HELPFULNESS IN PSYCHOTHERAPY.

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ABSTRACT

The study reported is grounded in psychotherapy process research. Therapist - client verbal interaction was examined with respect to experienced helpfulness.

The main objective of this N=1 study was to identify those therapist responses which the client experienced as being `most helpful'. It was hypothesised that therapist responses which attended to the emotional component of client speech would be seen to be most helpful by the client. Results provided support for this hypothesis.

Additional hypotheses examined the degree of similarity between therapist intention and client impact and independent ratings of therapist response. As well, the therapist verbal modes were examined to see if they reflected his stated orientation of `mostly psychodynamic'. Results indicated coherence between client impact, therapist intention and independent coding, and consistency between stated orientation and actual use of verbal response modes.
Data analysis took two forms: a) qualitative and descriptive, using rating scales and a verbal mode taxonomy, and b) time series analysis of data generated by the use of a dial analogue measuring device. The latter generated data on client and therapist perceived helpfulness which was analysed with respect to a) cyclicity, b) coherence between the two series of data, and c) phase of data series, using Spectral Analysis. Results indicated that within both therapist and client-generated data, significant cyclicity existed. The trend over time suggested increasing coherence between the two sets of observations.

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CHAPTER ONE - LITERATURE REVIEW

Part One

1 - 1 - 1 Beginnings

It is usual to attribute the origins of psychotherapy to Sigmund Freud (Millon, 1969; Urban & Ford, 1971; Strupp, 1978). However, most authors allude to the fact that people have always been curious about themselves and their behaviour. So while the essence of psychotherapy is rooted in our existence, only since about 1900 with the advent of Freud's psychoanalytic theory, has it been seen as a formalised psychological intervention (Strupp, 1962; Korchin & Sands, 1983). Strupp (1962) applauds Freud as scientist and skilled psychotherapist who first utilised the psychotherapeutic situation as both a window on the functioning of persons and as the opportunity to evoke change in the face of interpersonal difficulties.

Freud cannot be credited so much with original ideas, but with the tenacity required to work these ideas into a systematic theory. Millon (1969) names the important influences that shaped Freud's ideas as Helmholtz, Brucke, and Meynart's physiological energy theory, the concepts developed by Darwin, and finally the work by Charcot, Bernheim and Breuer on hypnosis and hysteria. The work of these men provided the setting in which Freud gave birth to his ideas on psychoanalysis.

Thousands of years before Freud's time persons exhibiting bizarre behaviour were thought to be afflicted with evil

spirits. They were flogged, exorcised or had their skulls trephined. Hippocrates in the 5th century was the first to propose that origins of mental illness be looked on as arising in the person, not in the spiritual realm. His treatment consisted of prescriptions of exercise, diet, tranquility and where necessary, bloodletting.

Following this was a period of some 1000 years when old superstitions and inhumane treatment returned for the mentally distrubed. Demonic notions of possession and witchcraft were evoked to account for the behaviour of those possessed. As early as the late 1400's the first sign of more humane treatment appeared together with the notion that introspection lead to the recalling of distant and painful memories. This is one of the earliest forerunners to modern psychoanalytic thought. Implicit in the practice is the modern notion of a helping dyad; the helper encouraging the reflection of the helpee with the resultant expression of the helpee's thoughts and feelings.

It is important to note in this brief historical tracing of the efforts to deal with man's aberrant behaviour that the postulated cause of the behaivour, dictated the nature of the remedy. Although contemporary theories of psychiatry and psychopathology are more informed than ancient and medieval ideas, this same principle still applies today (Urban & Ford, 1971).

The development of the history of psychotherapy reveals an action-reaction pattern. The 'unconscious/internal forces'

emphasis of psychodynamic therapy, evoked the behaviourist principles which dealt solely with observable behaviour and drew no inferences about internal events at all (though this view has altered since the original radical behavioural view). In reaction to this behavioural view the cognitivists developed ideas based on man's cognitive functioning. On a lateral progression, the humanistic and existential therapies were developing, emphasising the whole person and their view of the world.

As well as the burgeoning of the practice itself, the field of those who did psychotherapy broadened around 1950, and its suitability as being only for those mentally ill, was revised. Amongst the group of those who practice psychotherapy can be found physicians, ministers, social workers, psychologists, school counsellors and those involved in the judiciary system. Today, the term psychotherapy is a generic one which covers a range of psychological interventions under a number of different theoretical schools (Strupp, 1978).

Urban & Ford (1971) provide a conceptual analysis of the field of psychotherapy which has developed laterally since its initiation 80 years ago at the hands of Freud and Breuer. Part of their discussion addresses the issue of heterogeniety of problems treated, therapists applying the techniques and those to whom the treatments are given. This issue is the basis for the approach taken in their chapter which provides an historical perspective from an examination of the development of ideas and concepts. They model for other

researchers what they advocate the field of psychotherapy is in need of. That is, the identification and description of the underlying trends and interrelationships that have become obscured in the growth of the domain of psychotherapy. Fifteen years later, current research is taking such a 'microanalytic' approach in its emphasis on specificity across the main variables which come under study.

Currently the field of psychotherapy faces the following issues: a) as a profession, implications for the training of its members, b) accountability to third parties such as insurance companies, Government agencies and its consumers, and c) the continuation of research into this complex and challenging area of mental health (Strupp, 1986).

1 - 1 - 2 Research in Psychotherapy

As Freud is heralded as the founder of psychotherapy, Carl Rogers is acknowledged as the pioneer of research in psychotherapy (Strupp, 1962; Bordin, 1974; Kirsch & Winter, 1983). And in the same way that Freud was not the originator of the ideas which formed his theory, Rogers is preceded by others who explored the techniques, verbal and non-verbal interaction, and characteristics of the therapeutic relationship.

The earliest recordings of interviews can be traced to Earl F. Zinn in 1929 (Dittes cited in Kiesler, 1973; Gottman & Markman, 1978). He was a psychoanalytic therapist who began to make recordings of his own interviews in 1930. Harold D. Lasswell, also a psychoanalyst, recorded skin resistance, heart rate, breathing and bodily movements during interviews.

Rogers began his work in 1940 at Ohio State University. Others such as John Dollard, Richard Newman and F. C. Redlich are all credited with having made permanent records of their own therapeutic work, but it was Rogers who made the greatest impact on process research in psychotherapy. While the very exercise of making a permanent record of the events of psychotherapy was challenging enough, the personal doubts of those who made the attempt, appeared to loom even larger according to Dittes (cited in Kiesler, 1973).

Research in psychotherapy has proceeded broadly along the following lines. Investigation of the process, including a) the therapist and patient as variables in the therapeutic process; b) techniques and other in-therapy behaviour processes; and c) the therapeutic relationship. Secondly, investigation of the effects of psychotherapy, which gives rise to questions such as a) does psychotherapy work ?; b) which psychotherapy is most effective ?; c) how much do the variables of therapist, client, relationship or techniques account for variance in outcome ? A third closely related area is research in personality theory (Gottschalk & Auerbach, 1966; Kiesler, 1971).

Rsearch into the two major areas developed as follows. Rogers' landmark of recording psychotherapy (1942) was preceded by experimental forays, usually in the form of the case study, which were seldom linked to theory. Priority at this stage was given over to the privacy and commitment of the therapeutic relationship. The case study method met this criteria. It provided a clinical description of the patient

entering therapy, the therapy process and the outcome. Usually case studies were only written up some time after therapy had ended.

The American stance recognised the case study as a means of evaluating outcome of therapy. However it was Freud who saw the case study not only as a means of outcome assessment but also as a rich source of information about the experience, personality and psychological functioning of his patients. Freud thus began to see the interview as a laboratory in which to conduct process studies of what took place between client and therapist. Electronic recordings enabled the therapeutic process to be viewed and analysed by objective observers. Prior to the events of therapy being made public by the recording process, case studies were viewed as scientifically weak. Antagonists of this approach, concentrated their efforts on establishing sound methodology to demonstrate the efficacy of therapy. They were interested in its effects, not the process. Permanent records of therapy provided the much needed qualitative increase in data collection for the process researcher. The field swung once more in favour of process research, the studies of outcome being viewed as inadequate with regard to the mechanisms of therapy.

Thus a see-saw pattern in the history of research in psychotherapy emerges. First the case study, replaced by scientifically based outcome research, which in turn was usurped by improved process study.

Bordin (1974) understands the changing emphasis in psychotherapy research in a different way. The scientist-practitioner dilemma (Meltzoff & Kornreich, 1970; Kiesler, 1971) contributed to both the history of research into psychotherapy and the problems in the field. Those who conduct pscyotherapy do so with a faith in its efficacy. They understand the efficacy to be directly tied to the nature of the relationship between therapist and client. This relationship is characterised by interpersonal interaction untainted by chemical interventions, or surgical treatments for example. The therapist's 'tools' are his very personal involvement with his client. Bordin (1974) maintains it is this subjective, empathic stance which blocks many therapists from implementing the scientific rigors of experimentation, or even to doubt their position at all. The therapist is thus divided in his motivations - to be humane healer or objective researcher? This dilemma has influenced the directions that psychotherapy research has taken.

Initially therapy interviews were recorded to more accurately define the components of specific techniques (mostly those associated with the client-centred approach) and to try and establish their efficacy. More recently process research has become less 'approach' oriented and more directed to the examination of verbal response modes of both therapist and client, and the therapeutic relationship.

Gottman and Markman (1978) address three major questions which they see dominate both of the broad areas of research. 'Is psychotherapy effective ?'; 'Which therapy is the most

effective ?' and thirdly, 'What are the crucial change factors in therapy that lead to effective outcome ?' They challenge the meaningfulness of the first query as it is worded. With the coming to light of variables that lack uniformity the efficacy question must be more specific. Similarly, Gottman & Markman (1978) are critical of the second issue which has occupied researchers in the last decade. The assumption behind the question of 'which therapy is most effective ?' is that it is valid to examine different techniques executed by different therapies with varying groups of patients and then compare the effects. The third question addresses the 'how' of therapy: what are the variables which produce successful outcome? This is the issue which process research takes as its starting point.

The following section traces further development of research issues via three National Conferences held from 1959 - 1968.

1 - 1 - 3 Three National Conferences on Research into Psychotherapy

Between 1958 and 1966 three national conferences were held in the United States on Research in Psychotherapy. They were sponsored by the Division of Clinical Psychology of the American Psychological Association. That the impetus existed to initiate the first conference is in itself a telling fact. That sufficient momentum was gained for two further conferences to be held tells us something about the zeitgeist of research into psychotherapy over the years between 1958 and 1966. The three volumes that resulted from the conferences are a window on the issues, topics and research

that was being conducted at that time, and is considered important enough in the history and development of ideas in research into psychotherapy to warrant this separate section.

Conference One: Washington D. C. April 9-12, 1958, reported in Rubinstein & Parloff (1959).

The idea for this conference first originated in 1956. Its aim was to promote the practice of evaluative research into psychotherapy. The salient issues of the time are revealed in the different topic areas: problems of controls, methods for assessment of change and therapist-patient relationships. Details of these papers will not be given here. They are cited as illustrative of the issues of the day. It is clear that process research was the main focus for this conference. The two papers on problem of control in research reported on developments in research projects being conducted at Phipps Psychiatric Clinic, and the Menninger Foundation. Methods for assessment of change consisted of papers on the dimensions and measurement of process in psychotherapy.

Parloff & Rubinstein (1959) summarised the first conference proceedings as follows. Firstly goals for research could be addressed under the headings of outcome, process and personality theory. Secondly, the ways in which investigators approached a particular study was influenced by his or her own values and assumptions. Parloff and Rubinstein (1959) divide investigators into two camps; the experimenters and the observers or naturalists. (This division was later noted by Meltzoff & Kornreich (1970), Kiesler (1973) and Bordin

(1974). Issues such as identification with other sciences, complexity of variables, precision versus significance, data collection, rigors of design, and evaulation of evidence determine the type and quality of methodology applied in research. And thirdly, selection of variables. The last of these proved to be the least troublesome. While conference participants disagreed on both goals and methods, there was a consensus over which variables were most important for study. Specifically, form of therapy and technique, the therapist, the patient and role of therapy.

Conference Two: Chapel Hill, North Carolina May 17-20, 1961, reported in Strupp & Luborsky, (1962).

Conference One had attempted to cover the entire area of psychotherapy research. The second conference highlighted and attempted to deal exhaustively with specific issues. This is reflected in conference topic headings such as research problems relating to the psychotherapists contribution to the treatment process, to measuring personality change in psychotherapy and to the definition, measurement and analysis of significant variables in psychotherapy. The focus is still on process research but in a way which emphasises increasing precision of methodology and variable selection and measurement. It is as if the researcher of the day knew what they needed to study but had to struggle to refine the tools and methods to enable them to study the phenomenon in a scientifically sound way. A note of interest is that in spite of the order and organization overlaid on conference topics and sections, the same old

familiar issues pushed themselves to the fore to be discussed again (Luborsky & Strupp, 1962). This conferences' discussants were less sharply divided than the first. They identified major research goals as the labelling of the interactions among or within the main set of variables in psychotherapy. Methodological problems were discussed at length. Two possible reasons are advanced for this. First the conviction that difficulties in this area will slow progress in the field of psychotherapy research, and secondly, methodological problems, while not easy, are a safe meeting ground for a group of researchers whose diversity more easily brings them into disagreement than affirmation over many issues. Another major topic of discussion was selection of variables, which centred around a) problems of data reduction and the size of units and b) neglect of content variables.

There is a consensus on the slowness of research into psychotherapy and Luborsky & Strupp (1962) address six issues which are implicated. Firstly, most conference attenders thought the greatest gain made from the conference was in hearing about and being given the oportunity to build on others' work in the area. Secondly, it is easy to lose sight of the 'youth' of psychotherapy research and expect too much too soon. Thirdly, it is easy to be discouraged by the complexity of the subject under study, and disparate approaches make discussion and learning of new information difficult. Fourthly, those who do psychotherapy research are faced with long term research programmes calling for commitment and financial resources. Fifth, those who do

research must be adequately trained and informed of the issues in the area (i.e. both clinical and methodological). And finally, accurate measurement and viable concepts are needed to carry psychotherapy research further forward.

Some of the eleven new growth areas in psychotherapy research are the emergence of analogue research, the value in treating the therapist as the dependent variable in order to gain insight into the mechanisms underlying decision-making in therapy, further investigation of the patient-therapist interaction, the future use of computers in research and further investigation of the role of expressed affect by the client as an important factor influencing change.

Conference Three: Chicago, Illinois May 31- June 4 1966, reported in Shlien, editor, (1968).

The major themes of this conference, Behaviour Therapy, Therapist-Patient Interaction and Psychopharmacology in Relation to Psychotherapy, illustrate a change in focus from both the first and second conferences. It is indicative of the changes which took place in psychology and psychotherapy research and illustrates the heralding in of behaviourism and its contribution to psychotherapy. Exploration of the complex intra-therapy processes is still topical and a new theme is emerging in the form of psychopharmacology and its relation to psychotherapy. The topic headings were devised by survey of the rosters of mental health research grants held by the National Institute of Mental Health, and from questionnaires to researchers from the conference committee. Thus, they

reveal the nature of the actual current research taking place. Some research projects emerged that were of a high quality but not enough of them to warrant a section in the Conference. Two of these were child and family therapy and community mental health work.

The following are the main points of Shlien's (1968) introduction and overview. The psychiatrist - psychologist division had disappeared; which area of the field a researcher was working in seemed more important. Tape recordings of daily sessions and discussions revealed behaviourists identifying reinforcement schedules in the work of interactionists, and psychoanalysts seeing elements of their therapy in what the behaviourists did. The fourth 'special ' section of the conference comprised of a large scale study on the person of the therapist; the use of pupillary assessment in the study of affect and emotional change; and a summary of the work being carried out at the Menninger Clinic. Shlien (1968) notes the increasing use of videotape material that presenters illustrated their work with. The request for collaborative research was made again and in response a committee was set up to investigate the feasibility of such a project. The following section of this thesis looks at the findings of the committee.

1 - 1 - 4 What Emerged From the Third Conference

A major thrust of all three conferences had been the suggestion that research into psychotherapy take a collaborative shape. The setting up of an investigative

committee resulted in Bergin & Strupp's (1972) 'Changing Frontiers in the Science of Psychotherapy'. It is the product of three years investigation at both a formal scientific level as well as at a more personal level via interviews with researchers, therapists, psychiatrists and psychologists. The following is an overview of their work.

The first step involved in testing the feasibility of collaborative work was to review the literature on psychotherapy research to date. Their findings are reported in chapters two and three of the book. The conclusion regarding the feasibility of collaborative research was tentative and further investigation was recommended. The Feasibility Study undertook this recommendation and resulted in the folowing: a) exploration of research questions, designs and methodology, and discussion of the possibility of consultation and collaboration in these areas; b) the setting up of an inventory of resources available for collaborative research was explored and key personnel at different levels in the relevent agencies and centres were interviewed; c) recordings were made of the outcome of such visits and meetings with consultants. These would form the basis of a detailed report of the feasibility of specified collaborative research projects.

Bergin & Strupp (1972) present a richly informative view of the current state of psychotherapy research. In an unusual move, they include personal summaries and reflections throughout the discussion papers. The overview of their literature search seeks to be clear and objective. In this

way their work is a unique blend of objectivity and personal beliefs and opinions. They are of the opinion that research to date has not made an impact on the field of psychotherapy. The following reasons are cited. 1) Lack of sound methodological tools, 2) problems with design and control groups, 3) the collection and analysis of data from representative groups, 4) conducting follow up studies, 5) the co-operation of therapists, patients and institutions, 6) matching scientific designs to the complex phenomenon to be measured, 7) questionning of the usefulness of analogue studies that endeavour to overcome the above dificulties.

