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Empathy revisited: the effect of representational system matching on certain counseling process and outcome variables

William Philip Brockman
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EMPATHY REVISITED: THE EFFECT OF REPRESENTATIONAL SYSTEM
MATCHING ON CERTAIN COUNSELING PROCESS AND OUTCOME
VARIABLES

The College of William and Mary in Virginia

Ed.D.

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EMPATHY REVISITED:
THE EFFECT OF REPRESENTATIONAL SYSTEM
MATCHING ON CERTAIN COUNSELING
PROCESS AND OUTCOME VARIABLES

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Presented to
The Faculty of the School of Education
The College of William and Mary in Virginia

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

by
William Philip Brockman

May 1980

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Dedication

To Big Toot and Little Toot

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EMPATHY REVISITED:
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SYSTEM MATCHING ON CERTAIN
COUNSELING PROCESS AND
OUTCOME VARIABLES

CHAPTER 1: INTRODUCTION

While therapist offered empathy is probably the most thoroughly researched of all the variables thought to contribute to positive therapeutic outcome, the nature of empathy remains an enigma. That empathy is an important element of the therapeutic relationship is almost axiomatic.

The central ingredient of the psychotherapeutic process appears to be the therapist's ability to perceive and communicate accurately and with sensitivity, the feelings of the patient and the meaning of those feelings. By communicating "I am with you" and "I can accurately sense the world as you construe it" in a manner that fully acknowledges feelings and experiences, he facilitates the patient's movement toward a deeper self-awareness and knowledge of his own feelings and experiences and their import. (Truax & Carkhuff, 1967, p. 285.

The body of research relating empathy to counseling outcome is voluminous. (Carkhuff, 1969a, 1969b; Carkhuff & Berenson, 1967; Gurman, 1977; Mitchell, Bozarth, & Krauft, 1977; Orlinsky & Howard, 1978; Truax & Mitchell, 1971; Barrett-Lennard, Note 1).

That empathy is an important aspect of helping relationships has been established. What empathy is has not. Therapists, patients, researchers, educators, and students all claim to know empathy when they see it, hear it, or

feel it. Empathy is an elusive concept and many researchers (Barrett-Lennard, 1962; Carkhuff, 1969a, 1969b; Dymond, 1949; Kagan, Krathwohl, Goldberg, Campbell, Schauble, Greenberg, Danish, Resnikoff, Bowes & Bondy, 1967; Asbury, Balzer, Childers, & Walters, 1977; Truax & Carkhuff, 1967; Barrett-Lennard, Note 2) have used various operational definitions of the concept in devising measures of empathy. For the psychoanalytic school, empathy is the emotional consequence of the mechanism of identification (Fenichel, 1956). Some researchers (e.g. Dymond, 1949) have defined empathy in terms of one's prediction of another's response to personality trait ratings and other types of self-descriptive measures. Others (Hogan, 1969; Kagan et al., 1977) have operationalized empathy in terms of response to items comprising an empathy scale or as one's ability to identify the affective state of another. "Objective" measures of empathy (Carkhuff, 1969b; Truax & Carkhuff, 1967) define the construct as the accuracy of therapist statements reflecting client affect and meaning as judged by third party observers. "Perceived" empathy (Barrett-Lennard, 1962) is defined in terms of client responses to items comprising an index of therapist empathy. Most efforts at operationally defining empathy have been criticized on methodological grounds and the construct validity of such measures is suspect. Several

researchers have offered evidence indicating that objective ratings of empathy tend to be heavily loaded with the rater's evaluation of qualities other than therapist empathy; such as counselor commitment and involvement in the relationship, counselor verbal (e.g. verbosity, number of affect words used) and non verbal behavior (e.g. eye contact, body posture) (Chinsky & Rappaport, 1970; Fish, 1970; Keisler, Mathieu & Klein, 1967; Rapp, 1977, Rappaport & Chinsky, 1972). Studies wherein empathy ratings by helper, helpee and trained judges are correlated often yield nonsignificant results indicating that different raters, from different perspectives, may perceive different aspects of therapist offered empathy.

Empathy has been treated as a "therapist skill" which can be taught. The prominence of empathy training in counselor education and supervision is attested to by the number of published training paradigms. (Carkhuff, 1969a, 1969b; Gazda et al., 1977; Goldstein, 1973; Ivey, 1971; Ivey & Authier, 1978; Kagan, 1971; Kelly, 1978; Sydnor, Akridge & Parkhill, 1972; Carkhuff & Berenson, 1967). While empathy has been treated as a skill:

There appears to be a lack of agreement among investigators as to whether they are dealing with therapist attitudes that are manifested in the treatment setting, or with therapist traits, skills techniques, and language styles, or with the global

apperception of the therapists as a "good guy."
(Parloff et al., 1978, p. 247)

Much of the research relating empathy, as a therapist variable, to outcome measures has been challenged on methodological grounds (Gottmann & Markinson, 1978; Mitchell, et al., 1977; Parloff et al., 1978). The trend, for serious researchers, is away from treating empathy as an independent variable having a linear relationship with outcome. "Many investigators concede that more complex relationships exist among therapist, patients and techniques" (Parloff et al., 1978, p. 273).

Despite over twenty-five years of theoretical and empirical investigation empathy remains an enigma. What is it that enables high powered communicators to accurately and precisely assume the internal frame of reference of another or "'tune in' on the client's wavelength ... or merge in the experience of the client" (Carkhuff & Berenson, 1967, p. 27) in such a way as to set the stage for profound client change and growth?

Statement of the Problem

The problem faced by the present research is that of defining and investigating the validity and effect on counseling of a new dimension of empathy implied in the recent writings of Richard Bandler and John Grinder (Bandler & Grinder, 1975a, 1975b, 1979; Grinder & Bandler, 1976;

Grinder, Delozier & Bandler, 1977). By operationalizing empathy as counselor/client congruence on the proposed dimension it may be possible to account for more of the variance in counseling outcome than has heretofore been accounted for by conventional operational definitions of "this subtle, elusive quality" (Rogers, 1975, p. 6).

The work of Bandler and Grinder is essentially an extension of the work begun by Gregory Bateson and the "Palo Alto Group" in the early 1950's. Where Bateson and his colleagues began with culture contrast and psychosis and moved toward theory (e.g. Bateson et al., 1956), Bandler and Grinder began with a linguistic analysis of the work of some of the most powerful therapists of our day — Virginia Satir, Fritz Perls, Milton H. Erickson and Salvador Manuchin — and created precise models of therapeutic intervention. Among the many interesting and therapeutically useful discoveries of Bandler and Grinder is a model of human experience which relates directly to empathic communication in human interaction.

The authors have observed that client verbalizations reflect the ways in which individuals organize internal reality. Noting that we would be overwhelmed by the infinite amount of information which bombards our senses if we did not organize and synthesize this information in some logical way, Bandler and Grinder have explicated some of the patterns by which persons organize experience. They have analyzed the

language used by potent therapists and their clients and have recognized that the key to individual patterns of internal organization lies in the lexical structure used (largely unconsciously) by individuals. Philosophically the authors owe a debt to Alfred Korzybski (1933) who stated:

If words are not things, or maps are not actual territory, then, obviously, the only possible link between the objective world and the linguistic world is found in structure, and structure alone. The only usefulness of a map or a language depends on the similarity of structure between the empirical world and the map-languages (p. 61).

Our experience of the "real world" then is mediated by a map or series of maps which necessarily differ from the world which they model. According to Bandler and Grinder (1975)

We as human beings do not operate directly on the world. Each of us creates a representation of the world in which we live — that is, we create a map or model which we use to generate our behavior. Our representation of the world determines to a large degree what our experience of the world will be, how we will perceive the world, what choices we will see available to us as we live in the world (p. 7).

That "the map is not the territory" is an important guiding principle in all of Bandler and Grinder's work. "When people come to us in therapy expressing pain and dissatisfaction, the limitations which they experience are, typically in their representation of the world and not in the world

itself" (Grinder & Bandler, 1976, p. 3).

From their synthesis of the work of Noam Chomsky in transformational grammar; the work of the "Palo Alto Group" on human communication; the philosophical writings of Alfred Korzybski, Bertrand Russell, and Hans Vaihinger; the neurological and cybernetic investigations of George A. Miller and Karl Pribram, Bandler and Grinder have proposed the concept of representation systems. A representational system is a map or model used to organize experience.

Individuals create these models based on the sensory input channels of vision, audition, kinesthetics, olfaction, and gustation. Each sensory modality leads to a different model of experience. The visual, auditory, and kinesthetic models are the most important for communication in counseling and therapy and have received the most attention. Natural language is also a representational system as we use words to represent, organize, and communicate our experience. In organizing our experience via representational systems we create models of the "real world" which because they are models differ from the world itself.

A visual model or visual representational system consist of remembered and/or created visual images or pictures and like other representational systems is reflected in the natural language predicates used in everyday speech. Do you see what I mean? An auditory model results from remem-

bered or created sounds and conversation experienced as internal dialogue. In everyday speech, utterances such as "I hear you loud and clear" suggest an auditory representational system. A kinesthetic model organizes experience via created and/or remembered feelings and bodily sensations and is expressed via language in sentences such as "How does what I am putting you in touch with feel to you?"

The authors (Bandler & Grinder, 1975a) hypothesize that people tend to organize their experience via the most highly valued of three (V, A, K) representational systems.

By most highly valued representational system we mean the representational system the person typically uses to bring information into consciousness - that is, the one he typically uses to represent the world and his experience to himself (Bandler & Grinder, 1975a, p. 26).

Since their first published work (1975a) Bandler and Grinder have evolved instructions for recognizing the lexical and physiological patterns which identify a person's most highly valued representation system.

While it was Bandler and Grinder who made explicit the concept of representational systems it was Virginia Satir's implicit use of the concept in therapy which gave impetus to the present study. In therapy a client might describe his/her life difficulties to Virginia using words indicative of a visual representational system concluding with the plea "Do you see my problem? Virginia's reply, "I get the picture" communicates very clearly to the client's internal frame of

reference. Communicating via the client's most highly valued representational system establishes rapport and builds trust.

In the present study counselor/client congruence for most highly valued representational system will be operationalized as a major dimension of empathy which will result in enhanced counseling process and outcome variables.

Hypotheses

The major question addressed by the present study is: will counselors who respond with language (predicates) attuned to the client's most highly valued representational system be perceived as more empathic than counselors who do not so respond? For the purposes of research the following hypotheses are formulated:

(1) Counselors who communicate with language attuned to the client's representational system will be perceived by clients as being more empathic than counselors who do not so communicate.

(2) Counselors who communicate with language attuned to the client's representational system will be perceived by judges as being more empathic than counselors who do not so communicate.

(3) Clients will indicate a greater willingness to self-disclose to counselors who communicate to their represent-

ational system than to counselors who do not so communicate.

(4) Clients will be more willing to return to counselors who communicate to their representational system than to counselors who do not so communicate.

Definition of Terms

Following are key terms defined as they relate to this study:

Representational System - Internal "ways of representing our experience of the world" (Grinder & Bandler, 1976, p. 6) which differ from the world due to limitations of the nervous system and social and individual constraints. (Bandler & Grinder, 1975a). Thus a representational system is an internal map or model of the world created by individuals.

Visual Representational System - Representation system organized in terms of visual perception experienced as visual images or pictures.

Auditory Representational System - Representational system organized in terms of auditory perception experienced as sound, voices or internal dialogue.

Kenesthetic Representational System - Representational system organized in terms of kenesthetic perception experienced as feelings or bodily sensations.

Most Highly Valued Representational System - "The representational system the person typically uses to bring

information into consciousness — that is, the one he typically uses to represent the world and his experience to himself" (Grinder & Bandler, 1976, p. 26).

Predicates - verbs, adjectives and adverbs used in normal speech.

Plan of Presentation

In this chapter has been introduced the topic of the present research and the historical and theoretical structure in which it is framed. The problem has been addressed, the hypotheses have been stated, and pertinent terms have been defined. The remaining body of this volume will be divided into four chapters as follows:

Chapter 2 - Review of Literature

In this chapter will be reviewed that part of the literature relating directly to the variables as defined and to the means of assessing those variables.

Chapter 3 - Methodology

In Chapter III will be presented important information relevant to the population sampled and the instrumentation used. Statistical procedures and statistical analysis will be specified.

CHAPTER 2: REVIEW OF THE LITERATURE

The body of this chapter will be restricted to a review of that part of the literature which relates to the development of the theoretical rationale for the present study and to the measurement of the variables pertinent to the study.

Defining the Nature of Empathy

The phenomenon of empathy as a major interpersonal dimension has long been considered a key element in social and interpersonal understanding as well as in the psychotherapeutic relationship. Major writers in the fields of sociology (Mead, 1934), psychiatry (Fenichel, 1945; Fleiss, 1942; Fromm-Reichmann, 1950; Sullivan, 1953) and psychology (Rogers, 1951, 1957; Truax & Carkhuff, 1967) have concerned themselves with empathic understanding. However "empirical research on empathy does not parallel its theoretical salience" (Feshbach, 1978, p. 2). Diverse conceptions of empathy abound as do various operational definitions and methods of assessment. The problem of defining the concept of empathy is a difficult one and Katz (1963) has stated that

Any scientific judgement of empathy ... must take into consideration the fact that the problems to be solved are of such complexity and such subtlety that ordinary standards of measurement are simply not relevant (p. 19).

The German psychologist Theodore Lipps is credited with the first modern use of the term empathy when he applied the German word "Einfuhlung" to the process of aesthetic appreciation. Einfuhlung, or literally "feeling into another," was translated as "empathy" by the American psychologist E. B. Titchener (Katz, 1963).

The Psychoanalytic View of Empathy

Applied to psychotherapy the empathic process enables the therapist "to obtain ... an inside knowledge that is almost first hand" (Fleiss, 1942, p. 212) of the patient and his emotional world. In psychoanalytic theory this "knowledge is the emotional consequence of the mechanism of identification. According to Fenichel (1945):

Empathy consists of two acts: (1) an identification with the person; and (b) an awareness of one's own feelings after identification, in this way an awareness of the object's feelings (p. 511).

In emphasizing the importance of empathy in psychoanalytic therapy Frieda Fromm-Reichmann (1950) has stated:

We know that the success or failure of psychoanalytic therapy is ... greatly dependent upon the question of whether or not there is an empathic quality between the psychiatrist and the patient (p. 62).

Early conceptions of empathy in the psychoanalytic literature accentuated the affective dimension of the "empathic quality." The goal of gaining "inside knowledge" in order to facilitate the analysis is achieved by an awareness of the instinctual and unconscious emotional aspects of communication.

The dimension of empathy — representational system matching — explicated by the present study incorporates elements of the psychoanalytic view in that representational system organization is an unconscious phenomenon. In communicating one's experience via language one makes choices which are usually unconscious about which words best describe that experience (Grinder & Bandler, 1976).

Predictive Empathy

The philosopher and social psychologist George Herbert Mead (1934) conceptualized the phenomenon of empathy as a predominately cognitive process. While he did not use the word "empathy" he described the empathic process in formulating the concept of "role-taking" or assuming the attitude of another. Mead contended that the uniquely human trait of self-consciousness develops as one is able to regard oneself from the perspective of others. Role-taking or empathy is seen

not only as essential to personality development but also as fundamental to the operation of society. Persons interact by way of natural language and other shared symbols. In role-taking one participates in the experience of the other through an inward cognitive awareness of the shared meaning of the words and symbols used in communicating. Through role-taking one achieves empathy with another by creating images of the meaning of the other's communication. Affect, although not primary, is a component of role-taking and Mead (1934) has stated:

We feel with him and we are able to so feel ourselves into the other because we have, by our own attitudes, aroused in ourselves the attitude of the person we are assisting (p. 229).

Mead's description of the empathic process with its emphasis upon shared meaning and imagery is primarily cognitive. Role-taking ability is seen as a developmental aspect of socialization and as such it is suggested that various degrees of empathic skill may obtain.

