality, as well as the psychotherapist's attitude and impressions. This is because it is not known how the factors constituting this variable – psychotherapeutic alliance, transference, and the actual relationship – contribute to the investigated relations between the patient and the therapist.

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