Three problems that have beset researchers are highlighted. These are the problems inherent in man's study of man; the isolation of researchers in the field; and the variability of the factors involved in psychotherapy. This last issue is in line with Kiesler's (1971) explication of the `uniformity myth'. Bergin & Strupp (1972) call for specificity of therapist and patient variables, identification of the overlap between therapist, patient and treatment variables, precision of outcome criteria, and design strategies which enable the therapy efficacy controversy to be addressed.

Examples of prevailing trends are behavioural techniques and learning theories, the evolution of a non-school approach, greater specificity of technique, investigation of the therapist's personality vs technique, the ever-present outcome problems, and identification of the processes and ingredients of psychotherapy, including the patient's ability and desire to make use of the therapist-offered conditions

and interventions. The last area is one which has emerged progressively onto the centre stage of psychotherapy research. The study reported in this thesis is grounded in this context.

The foregoing summarises some of the main points in Bergin & Strupp (1972). The reader is recommended to this resource material for its honest, personal and informative view of psychotherapy research up to that time.

Part 2

1 - 2 - 1 A Definition of Psychotherapy

Investigation into any phenomenon requires accurate and cogent description and definition of the phenomenon according to Nagel (cited in Greenberg, 1983). The difficulties that may arise if this is not the case are that studies purporting to examine the same issues may in fact be examining different issues. Difficulty in coming to an agreed upon definition of psychotherapy has been acknowledged (Strupp, 1978; Korchin & Sands, 1983; Hersen, Michelson & Bellack, 1984). This difficulty seems to arise because of the inherently complex nature of the subject under study (Bordin, 1974). The term psychotherapy can be used in a generic sense to denote a range of psychological procedures and techniques developed from different psychological theory; in a specific instance is taken to mean an interpersonal relationship that aims to bring about change in the client of the therapeutic dyad; or to denote the actual mechanisms of problem-solving, suggestion, re-learning and emotional expression, as it is practised.

A distillation of the many offered definitions of psychotherapy (Meltzoff & Kornreich, 1970; Strupp, 1978; Korchin & Sands, 1983; Hersen et al, 1984) leaves us with the following core characteristics: 1) the deliberate application of psychological techniques based on scientifically derived principles which are, 2) carried out by a trained person who has the intention of helping to alter the thoughts, feelings and/or behaviour of the client, 3) in the context of a professional, mutually respectful human relationship. This distillation takes account of the four most basic elements which make up psychotherapy: the person of the therapist, the person of the client, their specialised human relationship, and the techniques which the therapist brings to bear within that relationship. That this 'definition' has some accuracy is borne out by the fact that the field of psychotherapy research takes as its main topics for study, the four elements cited.

These four main elements may be characterised as follows. 1) Psychological techniques are not applied in the sense that something is done to the client, but are entered into in a collaborative sense by both therapist and client (Strupp, 1978). Techniques form a diverse range which take as mediums the different channels of human expression and functioning e.g. behavioural techniques target behaviour acts; psychodynamic techniques use both verbal and emotional channels. An important caveat here is that no therapy uses exclusively one technique or one channel to access change in the client. Therapies have been shown to differ more within

schools, than between them (Yalom & Lieberman cited in Lambert & Bergin, 1983). Processes which all therapies may share have been identified (Korchin & Sands, 1983). These are suggestion, persuasion, emotional arousal, learning and relearning, identification and modeling, self-exploration and understanding, feedback and reality-testing, practice and rehearsal, mastery and success experiences.

2) Therapy is practised today by a wide range of people whose training varies from university-based post-gradutate courses in Clinical Psychology to short-term counselling skills courses offered in the community. Therapists have been likened to God in that they ought possess such virtures as patience, honesty, sensitivity, emotional maturity, wisdom and objectivity (Parloff, Waskow & Wolfe, 1978). The therapist must be aware of a number of ethical considerations e.g. adequate diagnosis, choices of treatment, length of time of treatment, and relative costs.

3) Those who receive psychotherapy may do so voluntarily to ameliorate painful affect or undesirable thoughts and behaviour. A different population of clientele will receive psychotherapy because the therapist, in collaboration with other professionals, makes an informed decision for him regarding the suitability of psychological intervention. The latter are more likely to be psychiatric patients or criminal offenders, while the former group are likely to suffer from neurotic disturbances of anxiety and depression, sexual dysfunction, and relationship difficulties. Psychotherapy is available for children, couples, families and adult

individuals.

Perhaps the most important characteristic that emerges from 2) and 3) with regard to research into psychotherapy is the heterogeneity of these two populations. The ramifications this has for the researcher is addressed in later sections.

4). All that is psychotherapy takes place within an interpersonal context. Many researchers today believe the therapeutic relationship to be one of the most vital factors leading to positive outcome (see section on Relationship variables). It differs from day-to-day human relationships in that the therapist is a specially trained person (Strupp, 1978), the intervention is a deliberate and planned one, and the relationship exists within the strictures of professionalism e.g. socialising and intimate contact between therapist and client is ruled out by these considerations.

Inclusion of the details from 1) through 4) in a definition of psychotherapy would be too cumbersome to be useful. However, they are stated here as evidence of the multi-faceted nature of psychotherapy and the difficulties encountered in trying to make a neat package out of the essental elements of such a complex human process.

1 - 2 - 2 The Therapeutic Relationship

If attempting a clear, concise definition of psychotherapy is a daunting task, then describing the therapeutic relationship, its potency in the therapeutic process, and

suggesting how and what aspects of it to measure, poses problems which appear insuperable (Bordin, 1974). The concept of the therapeutic relationship is confusing. Does it refer to the facilitative conditions espoused by Rogers (1957); other therapist-offered conditions such as specific techniques or aspects of his or her personality; client-offered conditions (Bordin, 1974; Lambert & Bergin, 1983); or is it the sum of the verbal communication between therapist and client ?

The term 'relationship' implies at least two components which behave in relation to each other. A Gestalt psychologist may assert that the relation between these two components is more than they each bring to the interaction. Others would say that the relationship arises out of the characteristics and qualities of the components and nothing more. This indicates to the author that research needs to proceed along parallel lines investigating both therapist and client attributes, as well as the purely interactional aspects of their relationship (Bergin & Strupp, 1972). Given this indication, variables targeted for study of the therapeutic relationship ought to be therapist and client personality, therapist-offered conditions and style, client readiness and ability to use therapy, and the verbal and nonverbal aspects of communication which makes up their interaction e.g. counsellor and client verbal responses and voice tone, eye contact etc.

Investigation of some of these variables has already been undertaken. Although the following are not always presented

under the rubric of 'the therapeutic relationship', a summary of one group of studies will be presented here because of their prolific nature and the impact they have had on psychotherapy process research.

Therapist-offered conditions as the definitive variables in the therapeutic relationship have received a great deal of attention from the Rogerian school of client-centred therapy (Rogers, 1957; Rogers, Gendlin, Kiesler & Truax, 1967). Accurate empathy, nonpossessive warmth and genuineness have been the subject of a number of studies, while other researchers have developed scales with which to measure the conditions (studies cited in Parloff et al, 1978). Parloff et al (1978) conclude that Roger's (1957) hypothesis remains essentially untested. Moreover, it would demand an incredibly sophisticated and complex research design to test Roger's (1957) ideas due to the fact that they cover several parameters of the phenomenon of psychotherapy. More importantly, they point out, these ideas have stimulated an enormous amount of work in the area of therapist/relationship variables in psychotherapy.

Despite the non-acceptance of Roger's (1957) specific hypothesis, researchers clearly affirm the importance of the therapist-client relationship in therapy (Butcher & Koss, 1978; Parloff et al, 1978; Korchin & Sands, 1983). Schools of therapy which differ in theoretical stance are in agreement regarding the therapeutic relationship's central importance to therapy outcome (Parloff et al, 1978). The relationship between therapist and client has been variously referred to

as the `therapeutic alliance' (Korchin & Sands, 1983; Strupp, 1978), the `working alliance' (Bordin, 1974), or simply the `therapeutic relationship' (Meltzoff & Kornreich, 1970; Parloff et al, 1978). Freud is one therapist/researcher who attempted to bring some clarity to the concept of the therapeutic relationship. He distinguished between the transference relationship and the working alliance (Korchin & Sands, 1983). Since then, other psychoanalytic theorists have continued to work on Freud's distinction (Greenson cited in Korchin & Sands, 1983).

The following are more recent examples of research in the therapeutic relationship area. Luborksy's (1977) study (cited in Korchin & Sands, 1983) is based on the concept of the therapeutic alliance. He makes the distinction between type 1 and type 2 working alliances. Type 1 refers to the experience of the patient as being the recipient of the therapist's help and support, whereas a type 2 alliance is characterised by a sense of patient and therapist working together to overcome the patient's difficulties. Over the course of therapy there may be movement from type 1 to type 2 alliance, and Luborsky (1977) hypothesised that patients who experience improvement are more likely to be engaged in type 2 working alliances. However, what he found was that patients who improve the most are more likely to belong to the type 1 category. It is noted that Luborsky's (1977) type 2 working alliance takes an interactional view of the therapeutic relatonship.

The Mintz, Luborsky & Auerbach (1971) study demonstrated

relationship variables to be strongly implicated in positive outcome. Further, it reveals these relationship factors to be therapist-offered. e.g. reassurance, warmth, acceptance of the patient, perceptive and empathic. However, the relationship variable factor was just one of four that accounted for succesful outcome.

This section has attempted to address the conceptual complexity of the therapeutic relationship. Confusion in the research has been acknowledged, as well as the important impact of the work of Rogers and his colleagues. Examples of more recent research are cited. A fuller review of this area is made difficult by the lack of clarity in the definition and description of the therapeutic relationship. Studies which compliment the area are reviewed under separate section titles such as The Person of the Therapist and The Client and her Characteristics. Three important points emerge from the foregoing: 1) the importance of the therapeutic relationship to therapy outcome is universally accepted therefore research must continue in this area; 2) as long as researchers do not specify their conceptual basis for study of the therapeutic relationship, confusion will continue to exist in the literature and workers in this area will be blocked from building on each others contributions, and 3) when relationship variables have been specified, accurate measuring devices need to be developed.

The immediate context of the study reported in this thesis is process or content analysis research. However, it also represents an indirect analysis of the therapeutic

relationship taking as it does the verbal interaction between therapist and client as its dependent variable. Therefore an implicit belief and part of the rationale of the current study is attached to the vital role played by the therapeutic relationship.

1 - 2 - 3 The Person of the Therapist

One of the main variables which comes under study in psychotherapy is the therapist. Researchers have acknowledged that the person of the therapist may be one of the most potent influencing factors on therapy outcome (Lambert & Bergin, 1983). Qualities such as warmth, empathy, experience, and specific personality characteristics have received a great deal of attention in this area (Lambert & Bergin, 1983). Two major reviews in the last fifteen years have attempted to present summaries of the numerous studies on the person of the therapist (Meltzoff & Kornreich, 1970; Parloff et al, 1978). More recently Barrett & Wright (1984) outlined there own summaries of these reviews and presented further summaries of studies conducted since 1977. In the interests of space, the interested reader is referred to the Meltzoff & Kornreich (1970) and Parloff et al (1978) reviews for the background to this inclusive, complex area of psychotherapy research. The more recent works of Barrett & Wright (1984) and Lambert & Bergin (1983) are the main sources for the following section. However, in some cases the Meltzoff & Kornreich (1970) and Parloff et al (1978) reviews remain the best existing accounts. They will be cited as necessary.

Therapist variables may be classified in a number of different ways. Lambert & Bergin (1983) suggest a static trait/process variable distinction which has clarity and meaning. For the purposes of the following summary, therapist variables are addressed under two categories which roughly map onto the Lambert & Bergin (1983) conceptualisation. These are: A. The person of the therapist, including (i) personality (ii) demographics of age, gender, race, socioeconomic status (iii) level of experience (iv) training and professional orientation (v) mental health and personal therapy (vi) attitudes and expectations; and B. In-therapy behaviour of the therapist, including (i) therapist style (ii) therapist interventions (iii) therapeutic relationship.

A. The Person of the Therapist.

(i) Personality

The personality of the therapist interacts with and influences the person of the client, therefore it is an important variable to study (Lambert & Bergin, 1983). One of the underlying rationales of such research is the possibility of matching therapist and client on personality dimensions to maximise the opportunity for positive therapy outcome (Lambert & Bergin, 1983).

Meltzoff & Kornreich (1970) distinguish between the possibility of a `therapeutic personality' and therapist-offered conditions (Rogers, 1957). This is an important distinction to make since confusion has appeared in the literature over these two concepts. One type of research

has dominated the field of study into the `therapeutic personality' (Lambert & Bergin, 1983; Barrett & Wright, 1984). This is the Whitehorn & Betz (1954) A-B classification of therapist types. Since their original study, researchers have failed to replicate their findings and the A-B therapist personality dimension has lost credibility.

Other studies reported by Barrett & Wright (1984) have attempted to control the therapist personality variable by having the same therapist conduct more than one treatment, by the use of manual guided therapies, and closely related, the standardising of therapies. They draw attention to the inherent difficulties of therapist personality research e.g. personality measurement, and the reliability of personality questionnaires. Their comments are an echo of fourteen years previously (Meltzoff & Kornreich, 1970).

(ii) Demographic variables

Gender.

There is no reliable evidence to suggest that clients should be assigned to therapists on the bais of gender (Lambert & Bergin, 1983).

Jones & Zoppel (1982) (cited in Barrett & Wright, 1984) are critical of the research to date on three counts. 1) The confounding of therapist gender with other variables (e.g. age, experience); 2) the weakness of analogue studies; and that 3) past research has usually used only female patients as dependent variables. They conducted two studies to

examine the effect of gender on outcome from both the therapists and the clients point of view. Results reveal differences in the way that male and female therapists view outcome and their clients and the therapeutic alliance.

Another study measured the responses of 118 patients to the gender of 27 therapists (Orlinsky & Howard, 1976). Reports of therapy sessions showed that 15 dimensions of their experience in therapy varied significantly as a result of therapist gender. However, these are serendipitous findings and may lack adequate controls (Meltzoff & Kornreich, 1970).

With the advance of womens' rights the effect of therapist gender may come more under study in the near future.

Age.

There is only brief mention in the literature covered regarding the effect of therapist age on therapeutic outcome. Karasu, Stein & Charles (1979) (cited in Lambert & Asay, 1984) discovered that therapists developed better relaionships with clients of approximately the same age.

Interestingly, age of the patient is a variable which has come under study (Meltzoff & Kornreich, 1970; Garfield, 1978; Lambert & Asay 1984). This reflects the earlier trend in psychotherapy research of taking the client as the dependent variable rather than the therapist (Parloff et al, 1978). This area is reviewed next in the section on the client and her characteristics.

It is reasonable to hypothesise, given the absence of any studies that the age of the therapist is an influencing factor on at least intermediate therapy outcome and the smoothness of the therapeutic process. Older therapists more easily fit into the transferential parent role, while younger therapists may raise anxieties regarding confidence and skill in older aged clients.

Race.

Studies to the time provide no conclusive evidence for or against racial matching (Lambert & Bergin, 1983). Further study should investigate therapist attitude and therapeutic approach toward racial issues (Parloff et al, 1978). Jones (1978) (cited in Barrett & Wright, 1984) suggests that racial factors may effect therapeutic process without effecting outcome measures.

Socioeconomic Status (ses)

There has been little research in this area (Parloff et al, 1978), though the issue has received widespread attention (Lambert & Bergin, 1983). Existing studies focus on therapist attitude and their response to patients of varying ses, and ses matching of the therapist-client pair. The following themes emerge. Middle class patients are more likely to receive psychological treatment and stay in treatment longer; middle class therapists are more likely to see middle class patients; therapist characteristics and attitudes may be more important in their treatment of patients from varying ses than their own ses of origin.

(iii) Level of Experience

It is intuitively appealing to associate a high level of therapist experience with positive therapy outcome. (If one's skills do not improve with age, the future seems rather bleak!) The literature is not clear on the results of studies in this area (Lambert & Bergin, 1983). Parloff et al, (1978) did not find experience to be highly related to outcome. Other studies have shown that both training and experience result in a demonstrable increase in skills (Barrett & Wright, 1984).

Level of experience is confounded with age, and adjustment to life. As well, this concept may obscure specific therapist characteristics such as confidence, integration, flexibility and knowledge (Lambert & Bergin, 1983). These and the following methodological problems may account for the confusion in this area of the literature. 1. Definition of 'experienced/inexperienced' therapists; 2. assignment of patients to therapists; 3. the problem of measurement of outcome (Parloff et al, 1978). They recommend future studies address these problems. Other recommendations have been to study therapist experience as a major independent variable (Lambert & Bergin, 1983).

(iv) Training and Professional Orientation

The most comprehensive review on the trained vs untrained therapist debate of the four works cited, is undertaken by Meltzoff & Kornreich (1970). They conclude that the issue remains untested. More recently Lambert & Bergin (1983) assert that type of training has yet to be documented as

exerting a major influence on therapy.

Theoretical or professional orientation has been shown to reflect itself in differential therapeutic behaviour (Gustavson, Cundick, & Lambert, 1981, cited in Lambert & Bergin, 1983). However, other studies have revealed that leaders of group therapy with different theoretical positions were more similar to each other in behaviour than different (Yalom & Lieberman, 1971, cited in Lambert & Bergin, 1983).

(v) Mental health & Personal Therapy

The evidence appears to be overwhelmingly in favour of a high degree of therapist mental health being linked to successful therapy outcome. (Parloff et al, 1978; Lambert & Bergin, 1983). However, Lambert & Bergin (1983) warn that further controlled studies are required in this area.

Barrett & Wright (1984) are unable to draw any firm conclusions regarding the desirability of personal therapy for therapists. At the least it makes sense that personal psychotherapy should be made avaialable to those training as therapists. This recommendation is based on the belief that the person of the therapist, her adjustment to life and level of comfort or acceptance of self, will be reflected in her degree of efficacy in the therapeutic process. This has implications for the training packages offered to psychologists, psychiatric registrars and less formalised counsellor training programmes.

(vi) Values and Expectations.