Mead's role-taking view of empathy provided the theoretical base for Dymond's (1949) early work on defining empathy. Dymond's (1948) contention that a person with empathic ability is able to "project himself into the thoughts and feelings of the other" (p. 228) was given operational expression in a scale designed to measure empathic ability. Hers was a pioneering effort at developing an objective measure of empathy (see below) but because it was based on one's prediction of

another's perception her work is reviewed in this section. The measure is based on how accurately A is able to predict B's self-ratings and B's ratings of A on six trait dimensions. While Dymond's work was a laudable attempt to operationalize empathy, the procedure has not proven clinically useful because of several methodological difficulties. The accuracy of correlations between an empathizer's predictions and the self-report of the stimulus person have been questioned. Cronbach (1955) has indicated that such measures are subject to spurious correlations which may reflect "scale tendencies, projection and item dispersion" (Feshbach, 1978, p. 4).

Other predictive measures of empathy have used therapist predictions of how a client will respond to a personality inventory (e.g. Kurtz & Grummon, 1972) or to other types of self-descriptive measures (e.g. Cartwright & Lerner, 1963). Such measures are fraught with the same methodological problems mentioned above. Kurtz and Grummon's (1972) finding of no relationship between predictive empathy and therapy outcome replicated earlier findings cited by those same authors and prompted them to conclude, "we doubt the value of a predictive measure of empathy in counseling and psychotherapy research" (p. 113).

Empathy as a Trait

Hogan (1969), noting that Mead's (1934) concept of role-taking and Kelly's (1955) concept of role-construction assume an underlying empathic capability, devised an empirically-keyed empathy scale for use in researching his (Hogan's) model of moral conduct. A Q-sort description of the "ideally empathic person," which was found to have been highly reliable ($r = .90$, Hogan, 1975), was used as a criterion to extract a scale from the combined MMPI-CPI item pool. Sixty-four items were retained as an operational definition of empathy. Hogan (1975) has reported correlations of above .40 with rated empathy and social acuity and has used the instrument in refining his role-theoretical model of personal conduct. While acknowledging the importance of empathy in counseling, Hogan (1975) does not ascribe "causal status to empathy as a therapeutic agent" (p. 17) and suggests that empathy is related to several other variables which promote client growth and change.

The Hogan Empathy Scale can be seen as a measure of trait empathy. However, such a trait may or may not be expressed by therapists with clients. Gough, Fox, and Hall (1972) have reported that the CPI protocols of 262 psychiatric residents scored for empathy did not correlate significantly with supervisors' ratings of performance. It is doubtful that trait empathy can be trained it is results from

genetic factors, intelligence, and early experience. Hogan (1975) notes that "simulated" or state empathy should be easy to model and/or train. Empirical evidence supplied by numerous authors (e.g. Carkhuff, 1969a, 1969b; Truax & Mitchell, 1971) supports Hogan's contention.

The trait/state distinction of empathy measures is an important one especially when empathy is hypothesized as being related to therapy process and outcome. Kagan and his associates at Michigan State University have developed a measure of "affective sensitivity" which can be viewed as an index of trait empathy (Campbell, Kagan & Krathwohle, 1971; Danish & Kagan, 1971; Kagan et al. 1967). Persons high in affective sensitivity are hypothesized to perceive accurately and identify without distortion the affective states of others. Stimulus items for the test are videotape excerpts of actual counseling interviews. After viewing a videotape segment S's choose the best of three statements describing the last feeling expressed by the client. The scale consists of 89 multiple-choice items. Internal reliability coefficients (Kuder-Richardson Formula 20) range from .52 - .77 and test-retest reliability has been reported at .75 for the instrument (Campbell et al. 1971); Concurrent validity studies cited by Campbell et al. (1971) reported average correlations of .26 indicating a low positive relationship between test scores and various judgements of counseling effectiveness. Studies by Danish and Kagan (1971)

reported positive although nonsubstantial gains in affective sensitivity scores as a result of training.

The Affective Sensitivity Scale does not measure empathy per se but rather one's ability to accurately perceive and identify the affective state of another; however researchers have hypothesized positive relationships between scale scores and other measures of empathy and therapy outcome. In an important study by Kurtz and Grummon (1972) various measures of therapist empathy were compared with each other and with several therapy outcome measures. Their data showed no relationship between the Affective Sensitivity Scale and the other empathy measures nor with any of the outcome measures. Like the Hogan Empathy Scale, the Affective Sensitivity Scale taps a component of empathy which is not necessarily manifest by therapists in responding to clients. Campbell et al. (1971) have stated:

The procedure measures an individual's ability to identify accurately the feelings of another; it does not measure his ability to use this knowledge or understanding effectively to promote positive client growth in a counseling relationship. A person may be highly sensitive but be unable to use this aptitude (p. 411).

The trait measured by Kagan's scale does appear to be at least somewhat amenable to training and the scale may have a place in counselor education but Danish and Kagan (1971) offer the following caution:

If affective sensitivity is a trait like that of intelligence, then both hereditary potential and environmental conditions may be influential and large gains by groups should probably not be expected to occur (p. 53).

The current status of the Affective Sensitivity Scale and, by implication, other measures of empathy as a trait was summed up by Kurtz and Grummon (1972) thusly:

We conclude that the Affective Sensitivity Scale is not a useful instrument for studying counseling and psychotherapy, even though it may be useful in training situations (p. 113).

Affective versus Cognitive Distinctions

It is evident that the multivariate nature of empathy has confounded research efforts rendering them less than rigorous. Attempts to distinguish between the affective and cognitive components of variability on measures of empathy have lent an aura of rigor to some research but the implications for psychotherapeutic practice have been disappointing. That the cognitive/affective distinction may be an arbitrary if not artificial one was noted by Feshbach (1975):

A contributing factor to the widely contrasting conceptions of empathy may be a confusion between process and product. Thus, it is possible to conceptualize empathy as a cognitive product mediated by emotional factors or as an affective response mediated by cognitive processes.

Further, by the complexity of social cognition and interaction, whereby products or responses acquire cue value and become incorporated into a feedback system, it becomes almost an arbitrary decision to specify the sequence of affect and cognition (p. 25).

Objective Measures of Empathy

The earliest attempt to measure empathy by objective means was that of Dymond (1949) mentioned above. With Carl Rogers' (1957) hypothesis that only six particular conditions (empathy among them) "are both necessary and sufficient to bring about "constructive personality change" (p. 98) interest in developing objective empathy scales grew. Although audacious, Rogers' hypothesis was highly specific and easily operationalized and the early studies of Rogers, his colleagues, and students "comprise in a very real sense the introduction of the scientific study of psychotherapy" (Mitchell et al. 1977, p. 482, emphasis theirs). Rogers (1957) defined empathy thusly:

The therapist is experiencing an accurate, empathic understanding of the client's awareness of his own experience. To sense the client's private world as if it were your own, but without ever losing the "as if" quality — this is empathy (p. 98).

Rogers' theory holds that therapist empathy, along with genuineness and unconditional positive regard be communicated, at least minimally, to the client in order for change to result. Thus empathy came to be seen as a therapist product resulting from a primarily cognitive process.

Rogers' original hypotheses (1951, 1957, 1959, 1962) held that empathic understanding of the client's internal frame of reference, in conjunction with the therapist's unconditional positive regard and congruence set the stage for the client to become more aware of his true feelings and experiences in order for his self-concept to become more congruent with the total experience of the organism (Rogers, 1951). Empathy is a catalyst. Understanding another from his internal frame of reference establishes rapport and builds trust. Freed from threat, the client is able to confront denied and distorted aspects of his experience and more realistically integrate his experience of self with his experience of the world. Implied in this formulation is the necessity for the client to disclose intimate and important aspects of his affective and cognitive experience within the therapy relationship. The theory holds that persons have an "inherent tendency toward actualization" which, by way of a facilitative relationship, is manifest in a new, more enriched, and healthier experience of self which leads to wider behavioral choices for change and growth.

While recent reports (Bergin & Suinn, 1975; Mitchell et al., 1977; Parloff, Waskow & Wolfe, 1978) call into question Rogers' (1957) hypothesis that the "core conditions" are the "necessary and sufficient" conditions of "constructive personality change," the sheer volume of research,

reviews, and editorial comments on empathy attest to the salience of the construct of empathy in counseling and therapy. Even though Rogers "necessary and sufficient" hypothesis has been challenged his intent, to inspire research on psychotherapeutic process and outcome, has been realized.

His aim was to provoke research that, in the course of testing his extraordinary hypothesis, would help advance the field. He hoped that research would ultimately succeed in identifying the elements critical to the therapeutic process. He challenged some of the most treasured beliefs of therapists regarding the role of techniques and training. The hypothesis, while stemming from the client-centered orientation and experience, was not confined to it. It addressed the therapeutic process per se (Parloff, et. al., 1978, p. 249).

In order to test Rogers' hypotheses several instruments designed to measure therapist empathy have been devised (Barrett-Lennard, 1962; Carkhuff, 1969b; Truax, 1967; Truax & Carkhuff, 1967; Barrett-Lennard, Note 3). The Truax Accurate Empathy Scale (AE) (Truax, 1967) and the Carkhuff Empathic Understanding Scale (EU) (Carkhuff 1969b) have been widely used in counseling and psychotherapy research. The scales have been used to research not only Rogers client-centered theory but also in the study of the effects of empathy in many other types of helping relationships.

Both the AE and EU scales are used to rate the level of therapist empathic response from the perspective of third

party judges trained in the use of the scales. The scales are most often used to rate audiotaped segments of therapy sessions and have been used with motion picture, videotape and typed transcripts of therapy interaction.

The Truax Accurate Empathy Scale

In defining accurate empathy Truax (1967) has stated:

Accurate empathy involves more than just the ability of the therapist to sense the client or patient's "private world" as if it were his own. It also involves more than just his ability to know what the patient means. Accurate empathy involves both the therapist's sensitivity to current feelings and his verbal facility to communicate this understanding in a language attuned to the client's current feelings (p. 555).

Truax (1967) delineated nine stages of accurate empathy ranging from Stage 1 where the therapist "seem completely unaware of even the most conspicuous of the client's feelings" (p. 556) to Stage 9 where the "therapist unerringly responds to the client's full range of feelings in their exact intensity" (p. 567). The emphasis is clearly on therapist response to client affect. Empathy, then, is a product of the cognitive process of attending and responding to client affect. Accurate empathy is achieved by a sensitive awareness of the client's feelings, not by sharing those feelings.

The Carkhuff Empathic Understanding Scale

The scale developed by Carkhuff (1969b) was derived

from the Truax measure and "was written to apply to all interpersonal processes and represents a systematic attempt to reduce ambiguity and increase reliability" (p. 315). The EU scale is a truncated version of the AE scale which places emphasis on empathic response to the content and meaning as well as the effect of client statements. Carkhuff supports Bergin's (1966) contention that

communicating empathic understanding which approximates the depth reflection of the client-centered school and the moderate interpretation of the psychoanalytic orientation appears to be of the greatest potentially demonstrable efficacy (Carkhuff & Berenson, 1967, p. 27).

Carkhuff (1969b) has compressed the nine stages of accurate empathy into five levels of empathic understanding setting level three as the "minimal level of facilitative interpersonal functioning" (p. 316) for the core condition of empathy. At level three therapist empathy is expressed in terms which are interchangeable with client statements for affect and meaning. Responses rated below level three are subtractive in that they either do not attend to or subtract noticeably from the intensity of client affect and the meaning of client content. Responses are rated above level three and termed additive if they add noticeably and/or significantly to client expressions. At additive levels (3+) therapist statements express feelings "at a level deeper than they were expressed and thus enables the second person to

experience and/or express feelings he was unable to express previously" (p. 316). At the highest level (5) therapist responses facilitate deep self-exploration and indicate that the therapist is "fully with him at his deepest moments" (p. 317).

Reliability and Validity of Objective Empathy Measures

Both the AE and EU scales have been used in counseling and therapy research to assess empathy not only as an independent and process variable but also as a dependent and outcome variable. As differences between the two scales have not been analyzed (Gormally & Hill, 1974) and it is questionable whether the changes made by Carkhuff are as "substantive as have been claimed" (Mitchell et al. 1977, p. 483) most reviewers of the empathy literature have treated AE and EU derived data as basically interchangeable. This reviewer will not deviate from that practice.

The "judged empathy" approach taken by Truax, Carkhuff, and their adherents assumes that, using the scales, third party judges are able to make accurate and reliable ratings of therapist offered empathic response. Most rater training paradigms establish .50 or better as the criterion for inter and intra-rater reliability. Such figures have been reported as high as .95 (Truax & Carkhuff, 1967). While some criticism has been leveled at the means of reliability assessment (Chinsky & Rappaport, 1970) it is generally

agreed that judges can be trained to use the scales with at least an adequate degree of consistency over time and across rates. The reliability of the "judge rated" approach to empathy assessment is not at issue here.

Largely as a result of the efforts of Truax, Carkhuff, and their associates to operationalize and measure Rogers' therapeutic triad, empathy has come to be seen, along with genuineness and unconditional positive regard, as a "therapist skill." Conceptualizing empathy as a skill which can be assessed by objective procedures, numerous authors have made empathy training central in their counselor training paradigms (e.g. Carkhuff & Berenson, 1967; Carkhuff, 1969a, 1969b, 1971; Cazda, Asbury, Balzer, Childers & Walters, 1977; Goldstein, 1973; Ivey, 1971; Ivey & Authier, 1978; Kagan et al., 1967; Kelly, 1978; Sydnor, Akridge & Parkhill, 1972). These authors have isolated aspects of empathic behavior such as "attending skills," "listening skills," "reflection of feeling" and "paraphrasing" based on the assumption that when such behaviors are put together judiciously the result will be something recognizable as therapist offered empathy. Studies cited by Truax and Mitchell (1971) indicate that such training can result in increased facilitative functioning as assessed by the scales but Truax and Mitchell noted:

The findings that these interpersonal skills can be learned in a short amount of time leads to either of two inferences. Perhaps these skills are relatively superficial and thus can be learned quickly. Since the skills have been related to significant client growth ..., however, it does not appear likely that they are superficial.

The second inference is that these skills are learned, either overtly or covertly, in early, formative interpersonal situations ... and that focused training capitalizes on what may often have been past incidental learning. (p. 327).

Having objective scales with which to assess the empathy variable has advanced the study of counseling and therapy considerably, constituting "one of the major research thrusts of the past three decades" (Whiteley, 1975, p. 2). However expert opinion varies widely on the nature of the variable/s assessed by way of objective empathy scales. Although the use of judged empathy ratings lent an additional aura of rigor to psychotherapy research much of that research has been challenged on both theoretical and methodological grounds.

Rogerian theory holds that for empathy to affect outcome therapist empathy must be perceived by the client. Therefore studies which have shown "judged empathy" to be positively related to outcome are theoretically suspect. That correlations between "judged empathy and client perceived empathy are rarely significant if even positive (Gurman, 1977; Kurtz & Grummon, 1972) lends empirical support to theoretical criticism.

The most significant criticism of objective empathy scales was initiated by Chinsky and Rappaport (1970). In questioning the construct validity of the AE scale Chinsky and Rappaport (1970) referred to a previous finding by Kiesler et al. (1967) indicating that AE ratings

were heavily loaded with the rater's evaluation of the depth and genuineness of the therapist's more general commitment to the therapeutic relationship, and the honesty and openness of his sharing of his perceptions and reactions in the relationship. In other words, rather than reflecting the accuracy and refinement of the therapist's responses, the Accurate Empathy Scale seems to have been tapping a more global therapist quality — the therapist's communicated commitment to the therapy interaction and involvement in the problems of a specific patient in the interaction (p. 305).

Chinsky and Rappaport also pointed out that AE ratings reported by Truax (1966) were essentially the same regardless of whether judges were rating therapist/patient interaction or therapist responses alone. These same authors (Rappaport & Chinsky, 1972) offered further evidence of the lack of construct validity of the AE scale and stated:

To assume that one can measure "both the therapist's sensitivity to current feelings and his verbal facility to communicate this understanding in a language attuned to the client's current feelings [Truax & Carkhuff, 1967, p. 46]" in the absence of the client's statements raises serious questions as to the meaning of the measurement (p. 400).

Avery, D'Augelli and Danish (1967) designed a study to assess the effect of various amounts of client/therapist interaction on EU ratings. Their finding, that judges tended

to assign therapist responses higher EU ratings in the therapist response only condition than in the client/therapist interaction, supports the position of Chinsky and Rappaport.