Therapist held values in psychotherapy are thought to be both important, and unresearchable, at least today, given the available methodology (Barrett & Wright, 1984).

Traditionally it is the patient's expectations which are the dependent variable, rather than the therapist's (Lambert & Bergin, 1983). Some research has focussed on the pre-therapy manipulation of therapist expectations of their client (Lambert & Bergin, 1983). Correlational and laboratory studies are the type most commonly used in this area. Unfortunately they rule out the possibility of establishing any causal relationship between therapist expectation and therapy outcome (Lambert & Bergin, 1983). This is due to the poor internal and external validity of these research designs.

B. In-Therapy Behaviour of the Therapist

(i) Therapist Style

The term style is intended to refer to the myriad of ways in which the therapist relates to her client (Lambert & Bergin, 1983). Focus is on the way in which the message is communicated, accompanying body language, voice tone, affective expression etc. The dimensions of therapist behaviour which come under the rubric of style are those aspects of the therapist's emotional expression which are less amenable to control e.g. voice tone (Lambert & Bergin, 1983). They review studies which examined the structual features of client and therapist language and amount of time therapist spent talking. Matarazzo (1978) claims that therapist style will change as a function of experience and

training. (e.g. length of sentence or paragraph decreases with either experience or training).

Ehrlich, D'Angeli & Danish (1979) examined the effect that the therapist's verbal response has on the client. Their dependent variables were clients verbal reponse and clients perception of therapist. Results showed that therapists reponses of the category `feeling reflections' were most likely to elicit desirable client behaviour. In addition therapists using this mode were seen to be more attractive, expert and trustworthy. The findings of this study are closely associated with the hypothesis of this thesis study (i.e. therapist attention to the affective component of client statements - `feeling reflections' - is experienced as most helpful on a scale of extremely helpful to extremely hindering by the client. Thus the study reported in this thesis can be anchored in therapist style research.

Therapist style can also be studied under the authoritarian, ambiguity-specificity dimensions, and the directive/non-directive dimension. Summarising the work done in this, Lambert & Bergin (1983) conclude that therapist directiveness or non-directiveness appears to influence therapy process but the relationship of this style to outcome is not clear.

(ii) Therapist interventions

There is certainly not a clear distinction between the interventions or operations of the therapist and therapist style (Lambert & Bergin, 1983). On another dimension,

confusion exists between therapist inervention and therapist-offered conditions (Lambert & Bergin, 1983). It is clear that this area is a difficult one in which to do controlled research. However, Lambert & Bergin (1983) identify several well known techniques and interventions some of which have been received attention in the research literature. These are the verbal techniques of interpretation and self-disclosure, and role-playing, use of imagery, and cognitive and behavioural techniques. The later section of Therapeutic Technique as a main variable provides more detail on this topic.

(iii) Relationship variables

The previous section dealt exclusively with relationship variables in psychotherapy outcome. The reader is referred to this.

1 - 2 - 4 <u>The Client and her Characteristics</u>

The other half of the therapeutic dyad is the client or patient. (In the following discussion the terms patient and client will be used interchangeably). The most important defining characteristic of the client is that she is troubled and dissatisfied with life (Strupp, 1978). The goal of the psychotherapeutic enterprise is to bring about change in the life of the client. Thus the client is a vital variable to study in psychotherapy research. Traditional research has examined client characteristics such as motivation, expectancy and maladjustment, as well as demographic variables (Meltzoff & Kornreich, 1970). More recently, the focus has shifted to other factors which the client brings

into therapy and which seem to be implicated in the formation of a therapeutic relationship (Lambert & Asay, 1984).

Similar difficulties exist in the study of patient characteristics as they do in the study of therapist variables. (e.g. confounding of demographic factors, measurement of constructs such as personality and motivation, difficulty of defining and measuring outcome, and the interaction of client with therapist variables.) Another of these is the assumed homogeneity of patient populations. There is evidence to suggest that clients fall into at least three distinct groupings (Garfield, 1978). These are 1. those who voluntarily seek psychotherapy; 2. those who are referred; and 3. those who are selected.
These distinctions have implications for the generalizability of study results, and suggest a closer examination of the assumed homogeneity of the client population.

Discussion of client variables and their influence on patient continuation in therapy and therapeutic outcome is addressed under the following headings. A. Personality B. Demographic Variables (age, gender, race, I.Q., education, socioeconomic status or SES) C. Pre-treatment factors (diagnosis, maladjustment, readiness) and D. In-therapy determinants (expectations, motivation and relationship with therapist)

A. Personality

Lambert & Asay (1984) report those studies which have examined aspects of client personality in relation to therapy outcome. Common dependent variables are ego strength, (as

measured by Barron Ego Strength Scale (Barron, 1953b, cited in Lambert & Asay, 1984) and the Klopfer Rorschach Prognostic Rating Scale (Klopfer, 1951, cited in Lambert & Asay, 1984); locus of control; introversion-extroversion; suggestability and psychological mindedness. Of these ego strength and locus of control are seen to be the most promising as therapy outcome predictors. Their is clearly a need for clear definition and accurate measurement in this area.

B. Demographic Variables

Age

The age of a client may be related to selection for therapy, continuation or outcome. The relation to continuation and outcome does not appear strong, however, there exists a considerable bias toward younger patients in selection for therapy. (Meltzoff & Kornreich, 1970; Lambert & Asay, 1984). Other issues in this area is the confounding of age with other client characteristics, (e.g. abilities or education), and the preference of most therapists to see younger clients or clients similar in age to themselves. (Bailey, Warshaw & Eichler, 1959 cited in Garfield, 1978); Lambert & Asay (1984).

Gender

Client gender is not seen to be significantly related to either therapy continuation or therapy outcome (Meltzoff & Kornreich, 1970; Garfield, 1978; Lambert & Asay, 1984).

Race

There is a frequent confounding of race with socioeconomic

status (SES), although there have been some studies which have looked at race distinct from SES (Krebs, 1971 cited in Lambert & Asay, 1984). It is generally agreed that the race of the client does not strongly effect outcome. However, attitudes and expectations of both client and therapist toward racial factors may effect the development and progress of therapy, particularly the formation of a therapeutic alliance (Garfield, 1978; Lambert & Asay, 1984). The claim that the race of the client per se does not effect outcome, only the attitudes and beliefs concerning it, may be too simplistic. Even a racially sympathetic and informed therapist of a different race to her client, begins from a handicapped position which must surely influence therapeutic outcome.

I.Q.

Not surprisingly, some research has offered support for the notion that outcome and I.Q. are positively correlated (Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971 cited in Lambert & Asay, 1984). Recommendations are that the relation between I.Q. and outcome be studied across varying therapies with different I.Q.'s for patient groups (Meltzoff & Kornreich (1970).

Education

It is acknowledged in the literature that I.Q., SES, and education are often correlated (Meltzoff & Kornreich, 1970). Garfield (1978) reports positive findings of educational status and its relation to outcome, but offers warnings regarding the poor methodology involved in some of these

studies. Like race, educational level may generate 'secondary variables' such as expectation and understanding of therapy, which may in turn dovetail into the therapists responding attitude towards his client (Meltzoff & Kornreich, 1970).

Socioeconomic Status

Meltzoff & Kornreich (1970) review studies in a range of areas; social class and source of referral, expectations about therapy, selection and acceptance for therapy, etc. The Hollingshead 2-factor index of Social Position is reported as being a common measuring device in these studies. Garfield (1978) and Lambert & Asay (1984) both report that social class is positively related to both selection for psychotherapy and continuation in therapy. However, the relationship between SES and outcome is less clear.

C. Pre-treatment Factors

Diagnosis

Meltzoff & Kornreich (1970) examine therapeutic outcome in relation to several different diagnostic groups including psychoneuroses and personality disorder, phobias and psychosomatic disorder. Apart from this contribution, there is little to be found in the literature regarding diagnosis of patient and the relation to outcome.

On examination it would seem that diagnosis could be confounded with such factors as therapist characteristics (e.g. experienced therapist matched to less favourable diagnosis, or the opposite; therapist attitude; type of therapy (school, out-patient, in-patient) and length of

treatment. (Heither, 1967 cited in Lambert & Bergin, 1983).

Maladjustment

It is commonsensical to supppose that those patients who are not severely maladjusted would do better in psychotherapy than those who are. However, not all the research has confirmed this (Meltzoff & Kornreich, 1970). They explain these conflicting findings with reference to the lack of specificity of the maladjustment/poor outcome hypothesis. Difficulty lies in the lack of precision of definition of maladjustment and its measurement, (Meltzoff & Kornreich, 1970; Lambert & Asay, 1984) and outcome criteria (Garfield, 1978).

Readiness

The concept of patient readiness to enter therapy and take an active and positive role makes intuitive sense but has had little empirical investigation (Meltzoff & Kornreich, 1970). It is conceptually unclear but seems to refer to something else other than motivation, or favourable client characteristics (e.g. psychological mindedness). This factor is useful clinically and heuristically but needs precise definition and measurement before research could yield useful results.

D. In-therapy Determinants

Expectations

Initially expectations of the client were assumed to refer to the pre-treatment period (Garfield, 1978). However, the literature reflects the exploration of this variable in

relation to both continuation and outcome (Garfield, 1978; Lambert & Asay, 1984). Conceptually it has been confused with such factors as faith, belief, credulity, anticipation and confidence. Garfield (1978) advises clarity with regard to the term before further research is undertaken. Results of studies in this area are at present unclear. However, they suggest that a) if patients and therapists expectations are compatible there is less chance of premature termination, b) there is a positive relationship between client expectation of improvement and actual later improvement, but no clear relation between expectation and outcome, and c) no doubt client expectations alter throughout the course of therapy and are influenced by those of the therapist.

Motivation

Most clinicians believe that motivation is one of the necessary pre-conditions of therapy for the client. Yet such an important variable remains ill-defined and measured. Lambert & Asay (1984) highlight two reasons why motivation is a difficult construct to research. Firstly, like expectations and attitudes, motivation changes during the course of therapy. And secondly, the term itself is imprecise. Understandably then, the literature reviewed reveals conflicting results; some studies show a positive relationship between motivation and successful outcome, others none at all (Lambert & Asay, 1984).

Relationship with Therapist

The relationship which therapist and client form has long

beeen acknowledged as a potent influencing factor on therapy outcome. Until recently, emphasis in the research has been on contributions of the therapist rather than the client. However, some researchers are beginning to identify client-offered conditions which may crucially effect the therapeutic relationship and thus the outcome of therapy (Gomes-Schwartz, 1978; Strupp, 1980 cited in Greenberg, 1983 Marziali, Marmor & Krupnick, 1981 cited in Lambert & Bergin, 1983). Lambert & Bergin (1983) conclude that therapeutic techniques might be better directed at reducing client opposition and resistance to becoming fully involved in the therapeutic relationship.

In the future, client characteristics targeted for research may be identified as willingness and ability to participate in, and make use of the therapeutic relationship and the techniques and interventions which are brought into play in its context (Strupp, 1980). The next section discusses the role of techniques in therapy alongside therapist, client and relationship factors already presented.

1 - 2 - 5 Therapeutic Technique

Section 1 - 2 - 1 attempted a definition of psychotherapy which could be summarised as a learning process involving both talking and experiencing which takes place within a specially designated human interaction. Psychotherapeutic techniques can be conceptualised as the planned interventions made by a therapist with the goal of effecting some kind of change in the client. Such interventions should be tied to psychological theory (Lambert & Bergin, 1983).

Varying techniques range over 200 different therapies that exist today (Herink, 1980 cited in Korchin & Sands, 1983). Examples of more well known techniques include interpretation, reflection, self-disclosure, action methods, gestalt methods and cognitive-behavioural interventions. This section aims to outline the current major issues for psychotherapeutic techniques in psychotherapy research.

Therapeutic techniques are inherently difficult to study and it is possibly this factor which has contributed to the debates which exist regarding them on more than one dimension. Firstly, technique in therapy is unable to be studied in isolation. Technique relies on an executor who is engaged in a relationship with another person - the client. This relationship is subject to change. Therefore technique interacts with the person of the therapist, the person of the client and the situational variables which exist at any one time (Bergin & Strupp, 1972). This has lead to the first of the questions prominent in this field; `Which is the most potent factor in therapy: the therapeutic alliance or applied therapeutic technques ?' Current feeling favours the former (Korchin & Sands, 1983). They divide the factors involved in the therapeutic interaction into two classes: the therapeutic climate and specific therapeutic processes. The latter is perceived as `figure' while the climate of the therapeutic encounter (relationship, therapist-offered conditions and characteristics of the patient) forms the `ground' against which the processes are developed. They argue for the dominant potency of the therapeutic climate on two grounds: 1) the climate sets the scene for the process or techniques

to take place, and 2) the different schools of psychotherapy have more in common in terms of climate than techniques. Rogers (1957) also conceived of therapeutic techniques as existing in the service of providing the necessary and sufficient conditions for personality change. In contrast, Sandell (1981) (cited in Lambert & Bergin, 1983) using the Vanderbilt Negative Indicators Scale (VNIS) to examine therapeutic processes and their relation to outcome, concluded that `errors in technique' (one of the 5 subscales) was the most successful at predicting outcome.

While many investigators today argue for commonality between the different therapies (Korchin & Sands, 1983) and major reviews and meta-analysis of studies supports the `therapy equivalence' position (Luborsky, Singer & Luborksy, 1975; Smith & Glass, 1977), evidence exists that points to remaining differences in technique. Studies on verbal technique have been able to differentiate schools of psychotherapy using Verbal Classification Systems (Gustavson, Cundick & Lambert, 1981, cited in Lambert & Bergin, 1983; Hill, Thames & Rardin, 1979; and Stiles, 1979). This apparent incongruency has been referred to as the outcome equivalence/content nonequivalence phenomenon (Stiles, Shapiro & Elliott, 1986). Stiles et al (1986) in the current bid for specificity, ask the question of the outcome equivalence result, `equivalence with regard to what?' They name three types of equivalence; outcome, content, and mechanism. Under these headings they review the possible resolutions to the equivalency/nonequivalency paradox.

1. Challenges to Outcome Results: a) Meta analysis reapplied (Shapiro, 1985) could reveal differences amongst the therapies in contrast to the original `Dodo' result i.e. as in `Alice in Wonderland', "all have won and all must have prizes." (Luborsky et al, 1975). b) The second proposed resolution to outcome equivalence comes from the relatively new understanding and acceptance of the variability that is inherent in the psychotherapeutic process. The equivalence outcome phenomenon is the result of averaged results across varied therapist, client and situational groups. The `matrix paradigm', treatment x therapist x client x problem x setting, poses practical research problems due to its complexity, but provides a way of ordering the thinking of psychotherapy investigators. c) The third challenge is directed at lack of specification and description of therapists operations. The `therapeutic technique label vs what the therapist actually does' issue. Manuals and `dismantling' methodology, (allows researchers to identify the active ingredient in therapy), are proposed as possible answers. d) The inability of outcome studies to clearly differentiate amongst therapies could be due to the lack of precision and specificity in measuring particular outcomes of different therapies.

2. Challenge to Content Equivalence. The proponents of this position argue that the common features across therapies outweigh the differences demonstrated in verbal techniques and that these common ingredients are responsible for effective outcome. a) Therapist characteristics of warmth and understanding are put forward as perhaps being the most

influential factor in psychotherapy. (Stiles et al, 1986 report that studies investigating this issue have not been successful). b) Another proposed resolution is that definitive characteristics of the client determine therapy outcome. c) The therapeutic alliance is posited as being responsible for good outcome. However, Stiles et al (1986) review some difficulties with this concept e.g the confounding of positive outcome with early outcome and the inexact nature of the therapeutic relationship (i.e. confounding with both therapist and client variables).

3. Challenge to Mechanism: The third and last alternative is that of accepting the paradox and reframing diverse therapeutic schools in one encompassing framework.

In a separate section which again takes issue with the equivalence result, Stiles et al (1986) question the validity of comparing entire treatments across content and outcome. They advocate a microanalysis approach, taking as subject matter the `events' of therapy (Elliott, 1985; Elliott, James, Reimschuessel, Cislo & Sack, 1985). It is this last proposed resolution of the equivalence-nonequivalence controversey which introduces the current study (Chapter Two, 2 - 1).

1 - 2 - 6 Process Studies

As therapist variables and client variables become different sides of the same coin, so too does process and outcome research in the investigation of psychotherapy. Beginning to

talk about what process research is, what the field covers and to name some of the more important work done in this area is like trying to keep a bag full of butterflies together once the bag has been opened!

Process research is a subdomain of the entire field of psychotherapy research. Its subject matter is concerned with all aspects of communication between therapist and client including the therapeutic relationship (Kiesler, 1973; Greenberg, 1983). In short, process studies examine what occurs in psychotherapy as opposed to outcome studies which emphasise the results of therapy. It aims to clearly delineate the change factors in psychotherapy.

Process studies have described a pendulum-like relation to outcome research over the last 40 years (Greenberg, 1983). The history of their respective developments has followed an action-reaction pattern (see Section 1 - 1 - 2). Various attempts have been made to bring order to this complex field of study.

Process research includes an area known as content analysis. This term refers to a mode of research which examines the communication between therapist and client (Marsden, 1971). He describes three models of content analysis: classical, pragmatic and non-quantitative. The classical model employs quantification in an effort to achieve systematic and objective analysis. In contrast the pragmatic model uses inference of therapist/client communication as the basis for coding. The nonquantitative model challenges the assumption

upon which the pragmatic and classical models rest by questioning the usefulness of frequency as an indicator of itensity. This model explores the possibility of using alternative measures as a gauge for intensity, including patterns of communication. This model, although presented as having methodological problems, appears to be the forerunner of a recent trend in process analysis, sequential analysis (Russell & Trull, 1986).

A landmark work in this area is Kiesler's (1973) review. He summarises and classifies both direct and indirect analysis systems for therapist, patient and therapist/patient interaction to date. The 17 scales which make up the direct classification system of psychotherapy process are tabulated with respect to the unit of measure for both therapist and patient behaviour. Kiesler (1973) has done the researcher a tremendous service by enabling him to see at a glance, whether or not the unit he wishes to study has already been researched.