Other authors have offered evidence that "judged empathy" ratings tend to be contaminated with therapist behaviors other than those defined by the scales used. In factor analyzing judges' ratings on the Carkhuff scales for EU, genuineness, concreteness and self-disclosure, Muelhberg, Pierce, and Drasgow (1969) extracted a single factor which accounted for 89% of the variance among the ratings. That their "good guy" factor accounted for such a large percentage of the variance is an indication that raters may respond to more global therapist behaviors than those operationalized by the Carkhuff scales. A similar factor analysis by Hefele, Collingwood, and Drasgow (1970) found a like factor accounting for 79% of the variance.

Caracena and Vicory (1969) found that AE ratings correlated with a measure of verbal dominance and the number of words spoken per interviewer response. Verbosity on the part of the interviewer was seen as being interpreted as interest and involvement by judges and resulted in higher AE ratings.

In two related studies Wenegrat (1974, 1976) found that AE scores correlated with several speech variables.

In the study which assessed AE in "analytic type" therapy Wenegrat (1974) found that AE loaded on only one factor defined as "therapist assertiveness or lack of hesitancy in approaching a client's emotions" (p. 50). The later study involved client-centered therapy and yielded significant correlations between AE ratings and (1) specific statements about emotion, (2) number of words spoken by therapist, and (3) therapist statements about client actions and the corresponding emotions. Factor analysis resulted in AE loadings on factors indicative of therapist assertiveness in dealing with client feelings and action, replicating the findings of her earlier study.

A recent study by Rapp (1978) found that the number of interviewer affect words correlated with objective empathy ratings but not with client ratings of empathy. The implication is that judges tend to assign higher ratings to therapist responses which are couched in feeling words regardless of their accuracy for the client.

Many researchers (e.g. Haase & Tepper, 1972; Shapiro, 1968) have investigated the effect of nonverbal behavior on empathy ratings. Shapiro (1969) found that visual cues accounted for 1/3 of the variance in AE ratings when judges used audio-visual material. Haase and Tepper (1972) found that the main effects of a number of nonverbal behaviors (eye contact, trunk lean, body orientation, and distance)

accounted for twice as much variance in level of judged empathy as did the verbal behavior. These findings are especially important when one considers the fact that most of the research relating empathy to therapy outcome (e.g. Rogers, 1967; Truax & Carkhuff, 1967) has used audiotaped excerpts of therapy sessions to assess the empathy variable.

Another factor further confounding the validity of objective empathy ratings involves the behavior sample used. Common practice is to rate short (10 sec. - 3 min.) audio-taped excerpts from two or three segments of a therapy interview assuming that such a sample will be representative of the entire interview and/or of the therapist's overall level of empathy. Studies by Beutler, Johnson, Neville, and Workman (1973) and Gurman (1973) found that therapists may vary their level of empathy within sessions and across patients. Thus much of the variability in therapist behavior may be submerged by average ratings and/or by ratings from a few brief excerpts. Blaas and Heck (1975) had two groups of trained judges rate the same ten counselor/client interaction tapes. One group of judges was given a one-page description of the client; the other group was given no information about the client. That the informed judges gave significantly higher and more "accurate" empathy ratings prompted the authors to suggest that short interview excerpts do not give judges enough information to accurately assess therapist empathy.

The above theoretical and empirical arguments against the validity of present day objective assessments of therapist empathy are compelling. While much of the literature relating judged empathy to therapeutic outcome may be seriously questioned on methodological grounds, few doubt the validity of the trend which has emerged from the data. The overall relationship between empathy, or those dimensions tapped by objective empathy scales, and therapy outcome appears to be positive. Much data concerning the nature of empathy has come to light and researchers should be cautioned that just as "one swallow doesn't make a summer" one empirical dimension doesn't stand for the totality of such a higher order construct. Studies have confirmed the multidimensionality of the construct and reaffirmed the contention of Kiesler et al. (1967) that empathy ratings tend to be heavily loaded with raters' perceptions of therapist characteristics other than those operationalized by the scales. That the AE and EU scales exhibit construct validity remains open to question and according to Mitchell et al. (1977)

The issue is far from settled. It may be that the Truax empathy scale ... is not "pure" (that is, raters may be responding to a more global "good therapist" construct encompassing a number of therapist dimensions in addition to empathy) or, the ... scale may measure one aspect of a more global empathy construct. A third possibility is that empathy is but one of a number of conceptually if not statistically different therapist variables

which constitute attitudinal and behavioral options open to the effective psychotherapist (p. 448-489).

Perceived Empathy

The objective or observer-judged empathy approach to the assessment of Rogerian theory has been predominant in the literature but not for the lack of a more theoretically consistent means of assessing therapist empathy. The Relationship Inventory (RI) developed by G.T. Barrett-Lennard (1962, Note 1) has been shown to be a valid and reliable tool for assessing the client's perception of therapist empathy (Barrett-Lennard, 1962; Note 1; Gurman, 1977; Kurtz & Grummon, 1972). The RI taps four dimensions of the therapeutic relationship based upon the constructs of Rogers (1951, 1957). Separate scores are derived for empathic understanding (E), level of regard (R), unconditionality of regard (U), congruence (C), and total (T). Barrett-Lennard conceptualize empathy as a process rather than a state as does Rogers (1975) in his more recent writings. In setting forth a definition of empathy the author (Barrett-Lennard, 1962) stated:

Degree of empathic understanding is conceived as the extent to which one person is conscious of the immediate awareness of another. Qualitatively it is an active process of desiring to know the full present and changing awareness of another person, or reaching out to receive his communication and meaning, and of translating his words and signs into experienced

meaning that matches at least those aspects of his awareness that are most important to him at the moment. It is an experiencing of the consciousness "behind" another's outward communication, but with continuous awareness that this consciousness is originating and proceeding in the other (p. 3).

The process of relational empathy develops in three phases:

- I. The "inner" process of empathic listening, resonance and personal understanding.
- II. Communicated, or (more accurately) expressed empathic understanding. ("Expressed" because "communicated" tends to imply something both sent and received.)
- III. Received empathy, or empathy as experienced by the person being empathised with. This has often been (misleadingly) called "perceived empathy" (Barrett-Lennard, 1976, p. 177).

Taking the logical as well as theoretical position "that it is what the client himself experiences that affects him directly" (Barrett-Lennard, 1962, p. 2) the RI assesses the total empathy process at phase III (received empathy) from the perspective of the client.

The RI consists of 64 items to which the client notes his level of agreement/disagreement on a six-point anchored scale. The E scale is comprised of 16 items distributed equally throughout the inventory. The respondent is not asked to discriminate or rate the therapist's level of empathy "rather, he reports a variety of facets of relational responses which are then put together and interpreted as providing an index of empathic understanding" (Barrett-Lennard, 1976, p. 177). An item such as "He nearly always knows exactly what

I mean" or "He does not realize how sensitive I am about some of the things we discuss" elicits a response to one of six possible levels of agreement/disagreement. Responses are scored +3 to -3: "I feel it is probably true (or not true)"; "I feel it is true (or not true)"; "I strongly feel it is true (or not true)." Positive and negative items are equally represented in the two halves of the test.

Reliability and Validity of the Relationship Inventory

Studies have reported consistently high split-half and test-retest reliability coefficients for the RI scales. In his original monograph Barrett-Lennard (1962) reported a split-half coefficient of .86 and a test-retest coefficient of .89 for the E scale. Later the author (Barrett-Lennard, Note 3) reported test-retest correlations of .86 and .91 for the E scale on the revised form (OS-64) of the inventory. From his review of 14 studies reporting internal reliability and 10 studies reporting test-retest figures Gurman (1977) computed a mean internal reliability of .84 and a mean test-retest reliability of .83 for the E scale. The majority of the test-retest studies used approximately one month intervals between testings, however, three studies cited by Gurman reported high degrees of stability ($r = .83, .93, .94$ for total scores) over periods of several months. Reports by Kurtz and Grummon (1972) and Rogers (1967) add further indication that clients' perceptions of therapist empathy

measured by the RI tend to remain stable throughout therapy.

To insure that all items were valid expressions of the dimensions they were designed to represent, items were subjected to a formal content validation procedure described by Barrett-Lennard (1962). Five judges were given formal descriptions of the variables and where perfect agreement was not reached as to the applicability of an item, the item was eliminated. A further item analysis resulted in the elimination of ambiguous items.

Because the RI is unique in assessing perceived empathy criterion-based validity is not established and the issue is best expressed in Barrett-Lennard's (1969) own words:

Direct criterion-based validity checks have not been possible due to the absence of alternative, established measures of theoretically equivalent dimensions of perceived interpersonal response. Also, it is not possible to cross-validate one form of the Inventory against a different form (although it would be quite appropriate to check e.g. a short or simplified version of the same form). On theoretical grounds, for example, there is no reason to expect that Partner A in a dyad would have the same perception of B's response to him ... as B would have of his own response to A. In fact, typically, the scores obtained from these two perspectives ought not to coincide or be strongly correlated if each respondent is giving a true report from his own perceptual frame of reference (see e.g. Barrett-Lennard, 1962, pp. 2-3). Similarly, an observer or "judge" viewing and describing the interaction between A and B would generate different scores from a third perspective (p. 4).

As empathy is a concept for which no single, agreed upon criterion exists, it is not surprising that assertions of the construct validity of empathy measures have been seriously questioned. While the conditions of the therapeutic triad

are theoretically assumed to represent distinct aspects of the therapy relationship, they are conceptually related to each other to some degree. The statistical interrelationships observed to obtain among various measures of the core conditions may account, in part, for the "good guy" factor noted by some researchers (see above). As with the several scales developed by Truax and by Carkhuff, moderate positive correlations have been reported among the RI scales.

Both Barrett-Lennard (1962) and Rogers and Truax (1967) have suggested that therapist congruence (C) is a precondition for the communication of the other conditions especially empathy (E). Barrett-Lennard (1962) found C to be: (1) positively related to E ($r = .85$) and (2) the best prediction of the total score (T) ($r = .92$). In his exhaustive review of the literature on the patient's perception of the therapeutic relationship, Gurman (1977) cited numerous studies confirming Barrett-Lennard's findings. Gurman noted moderate positive interrelationships among E, R, and C and after analyzing the data from some 23 studies concluded that the RI scales "while overlapping to some extent, are consistently measuring different dimensions of the patient's perceptions of the therapeutic relationship" (p. 511).

As with the Truax and the Carkhuff scales various factor analytic studies using different techniques and data have generated one or more factors accounting for variance on RI scores. After having critically reviewed nine studies which reported factor solutions for the RI, Gurman (1977) stated that

on the basis of the existing data deriving from properly conducted factor-analytic studies, it appears that the RI is tapping dimensions that are quite consistent with Barrett-Lennard's original work on the inventory (p. 513, emphasis his).

He went on to note the continuing need for such studies especially with data from actual treatment conditions.

The most important question as to the validity of the RI, both from a theoretical and a clinical standpoint, involves the relationship between RI scores and therapy outcome. Empirical evidence relating the RI to psychotherapeutic outcome has been impressive. Barrett-Lennard's original monograph (1962) reported significantly higher ($p < .005$) E scores at the fifth session and post-therapy for more changed clients than for less changed clients. Change indices used were therapist judged pre-post adjustments and change ratings, pre-post Q adjustment scale, Talor MA, and MMPI D. Therapy was client centered and average length of treatment was 33 sessions. For a subsample designated "initially more disturbed clients" E was found to correlate the highest of all scales ($r = .65$, $p < .005$) with the index of change derived from Q, MA, and D scores.

Gross and DeRidder (1966), using Rogers' psychotherapy process scale, found a positive association ($r = .78$) between the RI scales (excluding R) and the outcome measure of change in client experiencing.

Numerous researchers have noted the strong positive relationship between RI-E and therapy outcome. Recently Gurman (1977) tabulated the results of 26 studies which were felt to have been representative of outpatients in individual therapy. Twenty of those studies reported positive findings and Gurman (1977) concluded that

Despite methodological shortcomings in some of these studies ... it is clear from the findings ... that there exists substantial, if not overwhelming, evidence in support of the hypothesized relationship between patient-perceived therapeutic conditions and outcome in individual psychotherapy and counseling (p. 518 & 523, emphasis his).

Gurman's analysis was based on all of the conditions operationalized by the RI but the implication for client-perceived empathy is clear.

In their analysis of the relation of process to outcome in psychotherapy, Orlinsky and Howard (1978) cited 15 studies relating client-perceived empathy to therapeutic outcome. Five of those studies found significant positive associations. Five more found patient-perceived empathy to have been a significant predictor of positive outcome. Three studies reported positive although nonsignificant associations between E and positive outcome.

Of the research relating empathy to therapeutic outcome, the study published in 1972 by Kurtz and Grummon is probably the most instructive. After a review of the literature relating empathy to outcome the authors stated:

Studies have used several different ways of conceptualizing and measuring empathy, but it is not altogether clear whether they deal with one variable or several different variables employing the same label (Kurtz & Grummon, 1972, p. 106).

In an effort to explicate the variable/s involved, their investigation compared six different measures of therapist empathy with: (1) each other, (2) a therapy process variable, and (3) several outcome measures. The empathy measures were: (1) the Affective Sensitivity Scale, (2) tape judged EU, (3) a predictive measure based on the Interpersonal Checklist, (4) a predictive measure based on the Kelly Role Concept Repertory Test, (5) counselor-perceived RI-E, and (6) client perceived RI-E. The process variable was tape rated self-exploration (Carkhuff scale). The outcome measures, taken about a week posttherapy, were: (1) Tennessee Self-Concept Scale "total positive" score, (2) Tennessee Self-Concept "number of deviant signs" score, (3) a change index based on pre versus post therapy MMPI scores, (4) therapist evaluation, (5) client evaluation, and (6) composite outcome score.

Subjects were 31 clinical or counseling psychologists and interns in the final phase of doctoral training and their 31 respective clients. Clients were self-referred university undergraduates. Therapy ranged from 4 to 25 one hour sessions with a mean of 12 interviews.

Results showed that most of the correlations between the empathy measured and the outcome measures were nonsignificant and fully one-half were negative!

A clear-cut exception to this general trend is that client-perceived empathy after the third interview shows strong and mostly significant relationships with the several outcome measures (Kurtz & Grummond, 1972, p. 110-111).

Multiple-regression analysis revealed that client perceived empathy was the best predictor of outcome accounting for 44% of the variance on the MMPI index and 30% of the variance on the composite outcome score. The only other empathy measure or combination of measures to predict any outcome at the .10 level of probability or less was the combination of tape judged EU and client-perceived E which accounted for 30% of the variance on the Tennessee total positive score. These results support the contentions of numerous authors (e.g. Caracena & Vicory, 1969; Gladstein, 1977; Gurman, 1977; Lambert & DeJulio, 1977) who have argued for the construct validity of client-perceived empathy as measured by the RI and its usefulness in counseling and therapy research.

Further, Kurtz and Grummon's finding that none of the six empathy measures correlated with each other replicates the findings of most other studies which have reported correlations between various empathy measures (e.g. Burnstein & Carkhuff, 1968; Caracena & Vicory, 1969; Fish, 1970; Kiesler et al., 1967; Truax, 1966). The authors did find that E scores after the third interview correlated significantly (.66) with E scores after the final therapy interview.

That different empathy measures are often at variance with one another indicates that they are measuring different although overlapping variables and according to Gurman (1977)

Researchers are cautioned against assuming that evaluation ... from any one perspective may speak, by implication, for the persons who may occupy other phenomenological positions (p. 516, emphasis his).

A good deal of research is available indicating that judge rated empathy measures are contaminated with judges perceptions of therapist behaviors not operationalized by the scales. Such behaviors do not seem to have the same effect upon patient perceptions of therapist empathy. Not only do patient perceptions appear to be less confounded, they are assessed based on the universe of therapist behavior, not just two or three brief excerpts of therapist verbal behavior. In addition patient-perceived conditions of therapist communication are more consistent with Rogerian theory. As to the applicability of client-perceived empathy to counseling and

therapy Gurman (1977) offered the following conclusion, based on his thorough analysis of the literature:

In sum, while the existing data on the comparative predictive utility of judge-rated versus patient-rated therapeutic conditions is indeed sparse, it can be tentatively concluded that patient's ratings of the quality of the therapist-patient relationship are at least as powerful as predictors of therapeutic change as nonparticipant judges' ratings and perhaps even somewhat more powerful (p. 524, emphasis his).