Some of the chaos which characterises the field of psychotherapy process research (Kiesler, 1973) is due to the lack of a singular unified rationale for approaching the analysis of psychotherapy (Russell & Stiles, 1979; Greenberg, 1983; Russell & Trull, 1986.) Kiesler (1973) addresses the most complex questions which faces the researcher: what to measure ? Of the overwhelming number of variables involved in the psychotherapeutic interaction, how does the researcher decide which unit of behaviour to focus his analysis on? Clearly this decision ought to be tied to the theoretical

underpinnings of the study. This has not always been the case. (Kiesler, 1973). He distinguishes between three types of `units'; scoring, contextual and summarizing. The scoring unit is the chunk of behaviour under study which is assigned to a category (e.g. an utterance, a facial expression); the contextual unit is that part of the interview or interviews which is considered when scoring is undertaken (e.g. a paragraph, the first 6 sessions of a 36 session therapy relationship); and the summarizing unit is that which the researcher seeks to describe by summation of the scoring units (e.g. a whole interview, the middle phase of an interview).

Other problems in process research described by Kiesler (1973) include the confounding of patient variables when a therapist behavioural unit is being measured, and vice versa; sampling issues; the dimensionality of variables under study; the `clinical sophistication' of raters or judges, training of raters, and rater reliability.

A more recent review of the psychotherapy process literature is Greenberg (1983). He outlines three developments in process research.

1. The identification of intra-therapist and intra-therapy variability on dimensions that were previously thought to be static (e.g. therapist empathy). The implication of this is that research should focus on patterns of in-therapy behaviour rather than rates of behaviour (Gottman & Markman, 1978). Greenberg (1983) points to the explanatory power of

using patterns of events in process research rather than discrete events. 2. Following on from this, it is recommended that more attention be paid to describing and measuring client behaviour in addition to therapist behaviour. 3. Just as greater specificity of outcome criteria, treatment and client description and diagnosis has been undertaken, so too is specificity recommended in the description of in-therapy process events and behaviour. In addition, cognizance must be taken of the context in which these events take place. This method of analysis takes account of the variance in therapy variables and challenges the `uniformity myth' (Greenberg, 1983). Investigators already taking this approach are reviewed.

Greenberg (1983) suggests that the gap that exists between research and practice is due to the fact that researchers study what they are able to study. If process research investigated patterns of behaviour then their findings may be more amenable to practitioners who want to know about crucial change factors in therapy.

The Kiesler (1973) and Greenberg (1983) reviews of this complex and challenging area are complimentary. Kiesler (1973) reviews the tools then avaiable for classification of communication in therapy and brings clarity to the question of which unit to measure, while Greenberg (1983) examines more closely the mechanisms of therapy, highlighting the importance of patterns and context. He also updates the category systems avaiable for therapist and client verbal response units.

To conclude, several investigators have called for a synthesis of process research and outcome studies (Kiesler, 1973; Greenberg, 1983; Strupp, 1986). This makes intuitive sense, however, the methodological issues of definition and measurement will be the factors which hamper future projects that seek to bring closure to the process-outcome gap. The next section turns the research coin over to look at outcome studies.

1 - 2 - 7 Outcome Studies

In the preceding sections it has been helpful to examine the literature in chronological order, showing the pattern of investigation over 20, 30 or 40 years. In the case of outcome studies, there is a compulsion to begin with current reviews and opinions and work backwards. This is due to the rapidly changing approach towards assessing therapeutic outcome which is visible in the writings of Hersen, Michelson & Bellack, (1984); Strupp, (1986); and VandenBos, (1986). The movement is toward comparative outcome research (COR) as opposed to the `efficacy' outcome studies of the past (i.e. does psychotherapy work at all?). The term `comparative' has been described in various ways. Heimberg & Becker (1984) define COR as that which compares one technique with another, (either wihin or amongst schools of psychotherapy), while VandenBos (1986) describes comparative outcome studies as those which examine the relative benefits for patients of different treatments for specific psychological and behavioural disorders (including such factors as cost, length of treatment, and a desciption of the kind of change that is

the goal of therapy). In short, the current emphasis is on specificity, mirroring the thinking that is present in other areas of psychotherapy research. Strupp (1986) summarises the errors of past outcome studies. In their attempt to delineate a single change factor which influenced therapy outcome, researchers failed to take account of the inherently complex nature of the psychotherapeutic practice. Given this, it is no wonder that their efforts have failed. As well, review papers which combined these individual results were using `faulty materials' which weakened the effects further.

Apart from tracing some landmark studies in outcome research, attention will be given in this section to the issues that face the outcome researcher in what is an overwhelming task. Historically, the first question to be asked was `does psychotherapy work ?'. This gave rise to such studies as Eysenck (1952) and (1960), which threw down the gauntlet to other psychotherapy researchers. In 1970 Meltzoff & Kornreich concluded that psychotherapy had been shown to result in behavioural change. What was more, they stated that high quality research was more likely to give positive results.

Bergin & Lambert (1978) marked the turning point in the reporting of efficacy studies as well as comparative outcome studies in major review articles. Their conclusions regarding the COR are as follows: 1. Therapies including psychoanalytic, humanistic and behavioural and cognitive show beter results than no treatment. 2. At the present time, the varying schools of psychotherapy appear to be equally

efficacious. However, more sophisticated measuring devices may alter this conclusion. 3. Certain disorders (e.g. phobias and sexual dysfunctions) appear to be differentially responsive to behavioural techniques. 4. Given the apparent equality of the main psychotherapies, the issue of efficiency of treatment becomes even more important. 5. An attempt must be made to accurately describe therapist operations during therapy. 6. The rapprochment of psychodynamic and behavioural therapies has implications for future researchers. Outcome can no longer be related to stated procedures, but must be tied to specific in-therapy process. 7. Few studies are currently investigating the specific effects of specific treatments for specific problems.

The period of time which the Bergin & Lambert (1978) review covers, takes in the era of the 'box score' study, (Luborsky, Singer & Luborsky, 1975 comparison of 113 individual studies), and meta analysis study, (Smith & Glass, 1977: a statistical analysis of 400 studies). Both Luborsky et al (1975) and Smith & Glass (1977) concluded no differential effects between therapies. Heimberg & Becker (1984) offer critiques of these two major outcome research studies and review five of the better known COR studies.

As they see it the main issues facing comparative outcome researchers today are: 1. Underlying assumptions such as the uniformity myth. 2. The equality of treatment given (e.g. content, number of sessions, length of sessions etc.); the attitude of patient toward treatment received; adherence to particular type of treatment; and sufficient differences

between the treatments under study so as to avoid overlap of technique administered. 3. Therapist competence, bias, and issues of study design (e.g. should the same therapist conduct all treatments across varying techniques, or should different therapist only administer one type of treatment). 4. Problems of patient groups: analogue or clinical studies (see 2 - 9); sample characteristics (diversity vs specificity debate); sample selection with regard to treatment responsiveness; lack of control during follow up period regarding patients seeking further treatment voluntarily; and finally the question of drop out and the reasons why. 5. Outcome criterion (e.g. what relative level of functioning is attained; who attains it; the extent and permanency of the change; the efficiency, emotional and financial cost; and cost-effectiveness of treatment; who assesses outcome and follow up.

In conclusion, it does not seem too presumptuous to say that with the transition from efficacy to comparative outcome studies, the questions of whether or not psychotherapy as a phenomenon exists and is effective, have ceased to be serious issues. Instead they are the basic assumptions of todays psychotherapy researchers.

1 - 2 - 8 Methodology and Design

The last two sections have shown that the field of research into psychotherapy divides into two main areas: outcome and process studies. While each area has its characteristic difficulties, there are some perennial problems which pervade them both. These are the lack of precision and clarity in

the definition of psychotherapy itself, its constructs, processes, and the variables involved; the difficulty in measuring these constructs, variables and processes; and lastly, the difficulty of controlling extraneous variables in both experimental and naturalistic psychotherapy research. The nature of the research question and hypothesis of the investigator determines the shape of the investigation (Kiesler, 1971; Gottman & Markman, 1978) and will influence whether the research undertaken is process or outcome, group design or single case, and which particular problems are likely to be encountered with each of these design strategies. Clearly, design choice is a trade-off between the research question and the data to be collected in order to answer it, and the respective strengths and weaknesses which different experimental and quasi-experimental design strategies offer.

In order to weigh the relative merits of various research designs, it is necessary to consider the criteria for powerful designs. In essence this comprises of internal and external validity. Internal validity refers to the case where as far as possible it is known that the two variables under study, the dependent (A) and the independent (B) variable, covary with each other in a casual relationship. Internal validty is threatened when a third unspecified variable is involved in the causal relation between variables (A) and (B), such as history, maturation, testing and instrumentation (Cook & Campbell, 1979). External validity on the other hand refers to the power of the outcome of the study to generalise across settings, times and persons.

Threats to external validity include the behaviour of subjects in response to a known experimental situation (`reactivity'); `priming' of subjects by the use of pre- and posettest measures; and lack of generalizability of one construct measure or multiple outcome measures (Kazdin, 1980).

Single case designs are weak with regard to external validity but a rich source in terms of observed information, and more easily utilised by the practising clinician (Hayes, 1981). (See section on Research into psychotherapy for history of the case study method). Single case design methodology has been refined to the point where it provides a valid alternative to the more conventional group design (Kratochwill & Mace, 1984). Essentials of the methodology are repeated measures, knowledge of client variability, specification of dependent and independent variables, and the ability to replicate the study (Hayes, 1981). The last factor helps to overcome the external validity problem.

Accurate and systematically applied measures within single case studies address the internal validity issue (Nelson, 1981). She reviews methods such as self-monitoring, self-rating, card sorts, questionnaires, observations in the clinic, and others. The quality of different forms of data collection is discussed. The advent of electronic sound and visual recording is an important milestone in the area of dependent measures for both single case and group design studies. The value of the single case is in the generation of hypothesis and ideas which may be further explored under the

scientific rigor of the group design. In this way, the single case study interfaces with, and compliments experimental research (Kazdin, 1980).

Research questions aimed at explication of the therapy process seem best served by single case methodology although analogue studies are able to test some of the same processes in the laboratory. Questions of efficacy, within and across treatments are more suited to group experimental designs. This type of design has formed the backbone of conventional psychotherapy research. It enables the researcher to deal with most of the threats to internal validity and so provides the most powerful design for drawing conclusions regarding the causal relation between the dependent and independent variables. Quasi-experimetal designs and correlational designs are two further alternatives for researchers (Kazdin, 1980). The former differ from a true experimental situation by virture of the fact that the experimenter is not able to control all aspects of the experiment. Correlational designs do not attempt any manipulation but record instances of specified variables co-varying together. Frequently research will combine the features of both experimental and correlational designs so that relationships between variables can be studied under controlled conditions.

In summary then, experimental and quasi-experimental designs (including the case study) are not opposing, but complimentary methodologies. Experimental designs are more powerful while the single case study and correlational designs provide descriptive information about therapy

process, and generate new ideas to be tested experimentally. Group experimental design studies are costly and cumbersome to mount; in contrast the practising clinician is already conducting single case studies and needs only to specify and quantify the process (Hayes, 1981).

It is possible to conceptualise the field of psychotherapy research as a series of Russian dolls each hatched inside the other. The separate components have their own characteristic dilemmas while some overarching problems effect them all, as mentioned at the beginning of this section. The first of the dolls represents the research question: which part of the therapeutic process is its source; is it specific or general; and what measuring devices are available with which to quantify the variables under study ? Inside this largest doll is the next level of this research model: the experimental design. It is specified by the experimental question and within the restraints of subject availability, therapist procurability, time and financial resources, measurement devices, and access to equipment and computer statistical packages. Hatched in turn within this level, are the issues inherent in psychotherapy research. These are the multiplicity and heterogenity of variables involved in therapeutic practice e.g. therapist, patient, therapist-patient interaction, treatment etc.

Two approaches have attempted to organise the enormous complexity of information, and ease decision making and problem solving at the different levels described above. The first effort (Kiesler, 1971) is aimed particularly at the

last section. Traditionally a schism has existed between experimental psychology and psychotherapy research. This is due to the different emphasis of each; the former aiming to do away with variance or individual differences and the latter seeking to uncover and examine the differences between subjects. The major thrust of Kiesler's (1971) chapter is to achieve a reconciliation of these approaches. He presents both a theoretical grid model (pg 42) and specific experimental designs which address the conflict over individual differences in experimental research. He proposes factorial designs that measure interaction of both `organismic' and `environmental' variables. He understands that psychotherapy researchers are correlationists wanting to emphasise and explore individual differences and who have mistakenly assumed the `generalist' experimental procedures that aim to minimise individual differences. This has generated what Kiesler (1971) calls the 'uniformity myth'. Belief in the uniformity of patient, therapist and treatment groups has lead to confusing and often meaningless research. His grid model incorporating specified patient groups exhibiting particular problems and treated by therapist with certain characteristics using certain techniques attempts to tear down the uniformity myth that is present in conventional psychotherapy research and replace it with specificity and the measurement of interactions.

Building on Kiesler's (1971) ideas and specifically his artisan/scientist distinction, Gottman & Markman (1978) introduce the metaphor of the Program Development Model (PDM). Using the language of the PDM means that emphasis is

shifted away from global measures and concepts to specific subsets of particular therapists implementing specified treatments to an identified patient group. They reject the vastness of Kiesler's grid model but spotlight specific chunks of it, thus utilising his principles, and fitting them to practical requirements.

The proposed PDM would consist of eight stages: 1)selection of clients; 2) specificity of the content; 3) evaluative measures; 4) execution of the programme; 5) when and how to test the programme; 6) assessment of the programme; 7) dismantling (see previous section) and 8) program cost advantages and disadvantages. In stage 5, Gottman & Markman (1978) present their thesis on time series methods of experimentation. The interested reader is referred to Kratochwill & Mace (1984) for a fuller exposition than is permitted here. Gottman & Markman (1978) propose time series methodology as a forerunner to multivariate factorial experimental designs (a la Kiesler) and highlight the usage of the time dimension in psychotherapy research.

This section has firstly considered the main problems of specification, measurement and control that faces psychotherapy researchers. Next, the basis of sound scientific experimentation was stated in terms of internal and external validity. Then single case methodology was compared with experimental and quasi-experimental group designs. Lastly, three different conceptualisations of the psychotherapy research domain were offered. Reviews by Kiesler (1971) and Gottman & Markman (1978) were presented

with their solutions to the problems which researchers have faced in the past. Kiesler (1971) called for specificity of variables and the measurement of interaction between variables. Gottman & Markman (1978) used the PDM metaphor to provide a new way of looking at old problems. Their particular contribution was the use of time series methodology as a first step in experimentation in psychotherapy research.

1 - 2 - 9 Analogue Research

Like so much else in psychotherapy research, the field of research itself is not uniform. Analogue research provides an alternative to the more usual experimental research which is carried out. The following section explores the nature of analogue studies and its strengths and weaknesses.

There are important distinctions between analogue studies, clinical trials and clinical settings (Kazdin, 1984). The latter is the guidepost which clinical trials and analogue studies are rated against. Analogue research and clinical research vary along a continuum with regard to their similarity to the actual clinical setting (Kazdin, 1984). Implicit in this concept is the understanding that even clinical trials represent an analogue of the real clinical setting, but are closer to it on the continuum than traditional analogue research.

All experimental research seeks to verify a hypothesis regarding the relationship between two identified variables. The extent to which this is achieved depends on the power of

the study design or to what degree the requirements of internal and external validity are met (see Methodology and Design Section 1 - 2 - 8). From this perspective, analogue studies, clinical trials and clinical research can be seen to each achieve a different trade-off position between external and internal validity, or power of design. The following undertakes a description of analogue research from such a perspective.

Traditional analogue studies are studies conducted with non-human subjects, and experiments using voluntary human subjects in a laboratory setting designed to replicate the clinical setting (Kazdin, 1984). Experiments designed to study the development of emotional states in animals, and experiments which analyse the effects of verbal interchange on each member of a dyad, are both examples of analogue research (Kazdin, 1984). They represent an increase in internal validity over clinical trials and research in the following ways. The effects of selection constraints are minimised; random assignment of subjects carries less ethical considerations and so easier to achieve; subjects are less likely to seek out additional treatment and confound research treatment outcome; and lastly, analogue research therapists are probably more likely to adhere to treatment administration manuals as a result of not being entrenched in their own professional style which preserves equivalence of treatment.

On the other hand, analogue research suffers from low external validity. That is, the extent to which results can

be generalised to the broader population. Of the eight characteristics of analogue research listed by Kazdin (1984), most are illustrative of the cause of this low external validity. The research question may be directed at the problem behaviour in a different manner (e.g. the investigation of snake phobia; the population from which subjects are drawn is likely to be different from the population that genuine clientele come from (e.g. university students are often recruited); subjects are often paid or given course credit in exchange for participation; the clinician implementing the treatment can be untrained, or partly trained; it is likely the expectation for change of an analogue research subject is different from that of a person seeking treatment in a clinical setting; the treatment setting is different from the clinical treatment setting; and lastly, treatment may vary qualitatively when administered in analogue research for purposes of experimentation. The direct trade-off between internal and external validity is demonstrated clearly on the therapist dimension e.g. equivalence of treatment (high internal validity) over against qualitatively different treatment when compared to the clinical setting (low external validity).

Clinical trials represent a midway point between clinical research and analogue studies. Clinical trials are not considered qualitatively different from analogue research (Kazdin, 1984). Rather they vary in terms of the characteristics of analogue research mentioned earlier. As they move closer to the clinical setting the study design weakens in terms of its generalizability (external validity)

as well as its ability to demonstrate a causative relationship between identified variables (internal validity). Research which takes place in the clinical setting ceases to be truly experimental but is rich in descriptive information about the psychotherapeutic process.