Definitions of empathy, especially those stemming from the Rogerian viewpoint depict a very abstract concept. Phrases such as: "internal frame of reference of another" (Rogers, 1959, p. 210-211), "client's private world" (Rogers, 1957, p. 98), "therapist's ability to allow himself to experience or merge in the experience of the client" (Carkhuff & Berenson, 1967, p. 27), "experiencing the process and content of another's awareness in all its aspects" (Barrett-Lennard, 1962, p. 3) all connote a higher order construct than that defined operationally. Operational definitions have focused upon "therapist skills" such as: identifying the feelings of another, responding to feelings and experience, and even responding with "interchangeable responses" to the point where counselors are cautioned against "parroting" client statements (Egan, 1976). However, research cited above indicates that, at least for judged empathy, either global constructs such as counselor commitment and involvement ("good guy" factor) or lower order more concrete constructs such as counselor verbosity, number of

affect words used, or eye contact and body posture may account for a major proportion of the variance in therapist empathy. Empathy remains an enigma and it is evident that all of the dimensions which account for the empathic process have not been explicated.

The Theory

The present investigation is an attempt to examine the effect of a new dimension of empathy (i.e. representational system matching) on traditional measures of empathy (judged and client-perceived) and other counseling outcome variables (willingness to self-disclose, willingness to return to counselor). Throughout the empathy literature authors, especially Mead (1934), Rogers (1951, 1957, 1975), Truax and Carkhuff (1967), and Barrett-Lennard (1962, 1976), have either implicitly or explicitly stated that empathic communication can result only from an awareness of the other's internal frame of reference. For Mead (1934) role-taking (empathy) is accomplished by awareness of the shared meaning of the natural language and symbols used in communication. As one acquires role-taking skill one is better able to comprehend and respond to the idiosyncratic and subtle meaning another conveys. Barrett-Lennard's (1976) term "'relational empathy' is concerned broadly with responsively knowing the experiencing of another" (p. 174) whereby "A

'reads' or resonates to B in such a way that directly or indirectly expressed aspects of B's experience become experientially alive, vivid, and known to A" (p. 176).

In most existing definitions of empathy, the therapist's awareness of the client's frame of reference is achieved by focusing upon the affective and experiential meaning of client statements. The dimension of empathy which arises from the work of Bandler and Grinder (Bandler & Grinder, 1975a, 1979; Grinder & Bandler, 1976) is similar to that of Mead in that the focus is upon the idiosyncratic and subtle meaning conveyed by the client's lexical structure and is of higher order than traditional dimensions of empathy (e.g. reflection of feeling). Rogerian theory and Bandler and Grinder's model of therapy meet when frame of reference is operationally defined as representational system organization. Through awareness of the lexical structure which connotes a particular representational system, a therapist is able to enter into and communicate to the frame of reference of the client. When a therapist is aware of the ways in which persons organize experience via representational systems (visual, auditory, kinesthetic) he can truly "'read' or resonate" with the client and facilitate the empathic process by matching the lexical structure of his/her communication with that of the client.

The concept of representational system is but one of the innovative therapeutic tools developed by Bandler and Grinder. The method of analysis employed by Bandler and Grinder in developing their model of therapy was derived from a synthesis of linguistic, neurologic, cybernetic and communication theory. The authors claim to have incorporated some of the essential and potent ingredients of all forms of effective therapy and as such have created a "meta-model" or model of a model. As their "meta-model" is a-theoretical and derived from effective therapeutic practice, it is not surprising that many similarities to Rogerian theory are found in the writings of Bandler and Grinder. Like Rogers, Bandler and Grinder see individuals as having an inherent ability to understand themselves and their experience of the world in new ways which enable them to actualize new choices for change and growth. Rogers (1951) has stated that:

This theory is basically phenomenological in character and ... pictures the end point of personality development as being a basic congruence between the phenomenal field of experience and the conceptual structure of the self -- a situation which, if achieved, would represent freedom from internal strain and anxiety, and freedom from potential strain; which would represent the maximum in realistically oriented adaptation (p. 532).

This statement contains some of the same theoretical notions as does the following statement of Bandler and Grinder (1975a).

People who come to us in therapy typically have pain in their lives and experience little or no choice in matters which they consider important. All therapists are confronted with the problem of responding adequately to such people. Responding adequately ... means to us assisting in changing the client's experience in some way which enriches it. Rarely do therapies accomplish this by changing the world. Their approach, then, is typically to change the client's experience of the world. People do not operate directly on the world, but operate necessarily on the world through their perception or model of the world. Therapies, then, characteristically operate to change the client's model of the world and consequently the client's behavior and experiences (p. 156).

Bandler and Grinder's goal of "enriching the client's model of the world" echoes Rogers (1975) emphasis on client "experiencing":

When a person is perceptively understood, he finds himself coming in closer touch with a wider range of his experiencing. This gives him an expanded referent to which he can turn for guidance in understanding himself and in directing his behavior. If the empathy has been accurate and deep, he may also be able to unblock a flow of experiencing and permit it to run its uninhibited course (p. 6).

In Bandler and Grinder's "meta-model" the growth process is initiated by "the meaning of the client at the client's model of the world" or communicating in the client's most highly valued representational system (Grinder et al., 1977, p. 26).

Communicating to a client via the representational system by which he organizes his experience of the world is essentially an operationalization of entering into and communicating to the client's internal frame of reference, or in a word: empathy. In both Rogers' theory and Bandler and Grinders' "meta-model," empathy or representational system matching establishes rapport and builds trust. As a result, clients are better able to explore self and achieve a better understanding of feelings and experience or in Bandler and Grinder's terms to have an "enriched model" of the world. Therefore, in the present study, the theoretical rationale for the independent and dependent variables are essentially quite similar.

Representational Systems

The meta-model developed by Bandler and Grinder has been expanded since their original publication (1975a) and the tools of therapy and communication which they have formulated are now subsumed under the rubric, "Neurolinguistic Programming" (NLP). Their model has become a "hot" item and NLP workshops are much in demand throughout the country. While the popularity of the NLP has grown, there is precious little research attesting to the efficacy and generality of the techniques. In fact, the authors discourage research on aspects of the model (Bandler, Note 4). Their professed

interest is in developing a working model, not in empirical validation of their observations. If the model proves invalid in actual use, the model is changed. According to Goleman (1979) "Bandler and Grinder spurn experimental tests of their techniques on the grounds that NLP is a working model and not a formal theory with hypotheses than can be tested" (p. 78).

Despite Bandler and Grinder's impoverished notion of research — surely the process of refining a working model constitutes evaluation research — and lack of support for those who would engage in formal hypothesis testing, a few researchers have work in progress and two doctoral dissertations have been completed (Dilts, Note 5).

While the construct of representational systems proposed by Bandler and Grinder (1975a) is seen as but one speculative aspect of a larger model, it rests on sound neurological (summarized elsewhere by Bandler & Grinder, 1975a, 1975b; Grinder & Bandler, 1976; Grinder et al., 1977; Owens, 1977) as well as philosophical argument. However, the empirical validity of the construct of representational systems has been attested to only by clinical anecdotes provided by the authors.

Grinder and Bandler (1976) have postulated that by classifying the predicates - verbs, adverbs, and adjectives - used in everyday speech as either visual, auditory, or

kinesthetic one could infer the representational system used by individuals to organize internal reality. Information presented by John Grinder and Judith DeLozier in a 1977 workshop indicated that reflexive eye movements also provide cues indicative of representational system organization (Owens, 1977).

Based on the propositions of Grinder and Bandler and the assertions of Grinder and DeLozier, Owens (1977) designed a study to investigate the relation between verbalization, eye movement, and individual self-report as measures of representational system. Owens' review of the literature includes studies of split-brain, hemispheric asymmetry, and eye-movement patterns supportive of Bandler and Grinder's concept of representational systems. Research in the areas of memory accessing and learning disability theory were also shown to be in agreement with the construct of representational systems.

One hundred twenty-eight undergraduates who volunteered to participate in an "investigation of communication style" (Owens, 1977, p. 47) were classified as either visual, auditory, or kinesthetic by three methods. Seven raters trained by the author classified all subjects based on their verbal responses to formal stimulus situations. S's were designated as visual, auditory, or kinesthetic based on an additive count

of the identifiable predicates used in responding to the stimulus items. Predicates were identified as either visual, auditory, or kinesthetic based on information provided by Grinder and Bandler (1976) and Grinder and DeLozier (see above). Eight raters trained by Owens classified all S's again based on patterns of eye-movement observed in response to another formal stimulus situation. Specific information for the procedure was provided by Grinder and DeLozier at the workshop mentioned above.

Additionally S's were classified on the basis of individual self-report. S's were asked to indicate whether they organize experience internally primarily via (1) having visual images and pictures, (2) creating conversations and hearing sounds, or (3) having feelings and bodily sensations.

Of the original 128 S's, the responses of 79 were retained for data analysis. The data from 49 S's were eliminated because (1) S had sustained head injury with the loss of consciousness for one minute or longer (N=9), (2) S was left handed (N=32), or (3) data was incomplete (N=8). S's were eliminated for head injury and handedness based on indications that eye-movement patterns of such individuals are unreliable due to uncertain brain hemispherical dominance. The hypothesis that there would be agreement among the three methods of representational system assessment was stated in the form of four null hypotheses.

Results indicated that there was significant agreement at the .05 level between eye-movement and verbalization as a measure of representational system. In terms of the statistic used (Kappa) the degree of agreement was only slightly different from zero indicating that the practical significance of the finding is questionable. No significant agreement was found between any other pairs of methods of assessment or among all three methods. Owens (1977) concluded that his research suggests that eye-movement patterns and verbalizations can "serve in some way as indicators of representational systems" (p. 89) but because of the low level of significant agreement between the two measures recommended further research.

An interesting finding of the research is that no S's were classified as having a visual representational system on the basis of predicates used in verbalization. The author noted that the finding was contrary to expectations and suggested that the finding may have resulted, in part, as an artifact of the assessment procedure. Because Owen's study was the first of its kind it is not surprising that unforeseen methodological problems came to light. Owens made several recommendations for future like research.

The second completed study is that of Shaw (1978) who investigated recall as affected by representational system.

Her study used the S's previously designated (by Owens, see above) as either auditory or kinesthetic on the basis of verbalization (no visuals were found). S's were randomly assigned to three groups each of which viewed, via videotape, a different version — using either visual, auditory or kinesthetic predicates — of a story containing the same 27 items. S's were asked to recall as many of the items described in the story as they could. Results of analysis of variance did not approach significance indicating that the auditory and kinesthetic S's did not recall differentially the items described in visual, auditory, or kinesthetic terms. Additionally, the data were subjected to post-hoc analyses using eye-movement and self-report as independent variables. In neither case did results approach significance.

Whether the lack of statistical and practical significance reported by Owens and Shaw reflect methodological shortcomings or the lack of validity of the construct of representational system is difficult to determine on the basis of only these two related studies.

A review of the literature indicates that analytic studies have not delineated the totality of dimensions which account for variance on the empathy variable. Since the early 1950's empathy measures have been refined, bringing operational definitions more in line with the intended construct. The concept of representational system matching has

been presented as a dimension which may account for additional variance on empathy measures and the two extant analytic studies of the construct of representational system have been reviewed. While the proposed dimension may account for a substantial proportion of the variance on existing empathy measures, its construct validity is attested to further by the strength of the relationship between representational system matching and classical outcome measures. Congruent with Rogerian theory and the Bandler and Grinder model; the outcome variable chosen for the present study is a measure of the subject's willingness to self-disclose. If representational system matching is a major dimension of empathy then the resulting rapport and trust should predispose S's to be more willing to disclose to counselors who communicate by way of S's most highly valued representational system than to counselors who do not. Suffice it to say that client self-disclosure is an essential condition in most every system of counseling and psychotherapy. Following is a review of the self-disclosure literature as is pertinent to the present investigation.

Self-disclosure

In reviewing the literature on self-disclosure one finds little concordance among studies designed to explicate the variables effecting self-disclosing behavior. The various definitions of self-disclosing behavior, methods used to assess such behavior, and differing theoretical perspectives have contributed to the conflicting findings reported by researchers in the field. Self-disclosure cannot be said to be a unitary phenomenon. Like most complex behaviors, self-disclosure is a function of certain characteristics of: the discloser, the recipient of the disclosure, the relationship between the two individuals, the disclosing situation, and any number of possible interactions among these variables. While this and other reviewers seem to agree with Goodstein and Reinecker (1974) that "there still is a need to determine the generalization of self-disclosure," (p. 71) certain trends pertinent to the present study stand out.

Individual Differences

In general, women tend to obtain higher self-disclosure scores than men (Jourard & Lasakow, 1958). Numerous studies support Jourard and Lasakow's findings. While some studies have reported no sex differences in self-disclosure, "the fact that no study has reported greater male disclosure may

be indicative of actual sex differences" (Cozby, 1973, p. 76). While other individual differences may affect one's "trait" level of self-disclosure, "correlations involving self-disclosure scores and various personality measures have been generally low and often contradictory" (Cozby, 1973, p. 80).

The Target Person and Reciprocity of Self-disclosure

In their review of the self-disclosure literature, Goodstein and Reinecker (1974) suggest that a nonlinear relationship exists between intimacy and self-disclosure. It is not surprising to find empirical support for the contention that persons tend to disclose more to those with whom they are intimate than to casual acquaintances (Jourard, 1971). Based upon the results of a study by Rickers-Ovsiankina and Kusmin (1956), wherein some subjects indicated a preference for disclosure to a stranger rather than to an acquaintance or best friend, Goodstein and Reinecker (1974) hypothesized a "stranger on the bus" phenomenon. They concluded that "we self-disclose to those who have already demonstrated that they will not punish our self-disclosure and to those who have no capacity for punishing such behavior, namely, total strangers" (p. 52).

One's liking for the target person seems to have an effect upon one's self-disclosure. Goodstein and Reinecker

(1974) cite eight studies indicating that persons tend to disclose more to those whom they like than to those they don't like or are indifferent to. Jourard and Lasakow (1958) found significant correlations between self-disclosure to and liking for mother ($r=.63$) and father ($r=.53$). Worthy, Gary, and Kahn's (1969) hypothesis that liking for another leads to disclosure to the other and that disclosure from another would lead to greater liking was supported by their empirical findings. Taylor (1968), in studying self-disclosure over time, found that for both high and low disclosing roommate pairs, while disclosure increased over time, liking decreased. While such a finding may support the old saw that "familiarity breeds contempt," Cozby (1973) suggests that "most randomly chosen dyads are not compatible enough to be comfortable at prolonged high disclosure" (p. 85).

The results of the Worthy et al. (1969) study are more understandable in light of Jourard and Landsman's (1960) finding a stronger correlation between knowing and disclosure than between liking and disclosure.

While in the review by Cozby (1973) cited above the author did not elaborate on what he meant by "compatibility," a study by Persons and Marks (1970) sheds some light on the subject. In their research three college students and three prison inmates interviewed a group of inmates whom

they had not previously met. While no significant differences in the amount of self-disclosure elicited by either group of interviewers (student or inmate) was found, there was more interviewee self-disclosure when interviewer and interviewee were of the same MMPI code type. Such a finding suggests that personality compatibility may affect self-disclosure, however the authors did not wish to generalize their results and suggested further study of the matching hypothesis.

Jourard (1971) and Jourard and Lasakow (1958) have indicated that individuals disclose more to a same-sexed friends than to opposite-sexed friends, while married couples tend to disclose more to each other than to any other target person.

The above seems to indicate that persons tend to disclose more fully to those whom they know well, like, and are similar to in some ways.

Jourard (1971) reported his observation that, as a therapist, when he was more self-disclosing in therapy sessions he found the working relationship with the client was enhanced and the time in therapy was shortened. Jourard postulated a "dyadic effect" whereby one's self-disclosure tends to lead to self-disclosure by the other. Studies by Jourard (1969) and Jourard and Landsman (1970) tend to confirm the generality of the dyadic effect. After citing more than a dozen studies reporting high correlations between self-disclosure "input"

and "output" in dyads and groups, Goodstein and Reinecker (1974) concluded that there is "considerable support for Jourard's (1959b) original contention that self-disclosure tends to be a mutual, reciprocal process" (p. 61).