In summary, analogue research raises issues of power of design. The most persuasive factor in favour of analogue studies must be that it enables research to be undertaken under controlled conditions. The cost of this advantage is the loss of similarity to the actual clinical setting, in terms of patient and therapist populations, and treatment equality. Kazdin (1984) concludes that the relative disadvantages of clinical research have not been empirically tested over against the benefits derived from analogue studies.

The study reported in this thesis falls at the extreme of the `clinical trial' end. It is an observational rather than experimental study of the type suggested by Hayes (1981) that may narrow the gap between clinical trials and the clinical setting.

1 - 2 - 10 Ethical Issues

Finally in this chapter the meta-issue of ethics in psychotherapy research are addressed.

The ethical issues which are inherent in psychotherapy research arise out of respect for the human aspects of the practice rather than out of any appeal to objective laws or

knowledge (Alford & Johnson, 1984). Ethical considerations rest on beliefs about the intrinsic value of persons. Throughout history, there are incidences of the suspension of such beliefs (e.g. the experimentation with human subjects by the Nazi regime during World War II). These ethical issues seldom receive much attention in the literature (Imber, Glanz, Elkin, Sotsky, Boyer & Leber, 1986). However, this is probably due to lack of report rather than lack of concern.

The Nuremberg Code (Trials of War Criminals, 1949, cited in Alford & Johnson, 1984) was one of the first documents that clearly stated the considerations for human experimentation (Alford & Johnson, 1984; Imber et al, 1986). Its five guidelines are 1. Informed consent, including competency of the subject to understand the full nature of the experiment; the voluntary nature of the subject's consent; the responsibility of the investigator to fully inform the subject about the experiment; and the subject's comprehension of all that the experiment involves. 2. Freedom to withdraw. 3. Minimised risks to the participants in terms of their physical and psychological well being. 4. Relative benefits to the subject immediately involved and/or to society. 5. Experimenter competence.

The actual application of these principles is liable to become complex. However, dilemmas may be resolved by considering the recommendations in combination rather than independent from each other (Alford & Johnson, 1984). They describe the core issues of any ethical decision as a) the assessment of what change the procedure is likely to bring

about in a subject, and b) the informing of the subject and their voluntary consent to participate. Potential problems include the worsening of a subject's problem rather than diminishing it, the creation of a new additional difficulty, or the often referred to dilemma of delaying treatment for a patient, or administering a treatment known to be less effective.

Three of the most common ethical dilemmas faced by researchers are: firstly, should the subject be given complete information about the experimental procedure ? Secondly, should the subject be allowed to be deceived as part of the experimental process ? And thirdly, should appropriate and effective treatment be withheld from subjects to fulfil the purposes of research ? These three questions arise out of the requirements of the researcher to adequately test treatment efficacy and eliminate as far as possible subject expectation and bias.

Reviewing the literature, careful design of methodology, and formal consultation are ways that best prepare the research investigator to deal with the ethical issues that arise in psychotherapy research (Alford & Johnson, 1984). A review of the current literature can reveal difficulties with known treatments or specific patient populations. It can help to formulate study designs that have a minimum of inconvenience and risk to the subjects involved. It is also the responsibility of the researcher to be fully informed of alternative treatments and their nature, so that he can pass this information to the subjects. Such knowledge is gained

by reviewing the current literature in the area.

Almost every methodological design involves delayed treatment, the diminishing of treatment efficacy, or allows the return of symptoms (e.g. reversal designs). Study designs must weigh the possible harmful effects to the subject against the potential benefits, and in turn examine both of these alongside the research question. Another important aspect of designing the methodology is to ensure that adequately trained persons are employed in the carrying out of assessment and treatment.

In conjunction with these design requirements, formal consultation is advisable when significent risks are involved in the experimentation; there is controversy over the proposed research topic; problematic patient groups or issues are being investigated; and when the main investigators are not appropriately trained in all of the skills required for the experimental procedure.

As stated at the beginning of this section, there is a dirth of literature on ethical issues in psychotherapy research. However, a recent report presented the ethical problems relating to clinical trial designs and large collaborative studies (Imber et al, 1986). These occured in the context of a pilot study for research into the evaluation of two brief psychotherapies as treatment for depression. The Imber et al (1986) report represents an oasis in the desert. While the basic issues of ethical considerations in human experimentation have been reviewed in this section, the

interested reader is referred to the Imber et al (1986) study for a more detailed examination of the specific issues which arose in their pilot study. This article is a rare manifestation of the ethical considerations involved in much psychotherapy research, which are seldom reported.

CHAPTER TWO - METHODOLOGY

2 - 1 Introduction to the Current Study

The current study is lodged within the psychotherapy process research domain. Its main purpose was to identify those types of therapist responses which the client found most helpful in therapy. Specifically it examines the verbal interaction between therapist and client using videotape playback to enable post-session rating for both therapist and client. This method of post-session evaluation is based on Interpersonal Process Recall (Kagan, Krathwohl & Miller, 1963; Kagan, Schauble, Resinkoff, Danish & Krathwohl, 1969). Six consecutive therapy sessions were recorded. Variables measured were client and therapist perception of helpful or hindering therapist verbal responses; therapist intention of those verbal responses; client rated impact of therapist responses (following Hill & O'Grady's (1985) recommendation); and independent coding of those selected therapist statement(s) using a verbal response category system (Hill, 1978). Research design was naturalistic, resembling single case study design. No manipulations were applied and analysis was descriptive and correlational.

This study fits closely into current research in the following areas: sequential analysis of language (Russell & Trull, 1986) and change process research (Greenberg, 1986). It draws on existing studies such as client perceptions of therapist responses (Elliott, 1985); client and therapist perceptions of therapist response (Caskey, Barker & Elliott, 1984); client impact of therapist responses (Elliott et al, 1985; Hill & O'Grady, 1985); therapist intention (Hill &

O'Grady, 1985; Fuller & Hill, 1985) and coding of therapist verbal responses (Hill, 1978; Stiles, 1979). The current study differs from the studies cited in the following ways which are seen to be positive. These are firstly, whole sessions rather than segments of sessions are analysed (Mintz & Luborsky, 1971); secondly, the Intentions List (Hill & O'Grady, 1985; Fuller & Hill, 1985) is used in conjuncion with The Therapeutic Impact Content Analysis System (Elliott et al, 1985), and both of these are used in conjunction with the Counselor and Client Verbal Response Category System (Hill, 1978; Hill, Greenwald, Reed, Charles, O'Farrell & Carter, 1981); thirdly, the extended 9-point Helpfulness Rating Scale is used; fourthly, all categories of the Hill Verbal Response Category System are utilised, rather than a restricted number of response categories (Elliott et al, 1985); and lastly, the specific hypothesis about which response mode the client will find most helpful is put forward.

This research emphasis has arisen in response to the request by researchers for a) greater specificity of in-therapy variables (Russell & Trull, 1986; Greenberg, 1986); b) closer examination of therapy process (Greenberg, 1986); and c) specification of crucial change factors in the therapy process (Elliott, 1985; Greenberg, 1986; Elliott, Barker, Caskey & Pistrang, 1982). These requests emerge within the context of process research into psychotherapy. Specific elements of process research which are of relevance to this study include content analysis, the advent of permanent electronic recordings, and the development of devices with

which to measure therapy process, such as counsellor and client verbal response category systems. Implicit in these ideas for research is the importance attached to the closer examination of language use in psychotherapy (Havens, 1978; 1979). Few authors reviewed for this thesis have been explicit about the basis for their research into language in psychotherapy. Perhaps the rationale is too obvious, but it is the opinion of this author that the underlying assumptions and beliefs of process research (particularly verbal process) ought to be brought to light. To the researcher, psychotherapeutic process is a bombardment of information, interactions and procesess. Out of the tangle one, or a few, variables are targeted for research.

It has been acknowledged that psychotherapy is a special case of human communication (Kiesler, 1973). The communication concept needs further refinement as it can be both verbal and nonverbal and have several dimensions in each of these categories. The belief that forms the basis of this study is that the verbal component of therapist-client communication outweighs other quite legitimate communication forms in its contribution to therapeutic outcome. This then is the rationale for the study of language use in psychotherapy.

Traditionally the content of the client's thoughts and beliefs have been examined. The language which the therapist used to access this content took second place in research (Havens, 1978). Most therapies emphasise techniques (e.g. imagery in Gestalt therapy), or conditions (e.g. of empathy, genuineness etc in Rogerian therapy). Few have paid

attention to the medium by which these interventions are applied. Specification of the use of language arises within the psychodynamic tradition (Havens, 1979), in which conditions of empathy are seen as basic to the elicitation of painful affect, leading to the resolution of earlier life experiences.

This thesis takes then as its cornerstone, that language used by the therapist (particularly in psychodynamic therapies) represents the bridge between psychological theory and therapeutic practice, and in another dimension, it is the manifestation of 'felt' therapist empathy (Havens, 1979). The ability to demonstrate understanding of the client's affect (rather than just state it) is regarded as essential to the basic therapeutic condition which results in client change.

Secondly, it was regarded as helpful to actually ask the client what his or her experience was of helpful or hindering therapist verbal responses (Elliott et al, 1985). This procedure acknowledges the value of studying immediate therapeutic impacts as an adjunct to, rather than instead of, eventual final outcome. In order to identify the crucial events and acts of therapy that bring about change in the client, the therapy process needs to be examined at three stages and measure three different levels of communication (Greenberg, 1986). These 'stages' are the immediate impact of therapist response, intra-session outcome, and final outome of therapy. Codable units of speech, therapist and client speaking turn, and the relationship obtaining between

client and therapist are the three levels of communication.

2 - 2 Hypotheses

The main hypothesis under investigation was that the client would experience as 'most helpful' those therapist verbalisations which responded to the emotional content of the client's speech. Considerable support exists for this hypothesis (Greenberg, 1983). Additional hypotheses are: 2) that a reasonable degree of fit will exist between therapist intention and impact as measured by the covariation of these two variables; 3) that independent codings of therapist responses will be consistent with therapist intention and client impact; 4) that the professional orientation of the therapist as described by the therapist himself, would be able to be identified from the types of verbal interventions used. This is measured by independently coding therapist verbal responses, and self-ratings of therapist intentions; and 5) that there would be a reasonable degree of similarity between client and therapist dial recordings of perceived helpfulness.

2 - 3 Method

2 - 3 - 1 Participants

Therapist: Male, 58 years old with tertiary education (M.A.) Married. European/New Zealander. 21 years experience as psychotherapist. Initial training was in psychodynamic psychotherapy in Australia in 1964-65. Perceived orientation on a 1-5 scale (Fuller & Hill, 1985; Hill & O'Grady, 1985) (1= not at all; 5=very much) for psychodynamic 4; humanistic 3; cognitive-behavioural 2; other: systems 3-4. Current

position: Director of Counselling, Campbell Centre.

Client: Male, 35 years old with tertiary education. Married. European/New Zealander. No psychiatric background. Expectation of therapy outcome was 'neutral'; attitude toward seeking therapy was 'good'. These measures were collected retrospectively in an interview during which the client was asked to rate attitude as 'good, neutral or uncomfortable', and expectation of outcome as' successful, neutral, or unsuccessful'. The client had had prior exposure to the human relationship field via involvement in training and experiential groups, as well as therapy described below. The client continued in therapy with the same therapist at the conclusion of the six sessions required for this study for a further three intermittent sessions.

Client and therapist had previously undertaken individual psychotherapy together for a total of approximately 30 hours. The six sessions that constituted the therapy for this study was regarded by the therapist as being part of the beginning phase of therapy (Fuller & Hill, 1985; Tracey & Ray, 1984).

2 - 3 - 2 Dependent Variables

1. The Helpfulness Rating Scale (Elliott, 1985). A 9-point rating scale ranging from 1=Extremely Hindering to 5=Neutral to 9=Extremely Helpful (See Appendix 1). The unit rated was therapist reponse(s) selected by client. This could have constituted one sentence or several sentences and is referred to as the therapist speaking turn (Elliott, 1979; Elliott et al, 1985; Hill & O'Grady, 1985). Ratings are made on the

basis of the client's memory of how helpful or hindering he experienced that therapist reponse at the time (Elliott, 1979; Elliott et al, 1985; Hill & O'Grady, 1985).

2. Intentions List (Hill & O'Grady, 1985). A 19 category list of therapist intentions (See Appendix 2). The unit rated was the therapist reponse chosen by the client. Rating was made by the therapist on the basis of his recollection of intention at the time of the response. Each intention of the response could be rated from 1 - 5; 1=not at all, through to 5=very much. The therapist rated each of his own reponses using the appropriate intention categories and indicating degree of intention for each.

3. Therapeutic Impact Content Analysis System (Elliott et al, 1985). This system had 10 helpful impact categories and 6 hindering impact categories, as well as an 'other' helping or hindering category (See Appendix 3). Each impact of the response could be rated from 1 - 5; 1=not at all, through to 5=very much. Thus the client could rate therapist response using more than one impact category and indicating degree of each impact. Again rating was retrospective. The unit of measure was the therapist reponse previously chosen by the client as either particularly helpful or hindering.

4. The Counselor Verbal Reponse Category System (Hill, 1978; Hill et al, 1981). A category system is a classification system made up of two or more categories; the latter consisting of a description of a given behaviour into which events are coded (Kiesler, 1973). This system aims to

describe one level of counsellor-client interaction i.e. reponse type (e.g. interpretation, reflection). The system makes possible the analysis of both counsellor and client verbal responses. The categories are mutually exclusive and nominal, and minimum inference of therapist-client interaction is required for coding. The existing system has 14 counsellor reponses categories (See Appendix 4). Reliability has been tested over several studies (e.g. Hill, Thames & Rardin, 1979). The unit to be coded was therapist response chosen by the client. Therapist response was broken down into codable units using an adaptation of the rules from Auld & White (1956) as stipulated by Hill et al, (1981).

5. Continuous Dial Rating of 'experienced helpfulness': An analogue measure adapted from Gottman & Markman (1985). A plastic dial that could be turned through 180° was connected to an Apple 2 E Computer and manipulated by the client or therapist in accordance with their perceptions of helpfulness or unhelpfulness of therapist responses. This provided a continuous readout of figures between +128 (most helpful) and -128 (most hindering) with 0= neutral. Thus the dial corresponded to Elliott's (1985) Helpfulness Rating Scale, but is a continuous rather than discrete measure.

2 - 3 - 3 Independent Variables

These can be divided into two groups: environmental and organismic. In the first group, length of session, number of sessions, and type of psychotherapy are included. In the latter are the characteristics of both therapist and client,

including sex, age, race and education. Specific client factors are attitude to therapy and expectations of outcome. Specific therapist factors are experience, training and psychotherapeutic orientation.

2 - 3 - 4 Procedure

Selection of therapist was undertaken as follows. Two experienced therapists, one female and one male, both of whom were known to the author were approached and informed of the prospective study. After discussion, it was agreed that the male therapist would undertake the study. It is the belief of the author that psychotherapy process research is carried out using a 'self-selecting' population of therapists and clients. That is, the nature of the research question, and the psychotherapeutic process itself, rules out certain subpopulations of both therapists and clients. While this is probably an accepted fact of psychotherapy research, and other types of research as well, it is important to make this knowledge explicit as it will effect the internal and external validity of any study.

A series of six consecutive psychotherapy sessions were conducted and videotaped at the Campbell Centre over April - May 1986. Each session was approximately one hour long. Viewing of videotaped sessions by therapist and client took place at the Centre also.

The author spent approximately one and a half hours per videotaped session with each of the therapist and client when

ratings were undertaken. Latency between therapy sessions and video viewing varied from two days to two weeks. By necessity each viewing session was divided into two parts. This was because the computer programme for the continuous dial rating had to run continuously and in tandem with the video. At the same time as the dial ratings were made, the client picked out those therapist reponses which were perceived as either helpful or unhelpful. (These sections were identified by video recorder tape number). In a subsequent review session these were targeted by means of rewinding the video until the exact section was identified. The client then rated those sections for global helpfulness and then impact. To rate helpfulness he assigned each event a rating from 9 (extremely helpul) to 1 (extremely unhelpful). For the purposes of data analysis, only thos events rated 8 and over, were included in this subset of the total 42 events identified. Independently the therapist rated the same events for global helpfulness as he perceived the client experienced it, and for his intention at the time. The therapist also went through the video again and selected statements which he thought the client could have found very helpful or unhelpful, which were again identified by video recorder number. He also rated continuously with the dial.

On completion of the ratings by therapist and client, the author transcribed and typed up the six therapy sessions from videotape to word processor at the University of Canterbury. The 42 statements which had been selected by the client (that formed the basis for impact, intention, and response mode coding) were typed up separately. A reliability check for

accuracy of the selected statements was made by a colleague who independently viewed the videotapes and identified the statements by video recorder number. Reliability was approximately 99%.

In October, November and December 1986 training in the coding of counsellor verbal response types was undertaken by the author and a colleague. Coding of the forty two selected statements proceeded when approximately 80% agreement between the coders was reached. The author then coded the complete set of statements using the entire transcript as well to put the statements in context. A colleague again completed a reliability check on coding.

2 - 3 - 5 Data Analysis

For the purposes of describing data analysis it is necessary to divide the measuring instruments into two categories. The first consists of a) the Helpfulness Rating Scale; 2) the Counselor Verbal Response Category System; 3) the Intentions List; and 4) the Impact Content Analysis System. The analysis of the data generated by this first group of measures was mainly qualitative and descriptive; one frequency table was produced.

The second category consists of the dial analogue measurements. The data produced by this type of measuring device was analysed using Spectral Analysis. This type of statistical analysis describes data in terms of cyclical patterns. When one set of data points is present, the analysis is univariate; in the case of the current study

where two sets of data are analysed, the process is bivariate.