Researchers have looked at the mutuality of self-disclosure from two viewpoints. Several investigators (Rickers-Ovsiankina, 1958; Taylor, 1968; and Worthy et al., 1969) studied self-disclosure within a framework of exchange theory as conceptualized by Homans (1950) and Thibault and Kelley (1959). The "dyadic effect" is seen as an example of reciprocity or exchange of social reward. Other researchers attribute the "dyadic effect" to the effects of modeling of self-disclosure by the interviewer. Jourard and Jaffe (1970) indicated that interviewees modeled the interviewer not only for depth of self-disclosure but also for duration of utterance. Studies by Mann and Murphy (1975) and Simonson (1976) found that there was an optimal amount of self-disclosure which subjects would model. In both studies subjects disclosed more in the intermediate interviewer disclosure condition than in either the high or no disclosure conditions. The latter two conditions were found to have been statistically indistinguishable for subject self-disclosure.

Whether the "dyadic effect" is a function of reciprocity of social reward or of modeling or an interaction of these and possibly other variables has yet to be determined.

Suffice it to say that self-disclosure by an interviewer tends to have an effect on the self-disclosure of the interviewee and studies using a self-disclosure measure as a dependent variable would do well to control for interviewer disclosure.

Measurement of Willingness to Self-Disclose

The bulk of the research on self-disclosure has been carried out by Sidney Jourard and his colleagues using the Jourard Self-Disclosure Questionnaire (JSDQ). Since the development of the first instrument, the sixty-item Self-Disclosure Questionnaire (SD-60) (Jourard and Lasakow, 1958) many revisions and modifications have been made. The JSDQ is a specific self-report measure whose 25-, 40-, and 60- item versions (Jourard, 1971) have been most widely used for research purposes.

Chelune (1977) stated that "the general psychometric quality of the SD-60 is considered quite good" (p. 288). Split-half reliability coefficients of .93 (Jourard, 1961) and .94 (Jourard & Lasakow, 1958) have been reported. Jourard (1971) published test-retest reliability coefficients ranging from .55 - .94. While adequate reliability seems to have been established, the validity of the JSDQ has been argued. Pedersen and Higbee (1968) found evidence of both convergent and discriminant validity and concluded, as did Jourard (1971), that the JSDQ has construct validity.

In his review of the literature, Chelune (1977) concluded that the reliability and construct validity of the JSDQ are adequate but states that "the predictive validity of the instrument as a measure of general disclosingness has been seriously questioned" (p. 288). The lack of significant agreement as to the JSDQ's predictive validity seems to stem from the application of the instrument to many and varied types of self-disclosure situations. In its original form the instrument elicits subjects' report of past self-disclosure to various target persons (mother, father, best friend, etc.). The use of the JSDQ as a predictor of future self-disclosure has not proved valid (Himmelstein & Kimbrough, 1963; Hurley & Hurley, 1969; Vondracek, 1969; and Wilson & Rappaport, 1979).

In other words, given the importance of social-situational input variables, it is not surprising to find that "self-report measures of past disclosure to specified individuals or target persons are at variance with behavioral measures of on-going self-disclosure within specific situations" (Chelune, 1975a, p. 79) (Chelune, 1977, p. 289).

Jourard (1971) has noted that "... validity is a precise matter. Measures that are valid forecasters of one kind of behavior in one kind of situation may be quite useless and invalid ways of predicting behavior in other types of situations" (p. 171).

Studies using the JSDQ in a willingness to disclose format where the target person and situational variables are specified have yielded high correlations between scores on the Willingness-to-Disclose-Questionnaire (WDQ) version of the JSDQ and actual self-disclosure in the specified context (Jourard, 1971; Wilson & Rappaport, 1974; Simonson & Bahr, 1974; Simonson, 1976). Jourard (1971) reported correlation coefficients of .77 and .78 between WDQ scores and actual self-disclosure to a roommate.

In a study designed to examine self-disclosure as a function of: 1) general expectation, 2) specific expectation, 3) interviewer behavior, and 4) intimacy of topic, Wilson and Rappaport (1974) found that responses to the JSDQ scored for anticipated disclosure to a stranger interviewer predicted actual disclosure to the interviewer. In their factorial study 169 subjects were trichotomized based on their responses to the JSDQ scored for both past disclosure and anticipated disclosure to a stranger. The 48 highest and lowest scoring subjects were randomly assigned to one of two specific expectancy conditions. They were told, supposedly based upon their JSDQ scores, to expect disclosure of personal information to a stranger to be either easy or difficult depending on the group to which they were assigned. Prior to presenting subjects with either high or low ... intimacy topics to discuss, interviewers exhibited either personal, impersonal, or no self-disclosing behavior.

Subjects' interview behavior was independently scored for self-disclosure by two trained raters. While the $2 \times 2 \times 3 \times 2$ analysis of variance showed several significant main and interaction effects, the finding most pertinent for the present study was the effect of generalized expectancy measured by the JSDQ scored for anticipated disclosure. A significant interaction effect was found between JSDQ scores and intimacy level of topics. Post hoc comparisons indicated that JSDQ low scorers responded with more impersonal disclosure in the low-intimacy condition than in the high-intimacy condition while high scorers did not differ in their responses to the two intimacy conditions. That JSDQ scores predicted self-disclosure in the high intimacy condition but not in the low intimacy condition supports the construct validity of the instrument. "If a measure is related to self-disclosure one would expect it to reflect personal discussion rather than impersonal discussion" (Wilson & Rappaport, 1974, p. 906).

The 96 subjects were again trichotomized based on JSDQ scored for reported past disclosure and 31 were designated high disclosers and 26 low disclosers. An analysis of variance again yielded several main and interaction effects but "the effects of generalized expectancy measured by the JSDQ scored for recalled past disclosure were not significant" (Wilson & Rappaport, 1974, p. 905). The results of the study

suggest that the JSDQ scored for anticipated future disclosure can be an accurate predictor of actual behavior while reported past self-disclosure does not tend to predict future behavior.

Simonson and Bahr (1974) used the JSDQ in a study of self-disclosure to professional and paraprofessional therapists. After hearing an audio tape of an initial therapy session wherein the therapist offered one of the three levels of self-disclosure, 90 subjects completed the JSDQ indicating the degree to which they would be willing to discuss each item with the therapists heard on tape. The subjects were then interviewed by the therapist who was identified as either a professional or paraprofessional. The therapist was blind as to which cell subjects were randomly assigned in this 2x3 factorial analogue study. Interviews were recorded and rated for self-disclosure by two trained judges who were unaware of the purpose of the study. A Pearson correlation of .78 was obtained between actual self-disclosure in the interview and scores on the JSDQ. The authors reported that in the interview "the therapist asked the same series of open-ended questions ... encouraged the subject to elaborate on each topic and ... introduce any new topics that she might care to discuss" (Simonson & Bahr, 1974, p. 360). No mention was made of what the therapist self-disclosure conditions were during the actual interview but it is assumed they were held constant. While the

authors were careful not to generalize their findings beyond the analog paradigm adopted for their study, the high positive correlation between willingness to disclose and actual disclosure augurs well for the predictive validity of the JSDQ when used as an WDQ specifying target person and situational variables.

Simonson (1976) reported a study which, with the exception of one variable, was a replication of the Simonson and Bahr (1974) study cited above. Where the previous research manipulated the professional/paraprofessional variable, Simonson (1976) manipulated the "warm"/"cold" therapist variable. Prior to the actual interview subjects were told either that therapists tend to be friendly and warm people or generally reserved and cold as people. The other experimental procedures were essentially identical to those used by Simonson and Bahr (1974). The correlation between willingness to disclose as measured by the JSDQ and actual disclosure was .82.

Summary

In this chapter the various attempts to operationally define the construct of empathy have been critically reviewed. It has been shown that empathy is a multidimensional construct which has been viewed from several different

perspectives. The several measures of empathic communication in therapy have been presented and indications are that such measures tend to be heavily loaded with factors not operationalized by the scale definitions.

One measure, Barrett-Lennard's Relationship Inventory (RI), may avoid some of the methodological difficulties inherent in objective measures of empathy by having clients rate counselors on items which comprise an empathy (E) scale. RI-E scores appear to have a fairly consistent positive relationship with counseling outcome and will serve as a dependent variable measure in the present study.

The theoretical base for the current investigation has been presented and the concept of representational system matching of Bandler and Grinder has been hypothesized as a major dimension of empathy. Very little research has been done with representational systems; however, the two extant studies have been reviewed even though they have only peripheral relevance to the present study.

A major dependent variable of this study is that of self-disclosure and the literature pertaining to the measurement of self-disclosure has been reviewed. From that review it appears that the willingness-to-disclose version of Jourard's Self-Disclosure Questionnaire is a valid and reliable tool for assessing the dependent variable.

CHAPTER 3: METHODOLOGY

Chapter 3 is composed of a detailed account of the design and methodology of the present study wherein will be specified the sample, instrumentation, procedures used in data collection, and statistical analysis of obtained data.

The Sample

The subject sample for this study was drawn from undergraduate classes in the School of Education at The College of William and Mary, a coeducational liberal arts university in southeastern Virginia. It is a state institution with approximately three thousand of its four thousand undergraduate students coming from the Commonwealth of Virginia. The remaining one quarter of the student body come from throughout the United States and many foreign countries. Volunteers were solicited via class presentations briefly describing the nature of the study and subject participation.

At first contact with volunteers, the researchers apprised them of the ethical considerations pertinent to their participation in the study. The researcher contracted with subjects guaranteeing the confidentiality of their contributions to the study, securing permission to record

interviews, and insuring their awareness of the availability of the Center for Psychological Services of The College of William and Mary should they wish to continue in counseling as a result of their experience in the study. Subjects were assured by the researcher (and specified in the contract) that the instruments which they would complete would be for research purposes only and under no circumstances would counselors have any information about them other than what they might choose to divulge in the interview situations. A sample copy of the contract is reproduced in Appendix A.

All twenty subjects were fulltime undergraduates who ranged in age from 19-23. Mean age was 20.6 years. Subjects were sophomores, juniors and seniors with declared majors in all areas of the liberal arts. Sixteen of the subjects are female and four are male.

Instrumentation

The dependent variables were assessed using widely employed instruments which have demonstrated high degrees of validity and reliability.

The Relationship Inventory

The Relationship Inventory (RI) developed by Barrett-Lennard (1962, Note 3) has been shown to be a valid and reliable tool for assessing the client's perception of therapist

empathy. The instrument consists of 64 items to which the client notes his level of agreement/disagreement on a six-point anchored scale. The empathy (E) scale is comprised of 16 items distributed equally through the inventory. Reported internal and test-retest reliability coefficients have been consistently high (.83 - .91). The validity of the E scale is attested to by reports of a consistent positive relationship with counseling and therapy outcome. A complete discussion of the psychometric adequacy of the RI is included on page 47-56. A sample of RI items, instructions, and scoring sheets are reproduced in Appendix B.

The Willingness-to-Disclose Questionnaire.

The Willingness-to-Disclose Questionnaire (WDQ) is a variation of the Self-Disclosure Questionnaire of Jourard (Jourard & Lasakow, 1958). The WDQ elicits S's estimates of future self-disclosure to a target person within a specified context. Split-half and test-retest reliability coefficients have been reported in the .90's. The validity of the WDQ for the present study has been demonstrated by the high positive correlations obtained between WDQ scores and subsequent actual disclosure. Jourard (1971) reported correlations of .77 and .78 between WDQ scores and actual disclosure to a roommate. Studies by Simonson (1967), Simonson and Bahr (1974), and Wilson and Rappaport (1974) replicated Jourard's findings with other populations,

including actual clients, while manipulating variables hypothesized to effect self-disclosure. A more complete discussion is found on page 72-77. The 40-item version of the WDQ used in the present study, answer sheet, and scoring directions are reported in Appendix C.

Instruments used to assess covariate measures were:

The Empathic Understanding Scale

The Empathic Understanding (EU) scale of Carkhuff (1969b) was derived from the Truax Accurate Empathy Scale and has been widely used in counseling research. It is a five-point Likert-type scale which is used by non-participant judges in rating therapist-offered empathic response. Truax and Mitchell (1971) reported various reliability figures for 41 studies employing the EU scale. Coefficients ranged from .42 - .95 with a mean of .75. With training, judges are able to use the EU scale with at least adequate inter and intrarater reliability. The interrater reliability of the judges in this study was .82. The validity of the scale is a complex issue which is treated at length on page 37-45. While, as pointed out previously, many factors may account for variance on EU ratings, its use as a covariate measure to control for counselor differences is valid in the present investigation. Copies of the EU scale, judges instructions and scoring sheets are found in Appendix D. While the primary

function of the EU is that of a covariate to control for individual therapist difference the scale will also serve as a criterion measure in testing Hypothesis 2.

The Adjective Checklist

The Adjective Checklist (ACL) developed by Gough and Heilbrun (1965) consists of 300 adjectives commonly used in describing attributes of individuals. While the ACL yields scores on 24 different scales, the scale of interest for the present study is the Counseling Readiness (Crs) scale. The scale was developed through analysis of protocols of clients who showed a more positive response to counseling versus protocols of clients who showed a less positive response. The function of the scale is to identify individuals who are ready for help and are likely to profit from it. Gough and Heilbrun (1965) reported test-retest reliability for Crs as .71. As a covariate, the Crs will control for individual subject differences which may interact with treatment variables in small sample studies despite random assignment of subjects to treatment conditions. A copy of the ACL is reproduced in Appendix E. Frequency distribution and descriptive statistics for the Crs scale are presented in Appendix F.

The I-E Scale

The I-E scale (Rotter, 1966) is a forced choice test comprised of 29 items. For each item Subjects are asked to choose between two statements which express a common attitude. Six filler items are added to make the purpose of the test more ambiguous. Responses to the 23 scored items place Subjects on a continuum from zero (internal) to 23 (external). Rotter (1966) reported a split-half reliability (N=50) of .65. Kuder-Richardson reliabilities were .69, .70, and .70 (N=50-1000). Hersch and Scheibe (1967) computed test-retest reliabilities between .49 and .83 terming such figures "consistent and reliable." While the few researchers who have studied the relation between personality traits and client perceptions of empathy have reported non-significant results, the relation between I-E scores and empathy is of interest. Broadbent (1971) in an analogue study of the influence of mode of counseling (inquiry versus advisory) and locus of control found that while there was no effect for mode, external subjects reported higher levels of therapeutic conditions than did internal subjects. As a result of this finding, subject I-E scores will be covaried to control for possible confounding by the locus of control variable. A copy of the I-E scale and answer sheet are found in Appendix G. Frequency distribution and descriptive statistics for the I-E scale are presented in Appendix H.

Experimental Design

In order to test all relevant hypotheses and exert maximum experimental control it was necessary to enter all Subjects into both treatment conditions. The design chosen is a Latin-square—Design II of Campbell and Stanley (1963)— or counterbalanced design. Sampling error, a source of both main and interaction effects in Latin-square designs where naturally occurring groups (e.g. classrooms) are assigned to the various cells will be eliminated in the present study by randomly assigning Subjects to two groups. Each group will receive both levels of treatment in counterbalanced order. The design is represented schematically by:

	TIME	
	1	2
GROUP A	X_1O	X_2O
GROUP B	X_2O	X_1O

where: X_1 = Treatment 1 - No representational system matching

X_2 = Treatment 2 - Representational system matching

In the above design all of the effects are demonstrated in all of the comparison groups. The design "gains strength through the consistency of the internal replications of the experiment" (Campbell & Stanley, 1963, p. 52). In such a case the probability of possible interaction of groups and occasions imitating the effect of treatment is unlikely as "several matched interactions would be required" (Campbell & Stanley, 1963, p. 52).

While all of the effects are replicated in all comparison groups, the effects of treatment could be obscured if one therapist were consistently more empathic (in a generic sense) than the other. In order that individual therapist differences on empathy not confound treatment effects, EU scale scores will be covaried with the dependent variable measures.

Procedures

Gathering of the data proceeded in several stages. Upon volunteering, each subject was given the ACL and I-E scale to be completed prior to further participation in the study. Subjects were assigned code numbers to identify data and facilitate statistical analysis. Once the subject pool was obtained, each subject was randomly assigned to one of two groups. Groups were then randomly assigned to treatment orders ($T_1 - T_2$ versus $T_2 - T_1$). Each subject then participated in an analogue of a beginning counseling interview. Prior to

meeting with the counselor, subjects were given a brief description of what to expect from counseling and told that they would have an opportunity to discuss problems and experiences in an atmosphere of confidentiality with a trained counselor.

Depending on the group to which they were assigned, subjects then met with either Counselor 1 (C_1) or Counselor 2 (C_2) for a 30 minute interview. Interviews were recorded via audio tape. Upon completion of the interview subjects then completed the RI and WDQ based upon their experience in the interview. The above procedures constituted Time 1. At Time 2 subjects met with a different counselor (C_1 or C_2) after having been given the same instructions as at Time 1. Upon completion of the second interview subjects completed another RI and WDQ on the basis of that interview. In addition subjects were asked to indicate which counselor (C_1 or C_2) they would prefer to see should they choose to continue in counseling.

In order to implement the above procedures, it was necessary to recruit two graduate students from the counselor training program of the School of Education at The College of William and Mary to serve as therapists. Therapists were drawn from students who have completed Education 533, Techniques in Counseling. A survey of student records and

consultation with appropriate professors insured that counselors were comparable for basic counseling skills. Both counselors received three hours of basic counseling skills, training by the researcher using the training program of Kelly (1978). One counselor, selected at random, received training by the researcher in the Bandler and Grinder meta-model of identifying and responding to most highly valued representational system (see Appendix I for training paradigm). Prior to meeting with subjects counselors were instructed to use the counseling skills which they had learned (Ed. 533 or Ed. 533 plus meta-model training) to develop rapport, trust and understanding with their counselees. Counselors were blind to the purpose of the study until all data were collected.

Audio recordings of each interview session were rated for empathy on the EU scale by two trained judges. Both judges were doctoral students in the counselor training program of the School of Education at The College of William and Mary. They were also experienced counselors who were familiar with the EU scale. Empathy judges were trained by the researcher and evaluated to insure an acceptable degree of inter-rater reliability. Prior to rating tapes judges attained a discrimination index (Carkhuff, 1969a) of .3 which is considered excellent (Kelly, 1978).

Tapes were selected at random and two, 1-3 minute,

excerpts were rated for empathy. An average rating for each interview was used as a covariate measure.

Hypotheses

Below the four hypotheses relevant to the problem faced by the present study are stated in their null form and as statistical alternatives.

1. Null hypothesis: Subjects will perceive no difference in empathy as measured by the RI between treatment 1 and treatment 2.

$$\text{Symbolically: } H_{10}: \frac{X_{1.1} + X_{1.2}}{2} = \frac{X_{2.1} + X_{2.2}}{2}$$

Legend: $X_{1.1}$ = mean of group receiving treatment 1 at time 1.

$X_{1.2}$ = mean of group receiving treatment 1 at time 2.

$X_{2.1}$ = mean of group receiving treatment 2 at time 1.

$X_{2.2}$ = mean of group receiving treatment 2 at time 2.

Statistical alternative: Subjects will perceive higher empathy as measured by the RI as a result of treatment 2 than treatment 1.

$$H_{1a}: \frac{X_{1.1} + X_{1.2}}{2} < \frac{X_{2.1} + X_{2.2}}{2}$$

2. Null hypothesis: There will be no difference in empathy as measured by the EU scale between treatment 1 and treatment 2.

$$H_{20}: \frac{X_{1.1} + X_{1.2}}{2} = \frac{X_{2.1} + X_{2.2}}{2}$$

Statistical alternative: Empathy as measured by the EU scale will be higher for treatment 2 than treatment 1.

$$H_{2a}: \frac{X_{1.1} + X_{1.2}}{2} < \frac{X_{2.1} + X_{2.2}}{2}$$

3. Null hypothesis: There will be no difference in willingness-to-disclose as measured by the WDQ between treatment 1 and treatment 2.

$$H_{30}: \frac{X_{1.1} + X_{1.2}}{2} = \frac{X_{2.1} + X_{2.2}}{2}$$

Statistical alternative: Willingness-to-disclose as measured by the WDQ will be higher for treatment 2 than for treatment 1.

$$H_{3a}: \frac{X_{1.1} + X_{1.2}}{2} < \frac{X_{2.1} + X_{2.2}}{2}$$

4. Null hypothesis: There will be no difference in Subject's preference for counselor between Counselor 1 and Counselor 2.

$$H_{40}: O_1 - E_1 = O_2 - E_2$$

Legend: O_1 = observed preference for Counselor 1.

E_1 = expected preference for Counselor 1.

O_2 = observed preference for Counselor 2.

E_2 = expected preference for Counselor 2.

Statistical alternative: Subjects will indicate a greater preference for Counselor 2 than for Counselor 1.

$$H_{4a}: O_1 - E_1 < O_2 - E_2$$

Data Processing

In order to prepare data for statistical analysis the various protocols were scored by the researcher, and the data punched on computer cards. All protocols were handscored. More complete information on the scoring of these instruments is found in the relevant appendices and test manuals.

Statistical Analysis

Statistical methods were chosen to determine significant differences between treatments on the dependent variables while accounting for the various covariates, factors, and interactions. For hypotheses 1-3 repeated measure analysis of covariance was performed via the GENERAL LINEAR MODELS (GLM) program of the Statistical

Analysis System (SAS)(Statistical Analysis System Institute Inc., 1979) on the IBM 370/145 Computer at The College of William and Mary Computer Center. Hypothesis 4 was tested via the statistic Chi square.

Summary

The sample for the study consisted of 20 fulltime undergraduate students enrolled in education courses at The College of William and Mary. They ranged in age from 19-23 with a mean age of 20.6 years. Sixteen of the subjects were female and four were male.

Dependent variable measures were the empathy (RI-E) scale of the Relationship Inventory (Barrett-Lennard, Note 3), the 40-item Willingness-to-Disclose Questionnaire (WDQ)(Jourard & Lasakow, 1958) and the Empathic Understanding (EU) scale (Carkhuff, 1969b). The EU scale also served as a covariate measure for Hypotheses 1 and 3. Subject's preference to return to counselor served as the dependent measure for Hypothesis 4.

Covariate measures employed were the Counseling Readiness (CrS) scale of the Adjective Checklist (Gough & Heilbrun, 1965), the I-E Scale (Rotter, 1966) and the EU scale.

The design of the study was a Latin-square or counterbalanced design, wherein all subjects receive all levels of treatment in counterbalanced order.

Upon volunteering the researcher contracted with subjects guaranteeing confidentiality and securing permission to record interviews. Subjects were then administered the ACL and the I-E scale. Subjects met with both counselors in counterbalanced order for an analogue of a beginning counseling interview. After each interview was terminated subjects completed the RI and WDQ. Upon completion of their second interview, subjects were asked to indicate which counselor they would prefer to see should they choose to continue in counseling.

Counselors were two graduate students in counseling at The College of William and Mary. Both had had a beginning counseling course. Prior to meeting with subjects counselors were given a three-hour refresher course in basic counseling skills by the researcher. One counselor was chosen at random to receive six hours of training in Representational System Matching. Counselors were then instructed to use the skill they had learned to establish empathy, rapport and trust with the subjects.

Interviews were recorded via audio tape and rated for empathy by two raters trained by the researcher. Interrater reliability was .82. All protocols were handscored

and data punched on computer cards. Data for hypotheses 1-3 was analyzed via repeated measures analysis of covariance on the IBM 370/145 computer at The College of William and Mary Computer Center. Hypothesis 4 was tested by the statistic Chi square.

CHAPTER 4: RESULTS

The results of the statistical analysis are presented below by hypothesis.

Hypothesis 1

Subjects will perceive no difference in empathy as measured by the empathy scale of The Relationship Inventory (RI-E) between Treatment 1 and Treatment 2.

$$H_{10}: \frac{X_{1.1} + X_{1.2}}{2} = \frac{X_{2.1} + X_{2.2}}{2}$$

Legend: $X_{1.1}$ = mean of group receiving Treatment 1 at time 1.

$X_{1.2}$ = mean of group receiving Treatment 1 at time 2.

$X_{2.1}$ = mean of group receiving Treatment 2 at time 1.

$X_{2.2}$ = mean of group receiving Treatment 2 at time 2.

Repeated measures analysis of covariance resulted in an F value of 9.27 for the effects of treatment. With F significant at the .0045 level of probability the indication is that the groups differed significantly and the null hypothesis was rejected. Table 1 presents means,

Table 1
 Hypothesis 1 - Means, Standard Deviations, and
 Repeated Measures Analysis of Covariance for
 RI-E Scores, Covarying for EU, I-E, and Crs

Treatment/Time	Mean	Standard Deviation
X _{1.1}	24.8	7.05
X _{1.2}	20.7	14.79
X _{2.1}	29.7	11.60
X _{2.2}	32.2	11.60

Source of Variance	Sum of Squares	Degrees of Freedom	F	Level of Significance
Treatment	1143.309	1	9.27	.0045
EU	645.710	1	5.23	.0285
ORDER	14.313	1	.12	.7355
I-E	9.820	1	.08	.7795
Crs	68.449	1	.15	.4614
Error	4193.845	34		

standard deviations and F values for Hypothesis 1. Inspection of group means indicates that Treatment 2 (Representational System Matching) resulted in higher RI-E scores than Treatment 1 (no Representational Matching).

Of the covariates entered into the analysis — Judged empathy (EU), Internal-External Locus of Control (I-E), and the Counseling Readiness Scale of the Adjective Check List (Crs) — only EU resulted in a significant F value ($F = 5.23$, $p = .0285$) indicating that EU accounted for a significant portion of the variance on RI-E scores. There was no significant effect for order of treatment and none of the various interaction terms approached significance.

In addition to the analysis of covariance, a stepwise regression was performed regressing treatment (dummy variable), EU, I-E, and Crs on RI-E scores. Results indicate that EU accounted for 11.76 percent of the variance on RI-E scores, while treatment (the best predictor) accounted for 11.94 percent of the variance over and beyond that which was accounted for by EU.

Hypothesis 2

There will be no difference in empathy as measured by the Carkhuff Empathic Understanding Scale (EU) between Treatment 1 and Treatment 2.

$$H_{20}: \frac{X_{1.1} + X_{1.2}}{2} = \frac{X_{2.1} + X_{2.2}}{2}$$

Repeated measures analysis of covariance resulted in an F value of 6.35 for the effects of treatment which was significant at the .0163 level of probability. Table 2 presents means, standard deviations, and F values for Hypothesis 2. There was no significant effect for order of treatment nor did any of the covariate measures and interaction terms approach significance. The null hypothesis was rejected. Inspection of group means indicates that Treatment 2 resulted in higher EU scores than Treatment 1.

Hypothesis 3

There will be no difference in subjects' willingness to self-disclose as measured by the Willingness-to-Disclose Questionnaire (WDQ) between Treatment 1 and Treatment 2.

$$H_{30}: \frac{X_{1.1} + X_{1.2}}{2} = \frac{X_{2.1} + X_{2.2}}{2}$$

Table 2
 Hypothesis 2 - Means, Standard Deviations and
 Repeated Measures Analysis of Covariance for
 EU Scores, Covarying for I-E and Crs

Treatment/Time	Mean	Standard Deviation
X _{1.1}	3.087	.377
X _{1.2}	3.125	.288
X _{2.1}	3.425	.271
X _{2.2}	3.325	.378

Source of Variance	Sum of Squares	Degrees of Freedom	F	Level of Significance
Treatment	.7222	1	6.35	.0165
Order	.0097	1	.09	.7713
I-E	.0461	1	.41	.5282
Crs	.0008	1	.01	.9318
Error	3.9838	35		

Table 3
 Hypothesis 3 - Means, Standard Deviations and
 Repeated Measures Analysis of Covariance for
 WDQ Scores, Covarying for EU, I-E, and Crs

Treatment/Time	Mean	Standard Deviation
X _{1.1}	67.2	9.68
X _{1.2}	64.7	18.08
X _{2.1}	67.9	13.35
X _{2.2}	72.0	6.92

Source of Variance	Sum of Squares	Degrees of Freedom	F	Level of Significance
Treatment	329.864	1	2.07	.1591
Order	2.900	1	.02	.8934
EU	227.339	1	1.74	.1956
I-E	297.311	1	1.87	.1806
Crs	19.068	1	.12	.7313
Error	5409.679	34		

Repeated measures analysis of covariance resulted in nonsignificant F values for all factors, covariates, and interactions, and the null hypothesis failed to be rejected. Table 3 presents means, standard deviations and F values for Hypothesis 3. Inspection of Table 3 indicates that while the means for Treatment 2 were slightly higher the difference was not significant.

Hypothesis 4

There will be no difference in Subjects' preference for counselor between Counselor (C_1) and Counselor 2 (C_2)

$$H_{40}: O_1 - E_1 = O_2 - E_2$$

Legend: O_1 = observed preference for Counselor 1.

E_1 = expected preference for Counselor 1.

O_2 = observed preference for Counselor 2.

E_2 = expected preference for Counselor 2.

To test Hypothesis 4 the statistic Chi square was computed using subject preference as the observed frequency and 10 ($N=20$) as the expected frequency computations are shown below.

$$\chi^2 = \frac{(\text{observed } C_1 - 10)^2}{10} + \frac{(\text{observed } C_2 - 10)^2}{10}$$

$$\begin{aligned}
 &= \frac{(5 - 10)^2}{10} + \frac{(15 - 10)^2}{10} \\
 &= \frac{(-5)^2}{10} + \frac{(5)^2}{10} \\
 &= \frac{25}{10} + \frac{25}{10}
 \end{aligned}$$

= 5 with 1 degree of freedom

With 1 degree of freedom a X^2 of 5 is significant at less than the .05 level of probability resulting in rejection of the null hypothesis. With 15 subjects indicating a preference for Counselor 2 and 5 preferring Counselor 1 it is evident that Counselor 2, who applied the representational systems matching treatment was preferred by a ratio of 3 to 1.

Additional Findings

In addition to the above findings, other data obtained from the statistical analysis are of theoretical and clinical import.

While Hypothesis 3 failed to be rejected at the .05 level of probability, the data (Table 3) indicate that Treatment 2 resulted in higher WDQ scores. Correlation

coefficients were computed for the variables entered into the analysis and the correlation between WDQ and RI-E was .57 which was significant at the .0001 level of probability.

Also of interest is the correlation between the two measures of empathy - client perceived empathy (RI-E) and judged empathy (EU). The correlation coefficient of $-.18$ was not significant.

Summary

The results of the statistical analysis of the hypotheses and additional findings are presented in Table 4. Hypotheses 1 and 2 were rejected and the effects were in the expected direction. Treatment 2 (Representational System Matching) resulted in significantly higher scores for client perceived empathy (Hypothesis 1) and tape judged empathy (Hypothesis 2). Hypothesis 3 failed to be rejected indicating that treatments did not result in significantly different willingness to disclose scores. In addition WDQ correlated with RI-E $.57$ ($p = .0001$) and RI-E correlated with EU $-.18$ ($p = .26$).

Table 4
Summary of Statistical Findings

Hypothesis (Null)	Statistic	Probability	Reject
1	$\underline{F} = .927$.0045	yes
2	$\underline{F} = 6.35$.0163	yes
3	$\underline{F} = 2.07$.1591	no
4	$\chi^2 = 5.0$.05	yes

Variables	Coefficient of Correlation	Level of Significance
WDQ-RI-E	.57	.0001
RI-E-EU	-.18	.26

CHAPTER 5: SUMMARY, CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

In this chapter will be presented a major summary of the study and interpretation of results with relevant conclusions and implications. The limitations of the study will be noted and recommendations for counselor education and further study will be made.

Summary

The construct of therapist-offered empathy has been shown to be an important ingredient in the counseling relationship and the literature relating empathy to positive counseling outcome fills volumes. What is meant by empathy however remains an enigma. Many operational definitions of empathy have been posited in the form of empathy scales. While most empathy measures appear to have a positive relationship with effective therapy, most scales have been criticized on methodological grounds and the construct validity of such measures is suspect. Several researchers have offered evidence that objective empathy scales tend to be heavily loaded with raters' evaluation of qualities other than those operationalized by the scales (e.g. counselor verbosity, number of affect words used, eye contact, body

posture and a more global, "good guy," factor).

The present study attempted to define and investigate the validity and effect on counseling of a new dimension of empathy; that of representational system matching. Representational systems as defined by Grinder and Bandler (1976) are internal maps used by individuals to organize reality. Representational systems are either visual, auditory or kinesthetic and are reflected in the natural language predicates used in everyday speech. Do you see what I mean? I hear you loud and clear. It doesn't feel right to me. Empathy, for the purpose of this study, is defined as the counselor's matching language with that of the representational system used by the subject.