Spectral analysis uses algorithms to define the proportion of variance that is able to be accounted for by wave forms (or cycles) of various frequencies (Hudson, 1985). Bivariate analysis enables the examination of coherence and phase for two sets of data; coherence being the best linear relationship between the two sets at each individual frequency. If, and only if, there is significant coherence, can phase be examined.; phase being the temporal relationship between the two sets of data. Spectral analysis was computed using BMDP1T (Dixon, 1981,) with the following parameters: default bandwidths were 8, 3 1/3 n and n 2/3 degrees of freedom (n = number of observations); log transformations of spectral density were plotted and the significance of peaks in this density were assessed using the technique of Kruse & Gottman, 1982). Significance of coherence was calcuated by defining confidence levels which were non-overlapping (Jenkins & Watts, 1968). Phase and slope of phase were interpreted where appropriate, as described above (Hudson, 1985).

CHAPTER THREE - RESULTS

3 - 1 - 1 Results of Qualitative Analysis

This study tested five hypotheses (see Chapter two, 2 - 2). Briefly, these are 1) that the client would choose as `most helpful' those therapist responses which in some way responded to the affective component of client communication; 2) that the intention of the therapist would match with the impact experienced by the client; 3) that an independent coder would arrive at a similar description of therapist response as did the therapist himself, and his client; 4) that the therapeutic orientation of the therapist would be apparent in his choice of type of verbal interventions; and 5) that the client and therapist would have a similar perception of the helpfulness of therapist responses. The dependent variable was therapist response which was in turn analysed by several different instruments (e.g. helpfulness rating scale, intention list, impact content system etc). Therapist responses selected by the client ranged from one sentence to a paragraph length. In either instance, the chosen responses were labelled `events'. A total of forty two events were identified by the client, with an average of seven events per session. The dependent variable in each case was therapist response or speaking turn.

The main hypothesis was that the client would experience as 'most helpful' those therapist responses which attended to the emotional content of what he, the client, was saying. Analysis was undertaken firstly, of therapist response using the Counselor Verbal Response Category System (Hill, 1978)

and secondly of client perception of the helpfulness of that response, using the Helpfulness Rating Scale (Elliott, 1985). The client rated each chosen response from 9 (extremely helpful) through to 1 (extremely unhelpful). From the original pool of forty two events chosen by the client, fifteen were given a rating of 8 or above, and these form the subset of events which are analysed.

Results showed that the client chose as most helpful those therapist responses which were independently coded as interpretations (i.e. `Goes beyond what the client has overtly recognised. Might take one of several forms: might establish connections between seemingly isolated statements or events; interpret defenses, feelings, resistance, or transference (the interpersonal relationship between counselor and client); might indicate themes, patterns, or causal relationships in the client's behaviour or personlity. Usually gives alternative meanings for old behaviours or issues'). From this definition it can be seen that the category of interpretation can be an affective-oriented one, and is thus supportive of the main hypothesis. The second biggest category of therapist responses seen to be most helpful was `restatement', and third was `reflection'. (refer to Appendix 4 for a description of these categories). See Table 3-1.

TABLE 3-1
FREQUENCY OF TYPES OF THERAPIST RESPONSES

SESSION	INTERPRET	RESTATE	REFLECT
1	15	3	3
2	4	0	1
3	0	0	2
4	0	0	0
5	11	5	1
6	2	0	0
TOTALS:	32	8	7

The client rated the identified responses for impact using the Therapeutic Impact Content Analysis System (Elliott et al, 1985). See Table 3-3 of Raw Data. These results indicated that 'felt understood' was associated with perceived helpfulness 80% of the time. The categories of `realised something new' and 'awareness-clarification' were equally perceived the second most helpful kind of impact, 53% of the time respectively. The main hypothesis is clearly supported by the result of the impact 'felt understood' being associated with helpfulness 80% of the time. This conclusion is based on the understanding that 'felt understood' is a state of experiencing involving both cognitive and emotional components, and is more than an intellectual state.

An illustration of these results is presented in Table 3-2 below.

TABLE 3-2
ILLUSTRATION OF EVENT RATED 'VERY HELPFUL' AND IMPACT RATING

EVENT DESCRIPTION	HELPFULNESS RATING	IMPACT RATING
"There's something happen-in you, which is effecting how you feel towards me and how I behave towards you, that is troubling you, I guess."	9	Felt Understd Aware-Clarify Unpleast thgt

Table 3- 3 presents the complete set of raw data collected i.e. the four different analyses of therapist response (1. counselor verbal response rating by independent raters; 2. therapist rating for intention; 3. client rating for impact; and 4. therapist and client rating for helpfulness). This table is thus a useful reference for all results and can be used as an information source in conjunction with separate hypothesis-specific tables and qualitative descriptions. The events rated 8 and above by the client in terms of helpfulness (forming the subset of events on which the analysis has been carried out) are marked by an * for easy identification.

For the following, read:

Independent = rating by the author and a colleague of therapist response using the Counselor Verbal Response Category System

Therapist = rating by the therapist of his own responses using the Intentions List

Client = rating by the client of therapist responses using the Impact Content Analysis System

`H' = rating for global helpfulness by therapist and client using the Helpfulness Rating Scale

TABLE 3-3
RAW DATA SHOWING INDEPENDENT RATING OF VERBAL RESPONSE MODE TYPE, INTENTION AND IMPACT RATING AND HELPFULNESS RATING

EVENT	INDEPENDENT RATINGS	H	THERAPIST RATINGS	H	CLIENT RATINGS
1 *	Reflect Interpret	6	Clarify Insight	8	Aware-clarify Felt underst
2 *	Closed Q Interpret	6	Clarify Cognit Resist	8	Realised s.n. Felt underst
3 *	Ref Restate Interpret	8	Focus Clarify Change	9	Realised s.n. Felt underst
4 *	Min Enc Interpret	6	Clarify Cognit Self-cont	8	Realised s.n. Aware-clarify
5 *	Open Q Closed Q	7	Cathart Insight Change	8	Realised s.n. Aware-clarify Unpleasant ths
6	Restate Interpret	7	Hope Self-Cont	4	Felt Misunderst
7	Open Q	8	Feelings Insight Challenge	7	Realised s.n. Aware-clarify
8	Interpret	6	Feelings Insight Reinf Chg	7	Aware-clarify Felt understood
9	Interpret Confront Restate Dr Guide	7	Clarify Cognit Self Cont	3	Felt misunderst Distract/confuse
10 *	Min Enc Interpret Reflect Closed Q	6	Feelings Insight	8	Aware-Clarify Felt understood
11 *	Min Enc Interpret	8	Insight Clarify Challenge	8	Realised s.n. Felt understood
12	Interpret	8	Feelings Insight	7	Aware-Clarify Felt understood
13	Interpret	7	Cathart Self-cont	7	Aware-clarify Felt understood
14	Interpret Reflect	6	Focus	7	Realised s.n. Aware-clarify

					Felt understood
15	Information Reflect	7.5	Behaviour Feelings	7	Aware-clarify Felt understood
16 *	Reflection	5	Focus	8	Felt understood Felt closer Felt involved
17	Restate Open Q	8	Cathart Behaviours Feelings	7	Realised s.n. Felt understood
18	Interpret Closed Q	7	Feelings Insight	7	Felt understood Felt more comf
19	Information Interpret	4	Resistance Insight	3	Unpleasant ths Impatient/doubt
20 *	Confront	7	Focus	8	Aware-clarify Felt understood Felt involved
21	Open Q	8	Clarify Self-cont Insight	7	Aware-clarify
22	Min Enc Dr Guide Nonverbal Information Open Q Silence Closed Q	8	Feelings Change	7	Felt involved Felt closer
23	Min Enc Interpret Silence Dr Guidance Information Appro/Reass Closed Q	9	Change Challenge	7	Aware-clarify Realised s.n.
24	Min Enc Closed Q	7	Relshp Focus	7.5	Felt understood Felt involved Felt closer
25	Interpret	8	Feelings Insight Challenge	7	Realised s.n. Felt understood
26 *	Min Enc Information Confront	3	Set limits Give info Self-Cont	9	Realised s.n. Defn of problem Felt involved Felt closer
27 *	Open Q	6	Clarify	8	Aware-clarify Felt understood
28 *	Restate	9	Reinf Chg	8	Realised s.n.

	Reflect Interpret Closed Q		Feelings		Felt understood
29	Information Silence Interpret Open Q Dr Guide Reflect	8	Challenge Change	7	Defin of problem Felt understood
30	Open Q	8	Challenge Feelings	7	Aware-clarify
31 *	Information Restate Interpret Silence Open Q	9	Reinf Chg Challenge Feelings	9	Realised s.n. Aware-clarify Felt understood
32 *	Min Enc Silence Appro/Reass Interpret Restate	9	Support Hope Self-cont Insight Change Reinf Chg	8	Felt understood Felt supported
33	Open Q	7	Focus Feelings	7	Aware-clarify Defn of problem
34	Open Q	8	Focus Clarify Feelings	7	Realised s.n. Aware-clarify Felt understood
35	Open Q	8	Clarify Cathart Feelings	7	Aware-clarify Felt understood
36	Restate Closed Q	9	Cathart Feelings Change	7	Realised s.n. Felt understood
37	Interpret Silence Restate	7	Give info Change Insight	6	Felt understood Aware-clarify
38	Open Q	6	Feelings	7	Aware-clarify Felt understood
39	Interpret Silence Information	7	Challenge	7	Unpleasant ths
40 *	Interpret	8	Relshp Change	9	Aware-clarify Unpleasant ths Felt understood
41	Interpret	9	Challenge Insight	7	Unpleasant ths Felt understood
42	Open Q		Feelings	7	Aware-clarify Felt understood

The second hypothesis was that therapist rating for intention and client rating for impact of the responses identified as most helpful would be complimentary. Results show that the most frequently used category for rating impact was 'felt understood', (80%) as measured by the Therapeutic Impact Content Analysis System. The therapist intention of 'clarify', as measured by the Intentions List, was the most frequently used intention category (40%). These categories are described respectively as:

Felt Understood: "I felt my therapist really understood what I was saying, or what was going on with me at that moment in the session, or what I'm like as a person."
Clarify: "To provide or solict more elaboration, emphasis, or specification when client or therapist has been vague, incomplete, confusing, contradictory, or inaudible."

They occured together 33.3% of the time, more than any other combination of intention and impact categories. These results seems to indicate that there is a reasonable degree of fit between what the therapist intended and what the client experienced. This conclusion is based on the following understandings. Firstly, that the significance of the impact is more to do with the experience of being understood, a feeling in itself, than with what is understood. And secondly, that the intention of clarify, endeavours to make the client understand that he or she has been misheard, or heard, and more information is required. Thus the intention of clarify is an empathic communication and can be used to

attend to the client's feelings.

Table 3-4 presents an example of an event which seems to have received complimentary `intention' and `impact' ratings.

TABLE 3-4
ILLUSTRATION OF TYPE OF EVENT ASSOCIATED WITH MATCHED INTENTION AND IMPACT

EVENT DESCRIPTION	INTENTION RATING	IMPACT RATING
"In other words your firmness and your directness and levelling procedures with her, kind of bought things into perspective for both of you - a bit. You know she took notice and respected what you were doing and said maybe I've got some contribution to the way he is feeling and I can accept that he wants to do that."	Clarify Insight	Aware-Clarify Felt Understood
"What would you say that something inside you was?"	Clarify	Aware-Clarify Felt understood

The third hypothesis was that the independent codings, the ratings of therapist intention and ratings of client impact, for the responses rated 8 and over for helpfulness, would all be consistent with one another. This required the measurement of therapist responses using the Counselor Verbal Response Category System, the Intentions List, and the Therapeutic Impact Content Analysis System. Results show that 54% of all possible combinations of independent codings, intentions and impacts were accounted for by two clusters: 1) interpretation-clarify-felt understood, and 2) interpretation-insight-felt understood. See Table 3-3 for general results. As well, an example of this coherence is presented in Table 3-5 below. It is concluded that both these clusters describe a good degree of coherence between what was intended, what was experienced, and what independent coders identified.

TABLE 3-5
ILLUSTRATION OF EVENT ASSOCIATED WITH MATCHED INDEPENDENTLY CODED RESPONSE MODE, INTENTION AND IMPACT RATINGS

EVENT DESCRIPTION	INDEPENDENT RATING	INTENTION RATING	IMPACT RATING
"Hm, they're really saying, *, you haven't got what takes to weld us into a team - we feel good about each other and we each have our own level of confidence that's complimentary"	Min Enc Interpret	Insight Clarify Challenge	Realised Something New Felt Understood

NB * = edits of identifying information

It was hypothesised fourthly, that the orientation of the therapist would be revealed in the types of responses and intentions used. The therapist had perceived himself to be of a psychodynamic, and systems/humanistic orientation, in that order. Results show that the most frequently used response type overall, as measured by the Counselor Verbal Response Category System was `interpretation'(43%). The most frequently occuring intention as measured by the Intentions List was `feelings' (40%). Table 3-3 illustrates this specific usage of verbal mode.

The response type of interpretation and the intention of feelings are both seen to be consistent with the therapist's orientation of mainly psychodynamic, and a lesser systems/humanistic emphasis. Hill & O'Grady (1985) suggested that for psychodynamic/psychoanalytic orientation the intentions of feelings and insight are most frequently used.

The last hypothesis was that therapist and client would have a similar view of the helpfulness of therapist responses. Measuring devices were the Helpfulness Rating Scale (Elliott, 1985) and the dial analogue continuous recording. Results on the Helpfulness Rating Scale showed that 9.5 % of the time, therapist and client rated the same events equally helpful. With a one-digit difference,(i.e. within plus or minus one of each other) they rated the same event equally helpful 52 % of the time. These results suggest that client and therapist differed in terms of how they perceived helpfulness. The results of the dial analogue data are presented in the

following section.

3 - 1 - 2 Results of Spectral Analysis

A brief description of spectral analysis was given in Section 2 - 3 - 5 Data Analysis. In summary, this statistical technique is a type of time series analysis which identifies cyclicity, or wave forms of various frequencies. In the case of the current study, two sets of data are able to be examined with respect to a) individual cyclicity (spectral density); b) coherence (the best linear relationship between the series at each frequency; and c) phase, the temporal relationship between the data series at each frequency. Only if coherence reaches significance, can phase be interpreted. Phase examined over a range of signifanct coherence can describe the degree of lag between the two sets of data. That is, a negative slope indicates 'out of phase' with the first series leading, and conversely a positive slope indicates the second series is leading.

The data analysed was the continuous output generated by the dial analogue which both therapist and client manipulated to represent perceived helpfulness. The dial was attached to an Apple 2e microcomputer and produced one figure per second in the range -128 to +128. Two sets of data were produced for each session - one from the therapist and one from the client. These two series were analysed using the technique described above. Table 3-6 presents a summary of these results.

TABLE 3-6

NUMBER OF DATA POINTS (T), BANDWIDTH (BW), MEAN SPECTRAL DENSITY AND SIGNIFICANT CYCLICITY WITHIN SPECTRAL DENSITY ESTIMATES BY SESSION (S) AND SEG (SEGMENT)

S	SEG	T	BW	MEAN SP DENSITY	SUM OF PEAK	PERIOD RANGE PEAK	DF	CHI SQI	SIG
1	EP1	3291	.007	1464	.8606	12-19 16.5	230	270	.05
					3994		230	119	NS
	CAM1	3291	.007	1186	29881	33-132 66	184	1159	.01
					710		138	27.5	NS
					617		184	24	NS
2	EP2	2941	.0071	259.8	5420	39-78 52	126	876	.01
					3046	13-19 17	210	492	.01
					1249		168	201	NS
					1117		252	181	NS
	CAM2	2941	.0071	895.6	25057	39-78 52	126	1175	.01
					3020		210	142	NS
3	EP3	3299	.0070	547	3603	17-27 22	184	303	.01
					859		230	72	NS
	CAM3	3299	.0070	651	41313	19-00 132	368	2919	.01
					463		138	33	NS
4	EP4	2420	.0021	430	20001	15-00 30	90	465	.01
					2115		60	49	NS
	CAM4	2420	.0021	612	32768	15-00 30	90	535	.01
					1822		50	29	NS
5	EP5	2669	.0019	338	13520	22-243 50	110	400	.01
					2034		90	61	NS
	CAM5	2669	.0019	324	30285	22-243 50	110	934	.01
					1219		70	38	NS
6	EP6	3207	.0016	142	4486	17-169 34	100	314	.01
	CAM6	3207	.0016	653	40467	17-169 34	100	607	.01
					1556		-	23	NS

Session One

Both series (EP1 and CAM1) show evidence of significant cyclicity but at different ranges of frequency. The EP1 data series (generated by client ratings of helpfulness) shows a cyclical pattern with a period approximately a quarter of a minute long, and the CAM1 series (generated by the therapist ratings of helpfulness) is cycling significantly with a period of approximately one minute. Because cyclicity within the two series occured at different ranges of frequency, coherence and phase were not interpreted. See Table 3-6, and Figures 3-1 and 3-2 for raw data and Figure 3-3 for spectral density.

Session Two

Again both series show significant cyclicity, this time in the frequency range f=0.0128 - f=0.256. The centre of this range is approximately one minute. Coherence was able to be interpreted because both series were cycling at the same frequencies. It was found to be significant but only at shorter wavelengths within the above range, therefore phase interpretation was not possible (See Figures 3-5; 3-6; 3-7; and 3-8).

Session Three

As in Sessions One and Two, both series were shown to have significant cyclicity, but in this Session it was shown to be at different frequencies i.e. centred at approximately half a minute for EP3 and two minutes for CAM3. Therefore no coherence or phase was interpreted (See Figures 3-9; 3-10;

3-11; and 3-12).

Session Four

Both data series have significant cyclicity in the same frequency range; approximately half a minute. Coherence exceeded the critical level over the range of significant frequencies in the spectral density function. The phase relationship suggests an approximate two second lead by CAM4 (See Figures 3-13; 3-14; 3-15; and 3-16).

Session Five

The data series EP5 and CAM5 are again both showing significant cyclicity at around one minute. Coherence is significant only at the high end of this frequency band and therefore phase is difficult to interpret (See Figues 3-17; 3-18; 3-19; and 3-20).

Session Six

The last session completes the trend of significant cyclicity by the two series, this time within the half minute to one minute range. Coherence was interpreted and found to be significant at only one point over the range, therefore phase interpretation was not carried out (See Figures 3-21; 3-22; 3-23; and 3-24).

Summary

The results reported above and in Table 3-6 provide evidence for the occurence of patterns of interaction and experiencing within psychotherapy sessions, by both the therapist and the client. As well, they reveal an increasing trend toward more

coherence, (i.e. a linear relationship between the two), and simpler patterns of cyclicity going from Session One to Session Six. Overall, the therapist-generated data showed a slower cycle pattern than that generated by the client, although, as already mentioned, these cycle patterns came together over time, at the slower frequency.

In relation to the fifth hypothesis, that therapist and client would have a similar view of helpfulness, the spectral analysis results indicate a diverging view shared by the two participants. Thus, the hypothesis is partially supported.

Figure
3-1 Client Rating of Helpfulness for Session 1

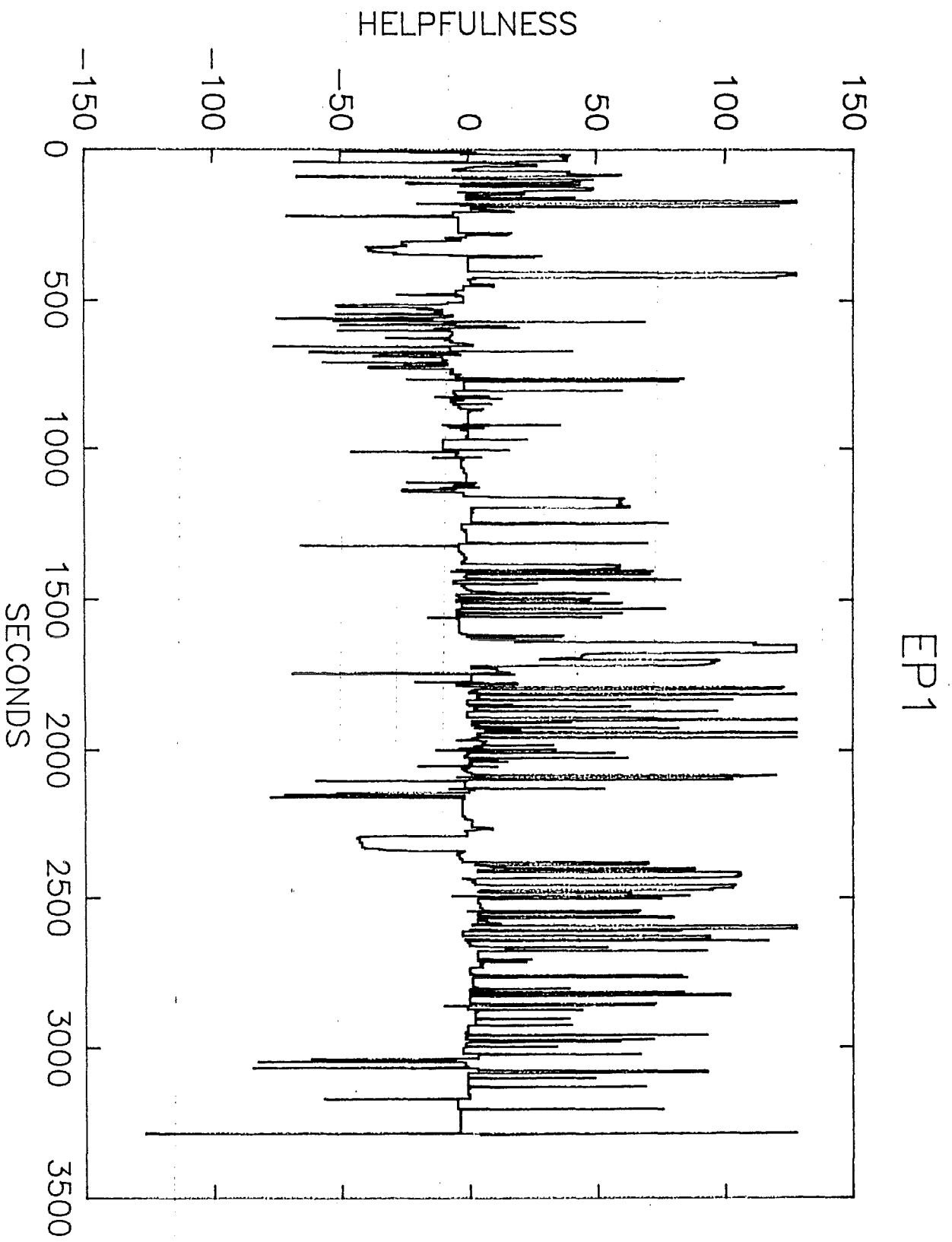


Figure
3-2 Therapist Rating of Helpfulness for Session 1

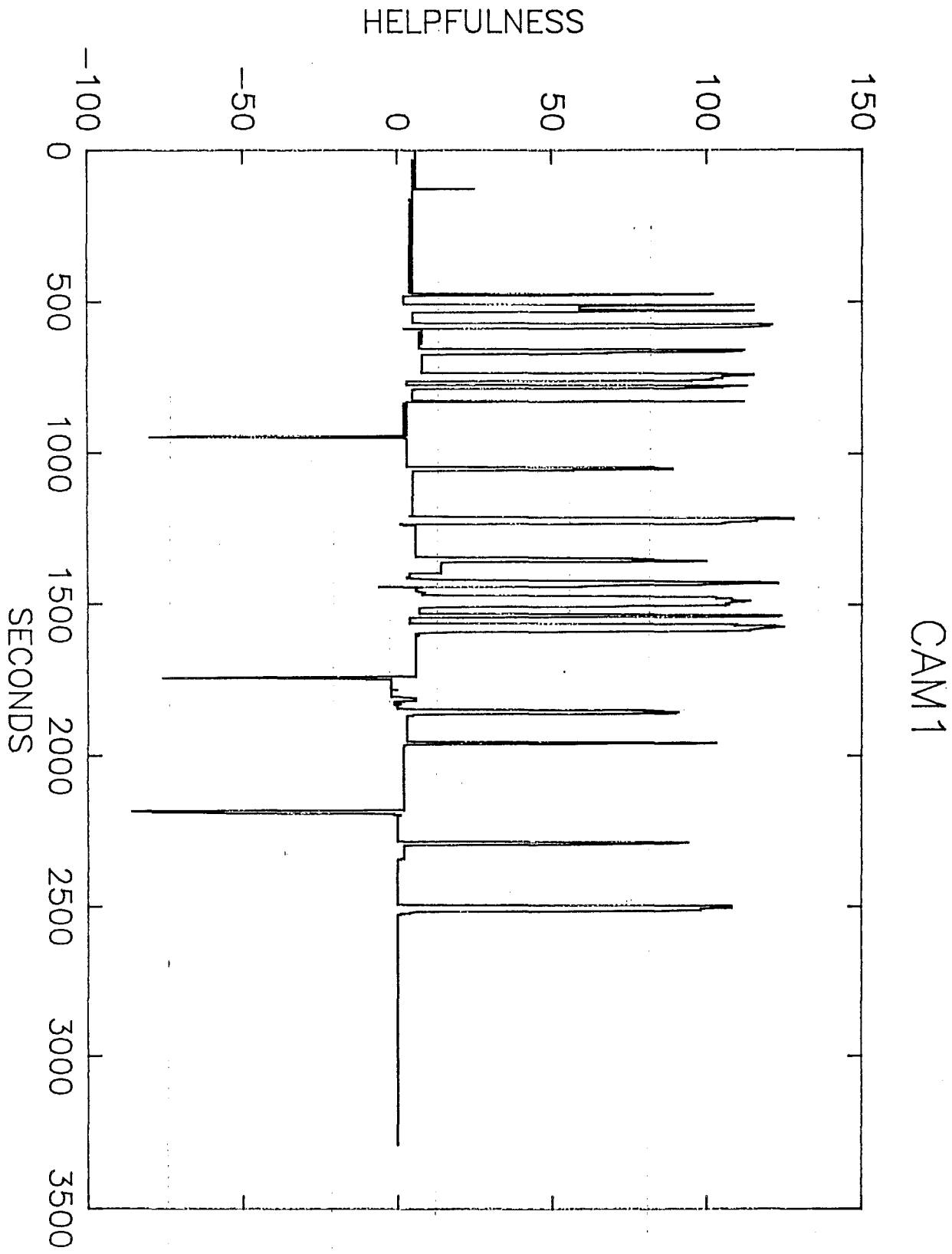
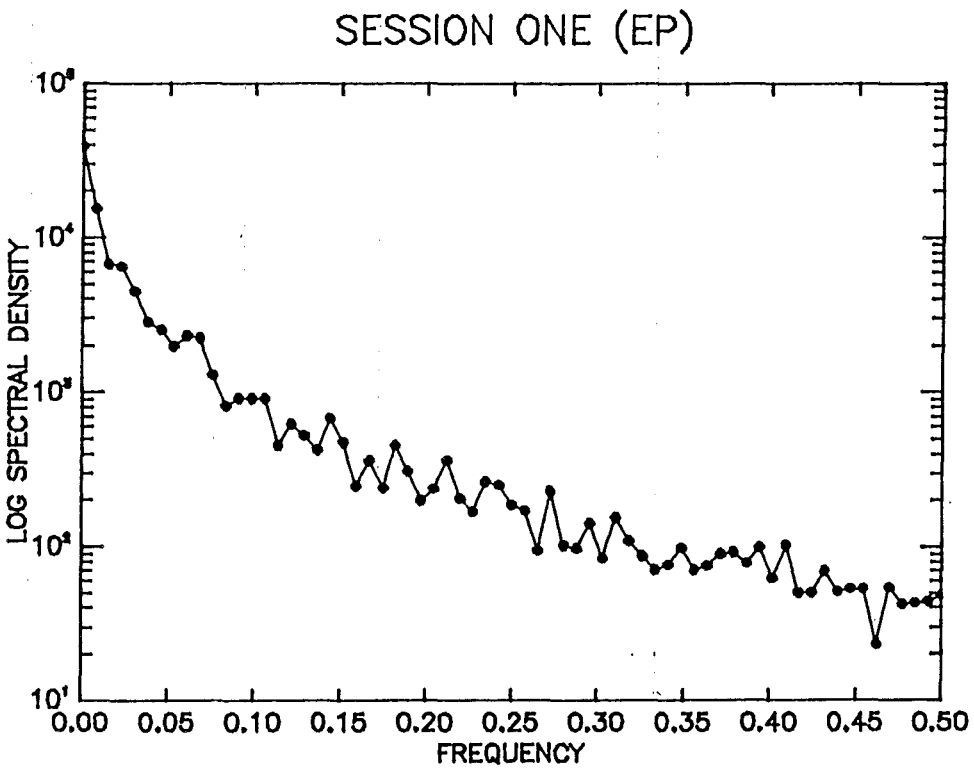
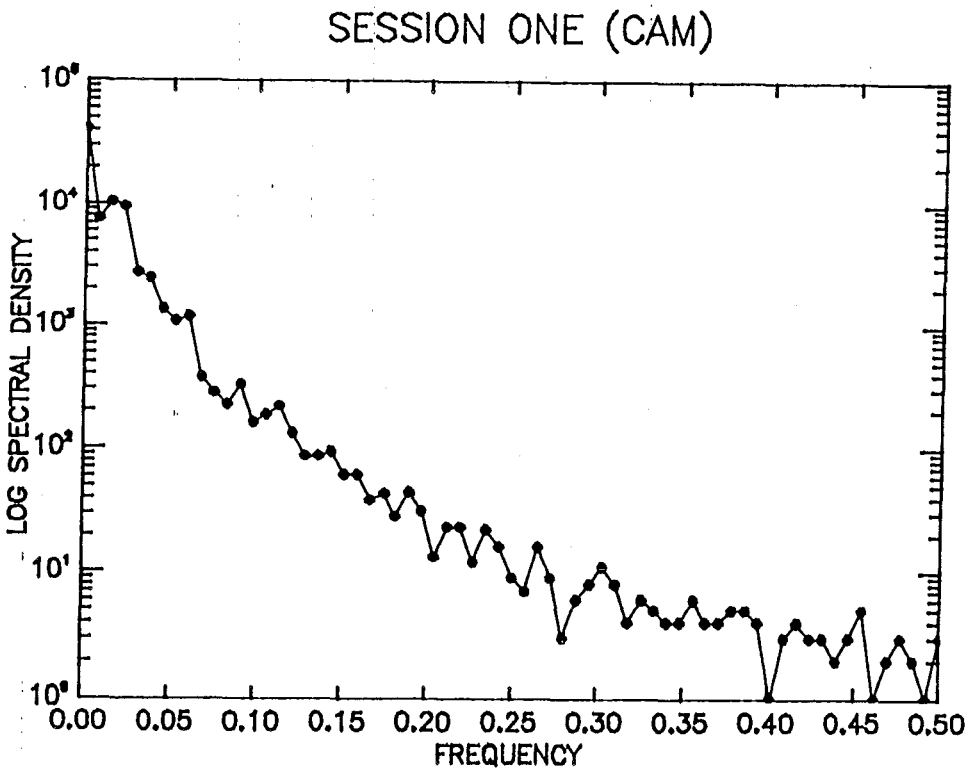
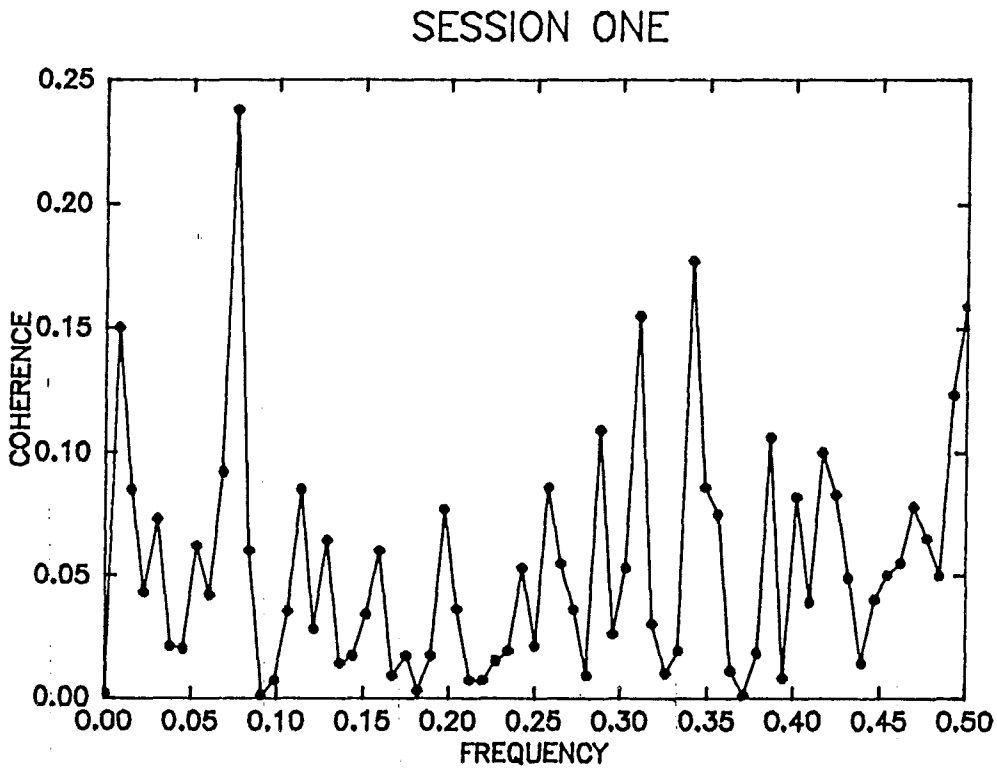