It was hypothesized that counselors who use language attuned to the subject's representational system would:

- 1) be perceived by subjects as more empathic than counselors who do not;
- 2) be perceived by third party judges as more empathic than counselors who do not;
- 3) elicit a greater willingness to self-disclose by subjects than counselors who do not and
- 4) be preferred by subjects over counselors who do not match representational systems.

The sample for the study consisted of full-time undergraduate students (N=20) enrolled in education courses at The College of William and Mary. All subjects met with two counselors, in counterbalanced order, for an analogue of

a beginning therapy session. One counselor had been trained to respond with representational system matching while the other took a more generic, human relations, approach to empathy in responding to subjects. After each interview subjects completed Barrett-Lennard's (Note 1) Relationship Inventory (RI) and Jourard and Lasakow's (1958) Willingness-to-Disclose Questionnaire (WDQ). Upon completion of their second interview subjects were asked to indicate the counselor they would choose to see should they continue in counseling. Covariate measures were Carkhuff's (1969b) Empathic Understanding Scale (EU), the Counseling Readiness Scale (CrS) of Gough and Heilbrun's (1965) Adjective Check List (ACL) and Rotter's (1966) Internal-External Locus of Control Scale (I-E). EU also served as the dependent variable measure for Hypothesis 2.

The experimental design was that of a Latin-square and the data were analysed by repeated measures analysis of covariance (Hypothesis 1-3) stepwise regression (Hypothesis 1 & 3) and Chi square (Hypothesis 4).

Statistical analysis resulted in significant F values for null hypotheses 1 and 2 and they were consequently rejected indicating that both subjects and third party judges perceived the representational systems matching counselor as being more empathic. The null Hypothesis 3

failed to be rejected indicating that there was no significant difference in subjects' willingness to self-disclose to counselors. The null Hypothesis 4 was rejected indicating that subjects preferred the representational system matching counselor by a margin of 3 to 1.

Conclusions

Conclusions regarding the construct of representational system matching as a major constituent of empathy and its effect on counseling will be presented by hypothesis.

Hypothesis 1

The null hypothesis that there would be no difference on Relationship Inventory Empathy Scale (RI-E) scores between treatments was rejected at the .0045 level of confidence. Repeated measures analysis of covariance resulted in an F value ($F = 9.27$) indicative of a significant difference in favor of representational system matching. While the covariate Carkhuff judged empathy (EU) accounted for 11.76 percent of the variance, ($F = 5.23$, $p = .0285$) representational system matching accounted for 11.94 percent of the variance beyond that accounted for by EU. The remaining covariates (Crs, I-E) did not account for a significant portion of the variance in the analysis. The indication is that subjects perceived the counselor who used representational system matching as significantly more empathic than

the counselor who took a more generic approach to empathy.

As there was a significant effect in favor of representational system matching it is instructive to look at the magnitude of the effect and compare it with that of therapy outcome studies. Glass (1976) has shown that effect size can be computed by dividing the mean difference on the variable in question by the within group standard deviation. For Hypothesis 1 the effect size is 1.58 standard deviations i.e. representational system matching resulted in mean RI-E scores just over one and one half standard deviations above mean RI-E scores for generic empathy.

Glass (1976) performed a meta-analysis of over 800 measures of effect size between subjects treated with psychotherapy and untreated controls. Average effect size was .68 standard deviations indicating that on average the therapy group mean was about two-thirds standard deviation above the control group mean on the outcome variable.

The meaning of the effect size of 1.58 standard deviations for the present study is attenuated by the fact that it resulted from an analogue study which used student volunteers rather than therapy clients as subjects. It was found however that most subjects did present personally relevant material and did engage in self-exploration and problem solving. Suffice it to say that an effect size of

1.58 standard deviations is substantial and analogous to a significant effect in actual therapy.

Hypothesis 2.

The null hypothesis that there would be no difference on Carkhuff judged empathy (EU) between treatments was rejected at the .016 level of confidence indicating that the counselor who used representational system matching was perceived by judges as being significantly more empathic than the counselor who took the generic approach to empathy. The effect size was .82 standard deviations which exceeds the .68 standard deviation average effect size for treated subjects reported by Glass (1976). The same reservations on interpretation and extension of results to actual therapy noted for Hypothesis 1 pertain to Hypothesis 2. However the fact that both subjects and judges perceived representational system matching as being more empathic than a generic approach augurs well for concluding that representational system matching be considered a major dimension of the empathy process. The data indicate that representational system matching had a strong effect on variables known to have a positive relationship with effective therapy thus strengthening the analogy between the present study and therapy outcome studies.

Hypothesis 3

The null hypothesis that there would be no difference in willingness to self-disclose between treatments failed to be rejected. While no significant difference was found, there was a trend in the data suggesting that representational system matching was associated with higher Willingness-to-Disclose scores. The effect size was .27 standard deviations in favor of representational system matching. Based on the data, it can be concluded that the effect of representational system matching on willingness to self-disclose was insignificant.

Hypothesis 4

The null hypothesis that there would be no difference in subjects' preference for counselor was rejected at better than the .05 level of confidence. Three times as many subjects (N=15) indicated a preference for the representational system matching counselor than chose the generic empathy counselor (N=5).

After subjects indicated a preference for counselor they were asked why they made the choice they did. It should be mentioned that most subjects reported that they found both counselors to have been understanding and empathic and that indicating a preference was not an easy matter. Comments of some of the subjects who chose the representational system matching counselor are quite telling especially

as regards representational systems used. One subject stated that she "felt" more "comfortable" and that the counselor "could say something the way I would feel it even if I didn't say it." Another indicated that she "was more in tune with how strongly and deeply I felt about things." One subject's comments may be indicative of how a counselors' awareness of and response to representational systems may help clients deal with confusion and ambivalence. "She helped me see what I was saying. At times I was confused (mixing representational systems?) but I'd keep talking. She was easier to talk to."

It can be concluded, based upon the hypotheses tested that in the present investigation empathy, expressed as representational system matching was superior to a more generic, human relations training, expression of empathy.

Limitations

The primary factor limiting the external validity of the present study is the small ($N=2$) number of counselors used. While the use of EU as a covariate extracted a significant portion of the variance between the two counselors, it is not unreasonable to assume that unknown variables may have operated in favor of the representational system matching counselor. It might be argued that she was

a "better" counselor and the researcher agrees; she was a better counselor by virtue of the training she received in representational system matching. In addition the study was not designed to assess how representational system matching may interact with other counselor behaviors and techniques nor with the sex matching of subject-counselor pairs.

Factors further limiting the generalizability of results pertain to the subject sample. As the subjects were undergraduates at an academically prestigious university they cannot be considered demographically representative of clients in counseling. In addition the subjects were paid to participate and ostensibly were not seeking help even though many stated that they found the sessions with both counselors quite helpful. The fact that of the sample 80% were female limits the extension of findings to other populations even though no significant effect for sex was observed in the data.

That the study employed an analogue of a beginning therapy session places further limitations on the generalization of findings.

Recommendations

With the above mentioned limitations in mind the conclusions drawn from the data have strong implications for

counselor education. As representational system matching accounted for a major proportion of the variance on two widely used empathy measures -- The Relationship Inventory (RI) and the Carkhuff Empathic Understanding Scale (EU) -- it is recommended that beginning courses in counseling techniques and human relations training include a section on identifying and responding to client representational systems. The present research has indicated not only that representational system matching is theoretically compatible with Rogerian theory but also that there is practical evidence for considering representational system matching a major dimension of empathy.

The first recommendation for further study is that future research employ more counselors in order that the effects of sex, race, experience and other personological variables be assessed. Such a study would require a larger sample size wherein randomization would replace some of the design controls used in the present study.

As this study used an analogue of therapy, more generalizable findings would result from future research using therapists and their actual clients along with several process and outcome measures and the associated multivariate statistical analysis.

Appendix

APPENDIX A
CONTRACT WITH SUBJECTS

CONTRACT

Subject: _____

Researcher: William P. Brockman

Title of Project: Empathy Revisited: The Effect of Representational System Matching on Certain Counseling Process and Outcome Variables

The researcher guarantees the confidentiality of your participation in the study. All data collected from you will be coded to preserve anonymity and the results will likewise be anonymous. The paper and pencil instruments which you will complete are for research purposes only and under no circumstances will counselors have any information about you other than that which you choose to divulge in the interviews. Should you wish to continue in counseling as a result of your participation in this study, as a student at William and Mary you may at no charge use the services of the Center for Psychological Services of the college. Following the completion of the study the researcher will discuss the results of the study with you on an individual basis. Upon completion of the second interview you will be paid \$5.00.

The Subject will meet separately with two counselors and complete questionnaires after each interview. In both interviews you will be asked to discuss problems and experiences in your life with the counselor. What you choose to discuss is up to you, however you are urged to include personally relevant material. While self-exploration and self-understanding implies some risk-taking, you will be with a trained counselor who will strive to be helpful and who is ethically bound to maintain confidentiality. The subject hereby gives consent for interviews to be recorded via audio tape.

Signature_____
William P. Brockman
Researcher_____
Print name_____
Date

APPENDIX B
THE RELATIONSHIP INVENTORY

Code:

Date:

(BARRETT-LENNARD) RELATIONSHIP INVENTORY -- FORM OS-F-64

Below are listed a variety of ways that one person may feel or behave in relation to another person.

Please consider each statement with reference to your present relationship with your _____.

Mark each statement in the left margin, according to how strongly you feel that it is true, or not true, in this relationship. Please mark every one. Write in +3, +2, +1, or -1, -2, -3, to stand for the following answers:

- +3: *Yes, I strongly feel that it is true.* -1: *No, I feel that it is probably untrue, or more untrue than true.*
- +2: *Yes, I feel it is true.* -2: *No, I feel it is not true.*
- +1: *Yes, I feel that it is probably true, or more true than untrue.* -3: *No, I strongly feel that it is not true.*

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

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* E scale items

- ___ 13. I feel appreciated by her.
- * ___ 14. She looks at what I do from her own point of view.
- ___ 15. Her feeling toward me doesn't depend on how I feel toward her.
- ___ 16. It makes her uneasy when I ask or talk about certain things.
- ___ 17. She is indifferent to me.
- * ___ 18. She usually senses or realises what I am feeling.
- ___ 19. She wants me to be a particular kind of person.
- ___ 20. I nearly always feel that what she says expresses exactly what she is feeling and thinking as she says it.
- ___ 21. She finds me rather dull and uninteresting.
- * ___ 22. Her own attitudes toward some of the things I do or say prevent her from understanding me.
- ___ 23. I can (or could) be openly critical or appreciative of her without really making her feel any differently about me.
- ___ 24. She wants me to think that she likes me or understands me more than she really does.
- ___ 25. She cares for me.
- * ___ 26. Sometimes she thinks that I feel a certain way, because that's the way she feels.
- ___ 27. She likes certain things about me, and there are other things she does not like.
- ___ 28. She does not avoid anything that is important for our relationship.
- ___ 29. I feel that she disapproves of me.
- * ___ 30. She realises what I mean even when I have difficulty in saying it.
- ___ 31. Her attitude toward me stays the same: she is not pleased with me sometimes and critical or disappointed at other times.
- ___ 32. Sometimes she is not at all comfortable but we go on, outwardly ignoring it.
- ___ 33. She just tolerates me.
- * ___ 34. She usually understands the whole of what I mean.
- ___ 35. If I show that I am angry with her she becomes hurt or angry with me, too.

- ___ 36. She expresses her true impressions and feelings with me.
- ___ 37. She is friendly and warm with me.
- * ___ 38. She just takes no notice of some things that I think or feel.
- ___ 39. How much she likes or dislikes me is not altered by anything that I tell her about myself.
- ___ 40. At times I sense that she is not aware of what she is really feeling with me.
- ___ 41. I feel that she really values me.
- * ___ 42. She appreciates exactly how the things I experience feel to me.
- ___ 43. She approves of some things I do, and plainly disapproves of others.
- ___ 44. She is willing to express whatever is actually in her mind with me, including any feelings about herself or about me.
- ___ 45. She doesn't like me for myself.
- * ___ 46. At times she thinks that I feel a lot more strongly about a particular thing than I really do.
- ___ 47. Whether I am in good spirits or feeling upset does not make her feel any more or less appreciative of me.
- ___ 48. She is openly herself in our relationship.
- ___ 49. I seem to irritate and bother her.
- * ___ 50. She does not realize how sensitive I am about some of the things we discuss.
- ___ 51. Whether the ideas and feelings I express are "good" or "bad" seems to make no difference to her feeling toward me.
- ___ 52. There are times when I feel that her outward response to me is quite different from the way she feels underneath.
- ___ 53. At times she feels contempt for me.
- * ___ 54. She understands me.
- ___ 55. Sometimes I am more worthwhile in her eyes than I am at other times.
- ___ 56. I have not felt she tries to hide anything from herself that she feels with me.
- ___ 57. She is truly interested in me.
- * ___ 58. Her response to me is usually so fixed and automatic that I don't really get through to her.

- ___ 59. I don't think that anything I say or do really changes the way she feels toward me.
- ___ 60. What she says to me often gives a wrong impression of her whole thought or feeling at the time.
- ___ 61. She feels deep affection for me.
- * ___ 62. When I am hurt or upset she can recognise my feelings exactly, without becoming upset herself.
- ___ 63. What other people think of me does (or would, if she knew) affect the way she feels toward me.
- ___ 64. I believe that she has feelings she does not tell me about that are causing difficulty in our relationship.
-

RELATIONSHIP INVENTORY SCORING SHEET

64 item forms

Code _____

Date answered _____

Hypothetical
data inserted
for one scale,
illustrating
scoring the
procedure.

	Level of Regard		Empathy		Unconditionality		Congruence	
	Positive items	Answer	Positive items	Answer	Positive items	Answer	Positive items	Answer
	1		2	3	7		4	
	5		10	2	15		12	
	13		18	2	23		20	
	25		30	1	31		28	
	37		34	-2	39		36	
	41		42	3	47		44	
	57		54	-1	51		48	
	61		62	2	59		56	
Sum: Sub-total #1				10				
	Negative items	Answer	Negative items	Answer	Negative items	Answer	Negative items	Answer
	9		6	-2	3		8	
	17		14	-3	11		16	
	21		22	-3	19		24	
	29		26	-2	27		32	
	33		38	1	35		40	
	45		46	-2	43		52	
	49		50	1	55		60	
	53		58	-3	63		64	
Sum (for neg. items)				-13				
-1 x Sum: Sub-total #2				13				
Sub-total #1 + #2: Scale Score				23				

APPENDIX C
THE WILLINGNESS-TO-DISCLOSE QUESTIONNAIRE

Answer Sheet for the Willingness-to-Disclose Questionnaire

Directions Please read each item on the Willingness-to-Disclose Questionnaire and indicate beside the appropriate number on this answer sheet the extent that you would be willing to talk about that item to the counselor you just saw; that is, the extent to which you would be willing to make yourself known to her in subsequent counseling sessions were you to continue in counseling with her. Please use the following rating scale to describe the extent that you would be willing to talk about each item:

- 0: Would tell the counselor nothing about this aspect of me.
- 1: Would talk in general terms about this. The counselor would have only a general idea about this aspect of me.
- 2: Would talk in full and complete detail about this item to the counselor. He would know me fully in this respect and could describe me accurately.
- X: Would lie or misrepresent myself to the counselor so that he would have a false picture of me.

Willingness-to-Disclose Questionnaire

1. What you dislike about your overall appearance.
2. The things about your appearance that you like most, or are proudest of.
3. Your chief health concern, worry, or problem, at the present time.
4. Your favorite spare-time hobbies or interests.
5. Your food dislikes at present.
6. Your religious activity at present--whether or not you go to church; which one; how often.
7. Your personal religious views.
8. Your favorite reading materials--kinds of magazines, books, or papers you usually read.
9. What particularly annoys you most about your closest friend of the opposite sex or your spouse.
10. Whether or not you have sex problems, and the nature of these problems, if any.
11. An accurate knowledge of your sex life up to the present e.g., the names of your sex partners in the past and present, if any; your ways of getting sexual gratification.
12. Things about your own personality that worry you or annoy you.
13. The chief pressures and strains in your daily work.
14. Things about the future that you worry about at present.
15. What you are most sensitive about.
16. What you feel the guiltiest about, or most ashamed of in your past.
17. Your views about what is acceptable sexual morality for people to follow.

18. The kinds of music you enjoy listening to the most.
19. The subjects you did not, or do not like in school.
20. Whether or not you do anything special to maintain or improve your appearance, e.g., diet, exercise, etc.
21. The kind of behavior in others that most annoys you, or makes you furious.
22. The characteristics of your father that you do not like, or did not like.
23. Characteristics of your mother that you do not like, or did not like.
24. Your most frequent daydreams—what you daydream about most.
25. The feelings you have the most trouble controlling, e.g., worry, depression, anger, jealousy, etc.
26. The biggest disappointment that you have had in your life.
27. How you feel about your choice of life work.
28. What you regard as your chief handicaps to doing a better job in your work or studies.
29. Your views on the segregation of whites and Negroes.
30. Your thoughts and feelings about other religious groups than your own.
31. Your strongest ambition at the present time.
32. Whether or not you have planned some major decision in near future, e.g., a new job, break engagement, get married, divorce, buy something big.
33. Your favorite jokes—the kind of jokes you like to hear.
34. Whether or not you have savings; if so, the amount.
35. The possessions you are proudest of and take greatest care of, e.g., your car, or musical instrument, or furniture, etc.

36. How you usually sleep, e.g., well, or poorly or with the help of drugs.
37. Your favorite television programs.
38. Your favorite comics.
39. The groups or clubs or organizations you belong to e.g., fraternity, lodge, bridge club, YMCA, professional organizations, etc.
40. The beverages you do not like to drink, e.g., coffee, tea, coke, beer, liquor, etc. and your preferred beverages.

1. _____ 11. _____ 21. _____ 31. _____
2. _____ 12. _____ 22. _____ 32. _____
3. _____ 13. _____ 23. _____ 33. _____
4. _____ 14. _____ 24. _____ 34. _____
5. _____ 15. _____ 25. _____ 35. _____
6. _____ 16. _____ 26. _____ 36. _____
7. _____ 17. _____ 27. _____ 37. _____
8. _____ 18. _____ 28. _____ 38. _____
9. _____ 19. _____ 29. _____ 39. _____
10. _____ 20. _____ 30. _____ 40. _____

Code: _____

Scoring the Willingness-to-Disclose Questionnaire

The Willingness-to Disclose Questionnaire is scored by summing the numerical entries for the single target person. X's are assigned a value of zero. Thus the highest possible score is 80. A higher score indicates a greater willingness to disclose to the target person.

APPENDIX D
THE CARKHUFF EMPATHIC UNDERSTANDING SCALE

Carkhuff Empathic Understanding ScaleLevel 1

The verbal and behavioral expressions of the first person either do not attend to or detract significantly from the verbal and behavioral expressions of the second person(s) in that they communicate significantly less of the second person's feelings than the second person has communicated himself.

EXAMPLES: The first person communicates no awareness of even the most obvious, expressed surface feelings of the second person. The first person may be bored or uninterested or simply operating from a preconceived frame of reference which totally excludes that of the other person(s).

In summary, the first person does everything but express that he is listening, understanding, or being sensitive to even the feelings of the other person in such a way as to detract significantly from the communications of the second person.

Level 2

While the first person responds to the expressed feelings of the second person(s), he does so in such a way that he subtracts noticeable affect from the communications of the second person.

EXAMPLES: The first person may communicate some awareness of obvious surface feelings of the second person, but his communications drain off a level of meaning. The first person may communicate his own ideas of what may be going on, but these are not congruent with the expression of the second person.

In summary, the first person tends to respond to other than what the second person is expressing or indicating.

Level 3

The expressions of the first person in response to the expressed feelings of the second person(s) are essentially interchangeable with those of the second person in that they express essentially the same affect and meaning.

EXAMPLE: The first person responds with accurate understanding of the surface feelings of the second person but may not respond to or may misinterpret the deeper feelings.

In summary, the first person is responding so as to neither subtract from nor add to the expressions of the second person; but he does not respond accurately to how that person really feels beneath the surface feelings. Level 3 constitutes the minimal level of facilitative interpersonal functioning.

Level 4

The responses of the first person add noticeably to the expressions of the second person(s) in such a way as to express feelings a level deeper than the second person was able to express himself.

EXAMPLE: The facilitator communicates his understanding of the expressions of the second person at a level deeper than they were expressed, and thus enables the second person to experience and/or express feelings he was unable to express previously.

In summary, the facilitator's responses add deeper feeling and meaning to the expressions of the second person.

Level 5

The first person's responses add significantly to the feeling and meaning of the expressions of the second person(s) in such a way as to (1) accurately express feelings levels below what the person himself was able to express or (2) in the event of on going deep self-exploration on the second person's part, to be fully with him in his deepest moments.

EXAMPLE: The facilitator responds with accuracy to all of the person's deeper as well as surface feelings. He is "together" with the second person or "tuned in" on his wave length. The facilitator and the

other person might proceed together to explore previously unexplored areas of human existence.

In summary, the facilitator is responding with a full awareness of who the other person is and a comprehensive and accurate empathic understanding of his deepest feelings.

EU Rating Form

Code _____

TAFE	RESPONSE		MEAN RATING
	1	2	
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

APPENDIX E
THE ADJECTIVE CHECK LIST (ACL)

APPENDIX F
FREQUENCY DISTRIBUTION AND
DESCRIPTIVE STATISTICS FOR THE ACL
COUNSELING READINESS (Crs) SCALE

Appendix F

Frequency Distribution and Descriptive Statistics
for the ACL Counseling Readiness Scale (Crs)

Crs Scores	Frequency
37	1
40	2
42	1
44	2
48	3
49	4
55	1
56	3
59	2
63	1
Mean	49.5
Median	48.75
Mode	49
Standard Deviation	7.003
Variance	49.05
Range	16

APPENDIX G
THE I-E SCALE

I - E SCALE

Instructions

This is a questionnaire to find out the way in which certain important events in our society affect different people. Each item consists of a pair of alternatives lettered a or b. Please select the one statement of each pair (and only one) which you more strongly believe to be the case as far as you're concerned. Be sure to select the one you actually believe to be more true rather than the one you think you should choose or the one you would like to be true. This is a measure of personal belief; obviously there are no right or wrong answers.

Your answers to the items on this inventory are to be recorded on a separate answer sheet provided. Print your name and any other information requested by the examiner on the answer sheet, then finish reading these directions. Do not begin until you are told to do so.

Please answer these items carefully but do not spend too much time on any one item. Be sure to find an answer for every choice. Find the number of the item on the answer sheet and mark the space under the letter a or b which you choose as the statement more true.

In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the one you more strongly believe to be the case as far as you're concerned. Also try to respond to each item independently when making your choice; do not be influenced by your previous choices.

1. a. Children get into trouble because their parents punish them too much.
 b. The trouble with most children nowadays is that their parents are too easy with them.
2. a. Many of the unhappy times in people's lives are partly due to bad luck.
 b. People's misfortunes result from the mistakes they make.
3. a. One of the major reasons why we have wars is because people don't take enough interest in politics.
 b. There will always be wars, no matter how hard people try to prevent them.

4.
 - a. In the long run people get the respect they deserve in this world.
 - b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.
5.
 - a. The idea that teachers are unfair to students is nonsense.
 - b. Most students don't realize the extent to which their grades are influenced by accidental happenings.
6.
 - a. Without the right breaks one cannot be an effective leader.
 - b. Capable people who fail to become leaders have not taken advantage of their opportunities.
7.
 - a. No matter how hard you try some people just don't like you.
 - b. People who can't get others to like them don't understand how to get along with others.
8.
 - a. Heredity plays the major role in determining one's personality.
 - b. It is one's experiences in life which determine what they're like.
9.
 - a. I have often found that what is going to happen will happen.
 - b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.
10.
 - a. In the case of the well prepared student there is rarely if ever such a thing as an unfair test.
 - b. Many times exam questions tend to be so unrelated to course work that studying is really useless.
11.
 - a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
 - b. Getting a good job depends mainly on being in the right place at the right time.
12.
 - a. The average citizen can have an influence in government decisions.
 - b. This world is run by the few people in power, and there is not much the little guy can do about it.
13.
 - a. When I make plans, I am almost certain that I can make them work.
 - b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14.
 - a. There are certain people who are just no good.
 - b. There is some good in everybody.
15.
 - a. In my case getting what I want has little or nothing to do with luck.
 - b. Many times we might just as well decide what to do by flipping a coin.
16.
 - a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
 - b. Getting people to do the right thing depends on ability, luck has little or nothing to do with it.
17.
 - a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.
 - b. By taking an active part in political and social affairs the people can control world events.
18.
 - a. Most people don't realize the extent to which their lives are controlled by accidental happenings.
 - b. There really is no such thing as "luck."
19.
 - a. One should always be willing to admit mistakes.
 - b. It is usually best to cover up one's mistakes.
20.
 - a. It is hard to know whether or not a person really likes you.
 - b. How many friends do you have depends on how nice a person you are.
21.
 - a. In the long run bad things that happen to us are balanced by the good ones.
 - b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.
22.
 - a. With enough effort we can wipe out political corruption.
 - b. It is difficult for people to have much control over the things politicians do in office.
23.
 - a. Sometime I can't understand how teachers arrive at the grades they give.
 - b. There is a direct connection between how hard I study and the grades I get.
24.
 - a. A good leader expects people to decide for themselves what they should do.
 - b. A good leader makes it clear to everybody what their jobs are.

25. a. Many times I feel that I have little influence over the things that happen to me.
b. It is impossible for me to believe that chance or luck plays an important role in my life.
26. a. People are lonely because they don't try to be friendly.
b. There's not much use in trying too hard to please people, if they like you, they like you.
27. a. There is too much emphasis on athletics in high school.
b. Team sports are an excellent way to build character.
28. a. What happens to me is my own doing.
b. Sometimes I feel that I don't have control over the direction my life is taking.
29. a. Most of the time I can't understand why politicians behave the way they do.
b. In the long run the people are responsible for bad government on a national as well as on a local level.

ANSWER SHEET I - E SCALE

Code: _____

	a	b
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

	a	b
21.		
22.		
23.		
24.		
25.		
26.		
27.		
28.		
29.		

PLACE A CHECK IN THE BOX OPPOSITE
THE NUMBER OF THE QUESTION YOU ARE
RESPONDING TO.

APPENDIX H
FREQUENCY DISTRIBUTION AND
DESCRIPTIVE STATISTICS FOR THE I-E
SCALE

Appendix H

Frequency Distribution and Descriptive
Statistics for the I-E Scale

I- E Scores	Frequency
2	1
6	1
7	2
8	1
9	3
10	1
11	1
12	1
13	2
14	2
15	2
16	3

-Mean 11.1
 -Median 11.5
 -Mode 9 & 6
 -Standard Deviation 3.83
 -Variance 14.69
 -Range 14

APPENDIX I
REPRESENTATIONAL SYSTEM
MATCHING TRAINING

Representational System Matching Training

The formal training program was conducted by the researcher with the assistance of a highly experienced counselor educator who had previously attended an NLP workshop. Prior to actual training, the chosen counselor read relevant portions of The Structure of Magic II (Grinder & Bandler, 1976, Pp. 3-19) and Frogs into Princes (Bandler & Grinder, 1979, Pp. 5-78). Training began with a discussion of the model with particular emphasis on identifying predicates as either visual, auditory, or kinesthetic. Next the trainee was drilled in identifying predicates used in statements presented by the trainer. The first two-hour training session ended with the trainee being instructed to practice identifying predicates used by the persons she came in contact with in her day-to-day life.

During the second session the trainee practiced responses which matched the representational system presented in statements made by the trainer. Next the trainee was drilled in identifying the patterns of eye movements which denote representational system accessing. Following a demonstration of representational system matching in counseling by the trainer and his assistant, the trainee incorporated what she had learned in role-play counseling with the

trainers. The homework assignment following the second two-hour session was to use representational system matching in everyday conversation.

The final two-hour session consisted of drills in responding to the representational system inherent in statements made by the trainer and role-play counseling with the trainer. Total training time was six hours. Following are words and phrases denotative of visual, auditory, and kinesthetic representational systems which were used in the training drills.

References

Visual

see after
 see eye to eye
 see fit
 see it through
 see your (my) way
 see red
 see the light
 see to
 blind to
 notice
 regard
 viewpoint
 point of view
 outlook
 catch sight of
 look straight in the eye
 clear sighted
 sharp sighted
 far seeing
 sight unseen
 short sighted
 blind spot
 flash
 recognize
 obscure
 hazy
 picture

Auditory

lend an ear
 make oneself heard
 fall of deaf ears
 sound
 noise
 tone
 pitch
 note, sweet/sour
 overtone
 undertone
 tone of voice
 harmonious
 clash
 tune in, out
 quiet
 still
 hold one's tongue
 not breathe a word
 make an uproar
 vibration--vibes
 resounding
 repercussion
 echo back
 hollow words
 disharmony
 off key
 hear

Kinesthetic

sensation
 gentle
 tender
 penetrate
 touch a chord
 (also Auditory)
 piercing
 callous
 cold hearted
 unmoved
 feel for
 feel one's way
 sore spot
 touchy, touchiness
 ache
 pang
 tingle
 numb
 paralyze
 stun
 burning desire, etc.
 far reaching
 irritating
 rub the wrong way
 grate on
 in touch
 handle with care

I don't see what ...

I'm not clear on what I should do.

It just doesn't ring true.

I just can't get a grasp on ...

He's so hard on me.

I'm trying to keep things in perspective.

I know it sounds crazy but...

My course load is so heavy.

I hear what you're saying.

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Abstract

Empathy Revisited: The Effect of Representational System Matching on Certain Counseling Process and Outcome Variables

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The College of William and Mary in Virginia, May 1980

Chairman: Charles O. Matthews, Ph.D.

Therapist-offered empathy has been shown to be an important ingredient in the counseling relationship. Many operational definitions of empathy and tools for measurement of this elusive quality exist. Most empathy measures have been criticized on methodological grounds and their construct validity is suspect. Yet there is little argument with the trend which emerges from the data; the overall relationship between empathy, or those dimensions tapped by empathy measures and effective therapy appears positive. The nature of empathy however remains enigmatic and it is evident that all of the variables which account for the empathic process have not been explicated.

This study defined and investigated the validity and effect on counseling of a new dimension of empathy. From their linguistic analysis of effective therapy Bandler and Grinder have formulated the construct of representational systems or internal maps used by individuals to organize reality. Such maps are visual, auditory or kinesthetic and are reflected in natural language. Do you see what I mean? Empathy, then, is operationally defined as the counselor's matching language with the representational system used by the client.

It was hypothesized that counselors who use representational system matching would: 1) be perceived by subjects as more empathic than counselors who do not (accepted, $p = .0045$); 2) be perceived by judges as more empathic than counselors who do not (accepted, $p = .0165$); elicit a greater willingness to self-disclose than counselors who do not (rejected) and 4) be preferred by clients over counselors who do not use representational matching (accepted $p < .05$).

Subjects (N=20) were undergraduates at The College of William and Mary who met with each of two counselors, in counterbalanced order, for an analogue of a beginning counseling interview. One counselor used representational system matching; the other counselor took a more generic, human relations, approach to empathy. After each interview subjects completed Barrett-Lennard's Relationship Inventory (RI) and Jourard's Willingness-to-Disclose Questionnaire (WDQ). Following their second interview subjects indicated their preferred counselor. Covariates were: 1) Carkhuff's Empathic Understanding Scale (EU) which also served as a dependent measure; 2) The Counseling Readiness Scale (Crs) of Gough and Heilbrun's Adjective Check List and 3) Rotter's I-E scale. The Latin-square design produced data analyzed by: repeated measures analysis of covariance (Hypotheses 1-3); stepwise regression (Hypotheses 1 & 2) and Chi square (Hypothesis 4).

Results indicate that both subjects and judges perceived the representational system matching counselor as more empathic than the generic empathy counselor. While EU accounted for 11.76% of the variance on RI-empathy scale scores, representational system matching accounted for 11.94% of the variance beyond that accounted for by EU. Clients preferred the representational system matching counselor by a ratio of 3 to 1.

It was concluded that representational system matching is an important dimension of empathy and the recommendation was made that beginning courses in counseling techniques and human relations training include a section on identifying and responding to client's representational systems. Recommendations were made for further study.