Figure
3-3 Log Spectral Density for Both Series for Session 1





3-4 Coherence & Phase Results from Bivariate Analysis for Session 1



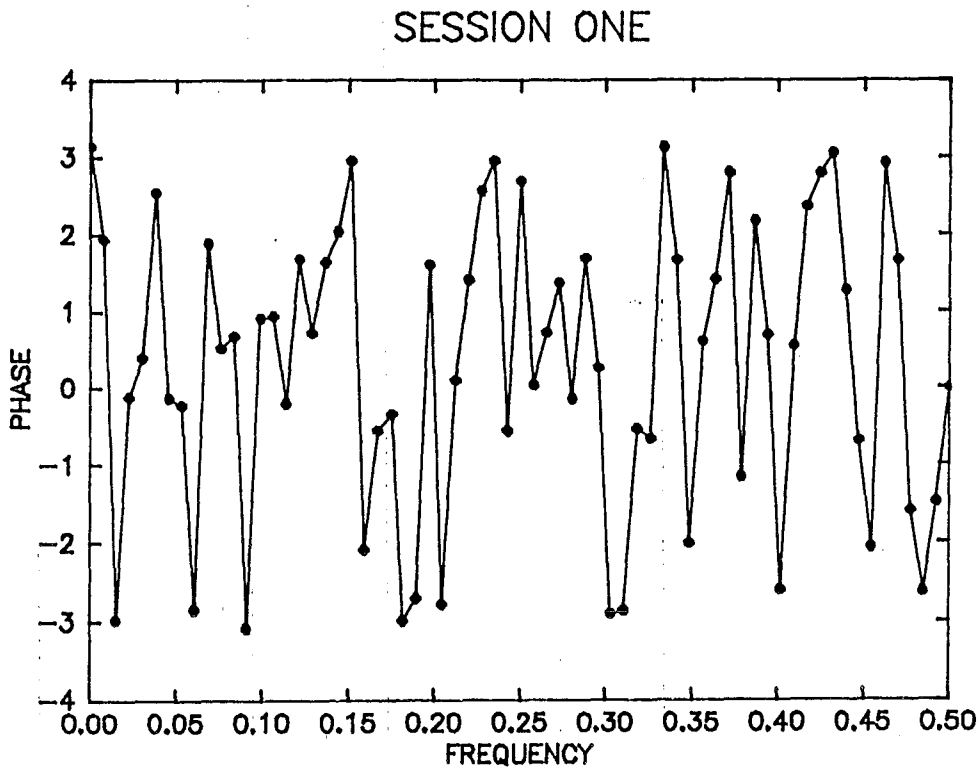


Figure
3-5 Client Rating of Helpfulness for Session 2

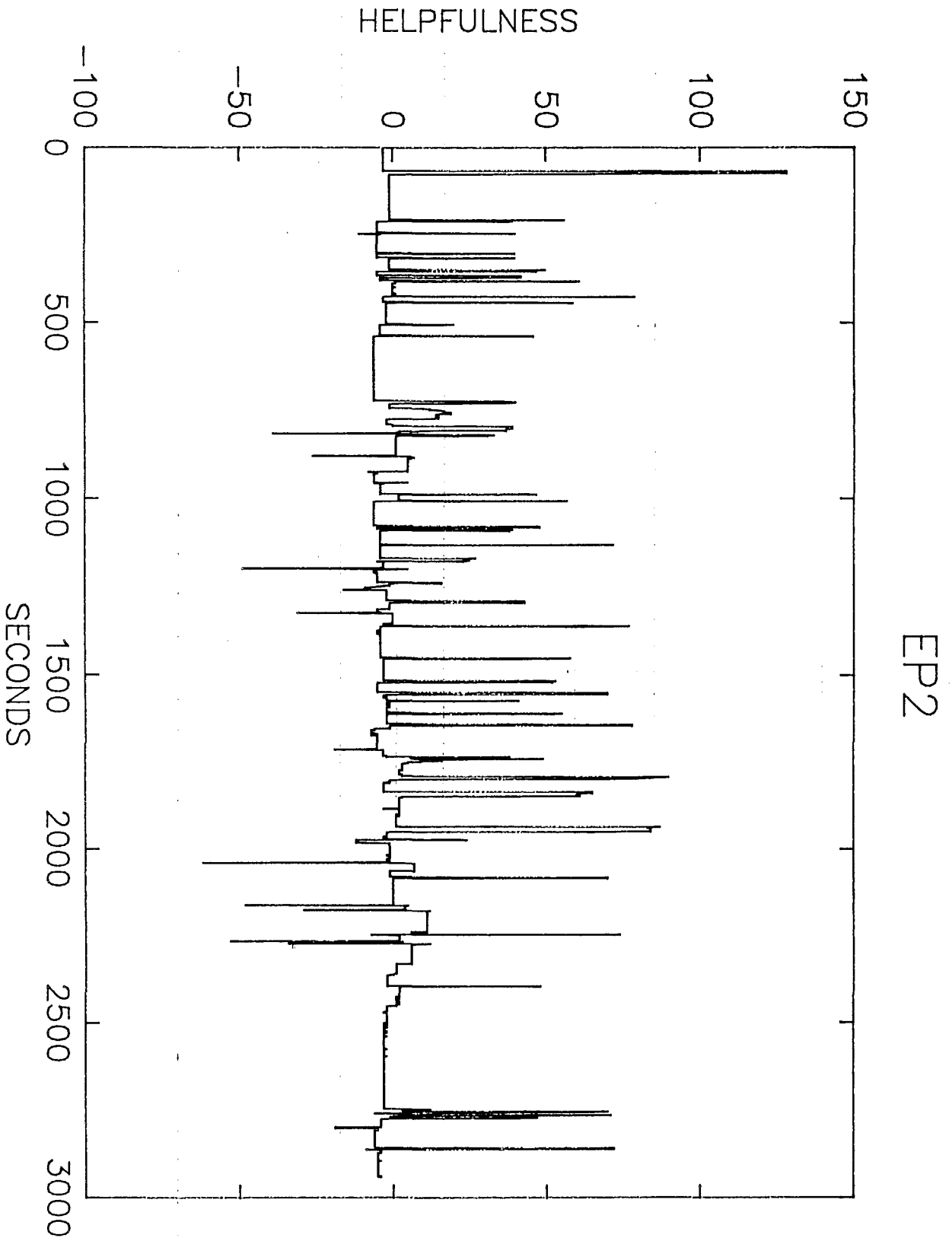


Figure 3-6 Therapist Rating of Helpfulness for Session 2

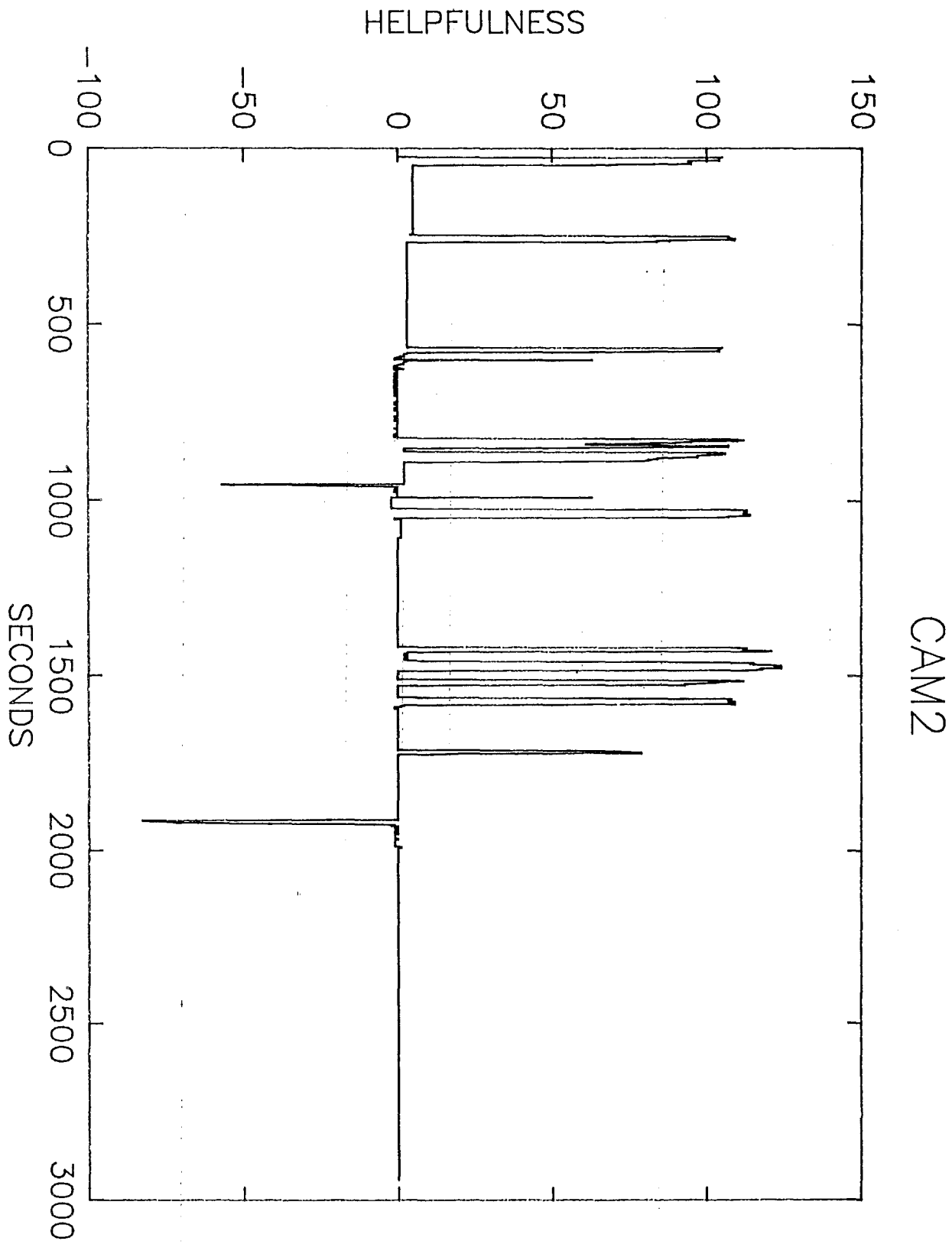
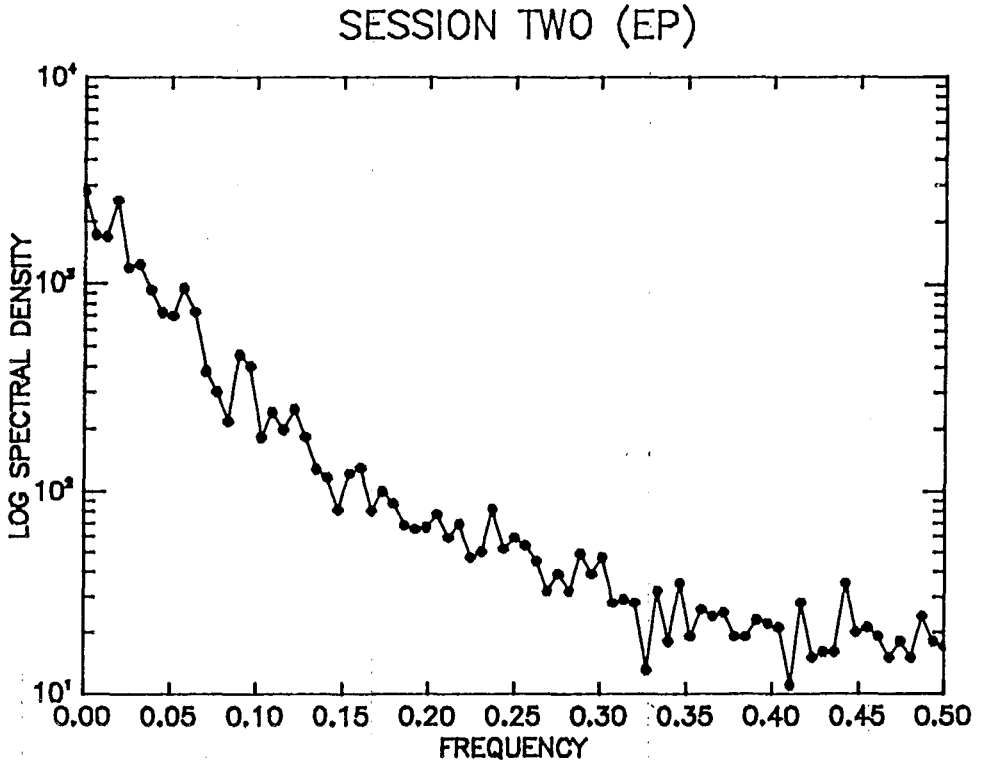


Figure
3-7 Log Spectral Density for Both Series for Session 2



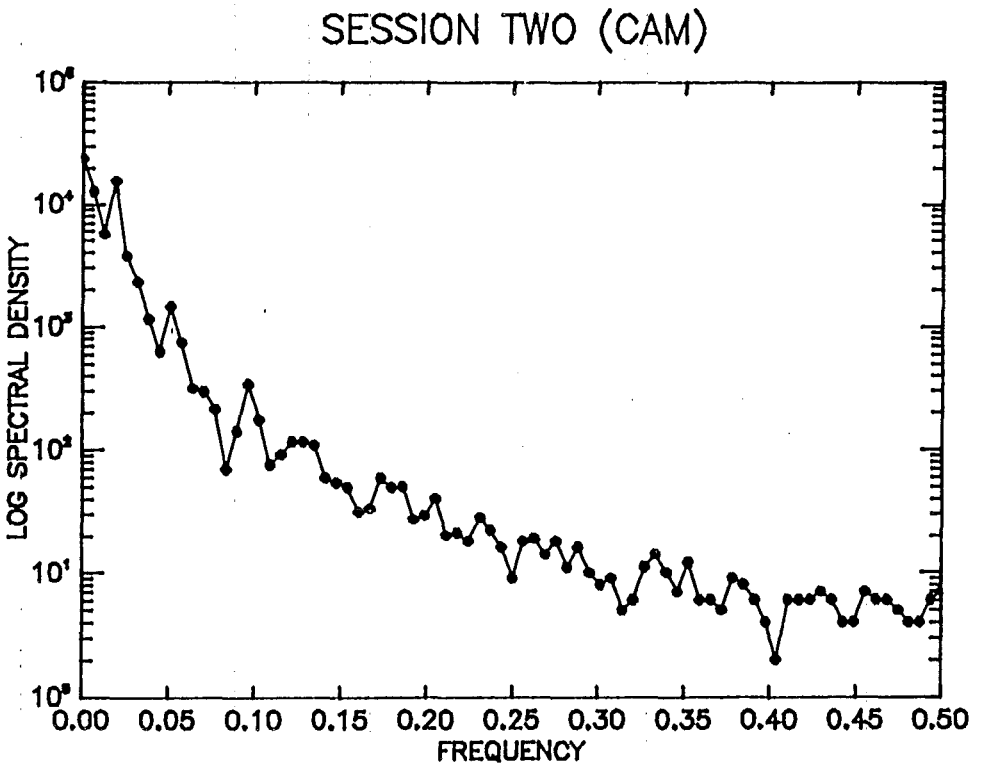
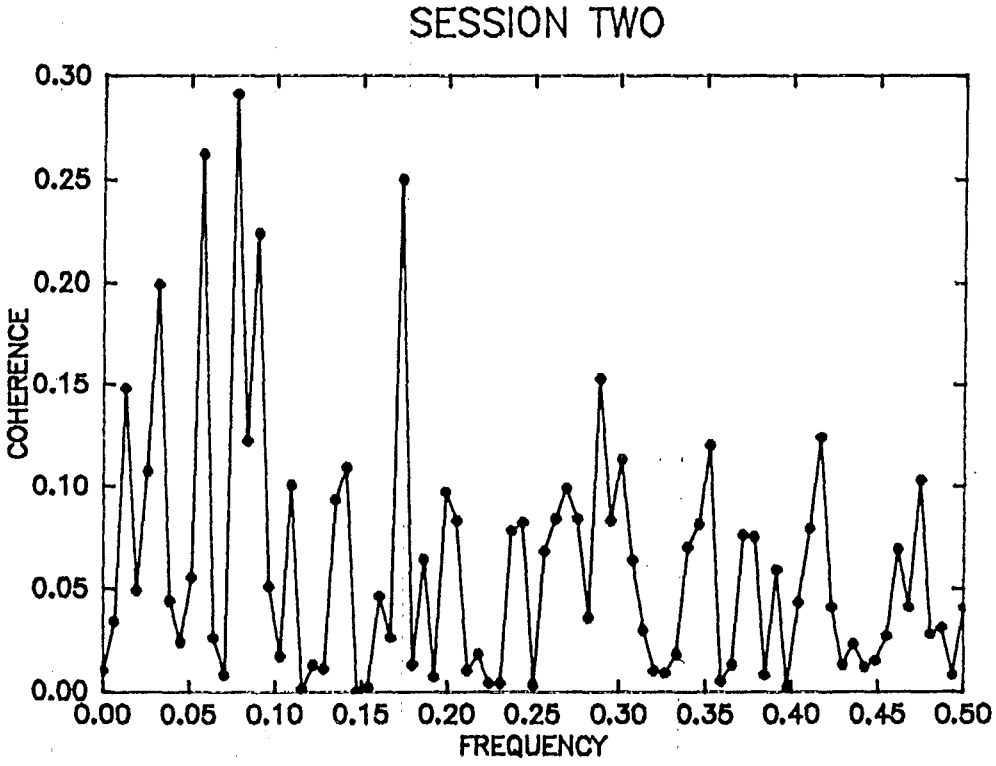


Figure
3-8 Coherence & Phase Results from Bivariate Analysis for Session 2



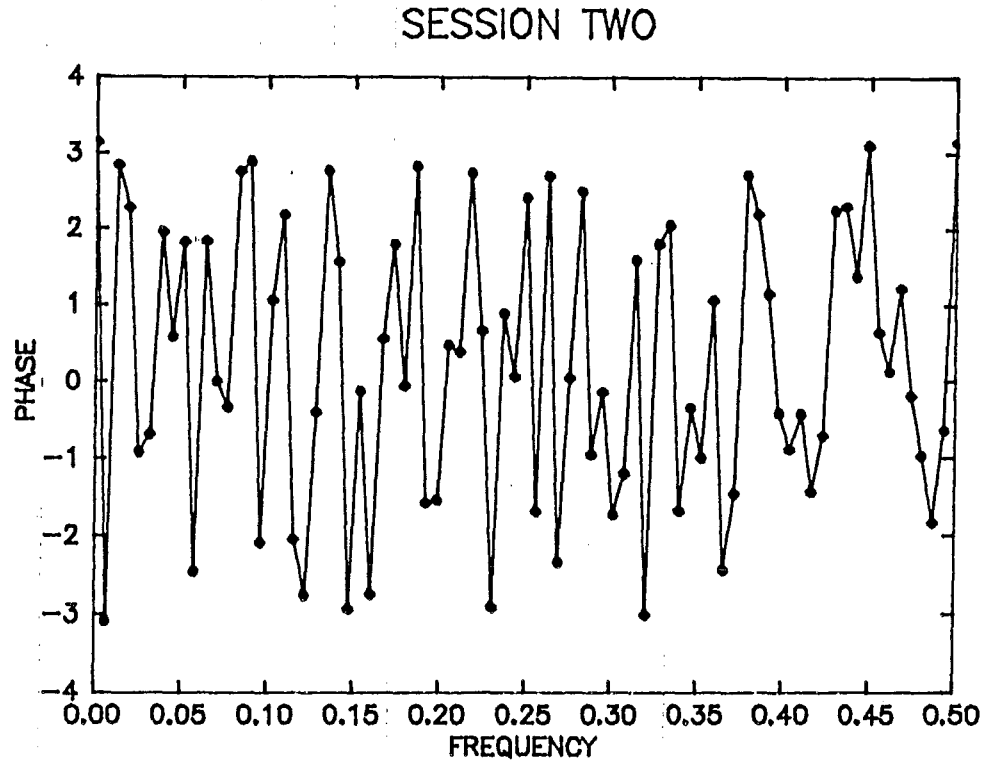


Figure 3-9 Client Rating of Helpfulness for Session 3

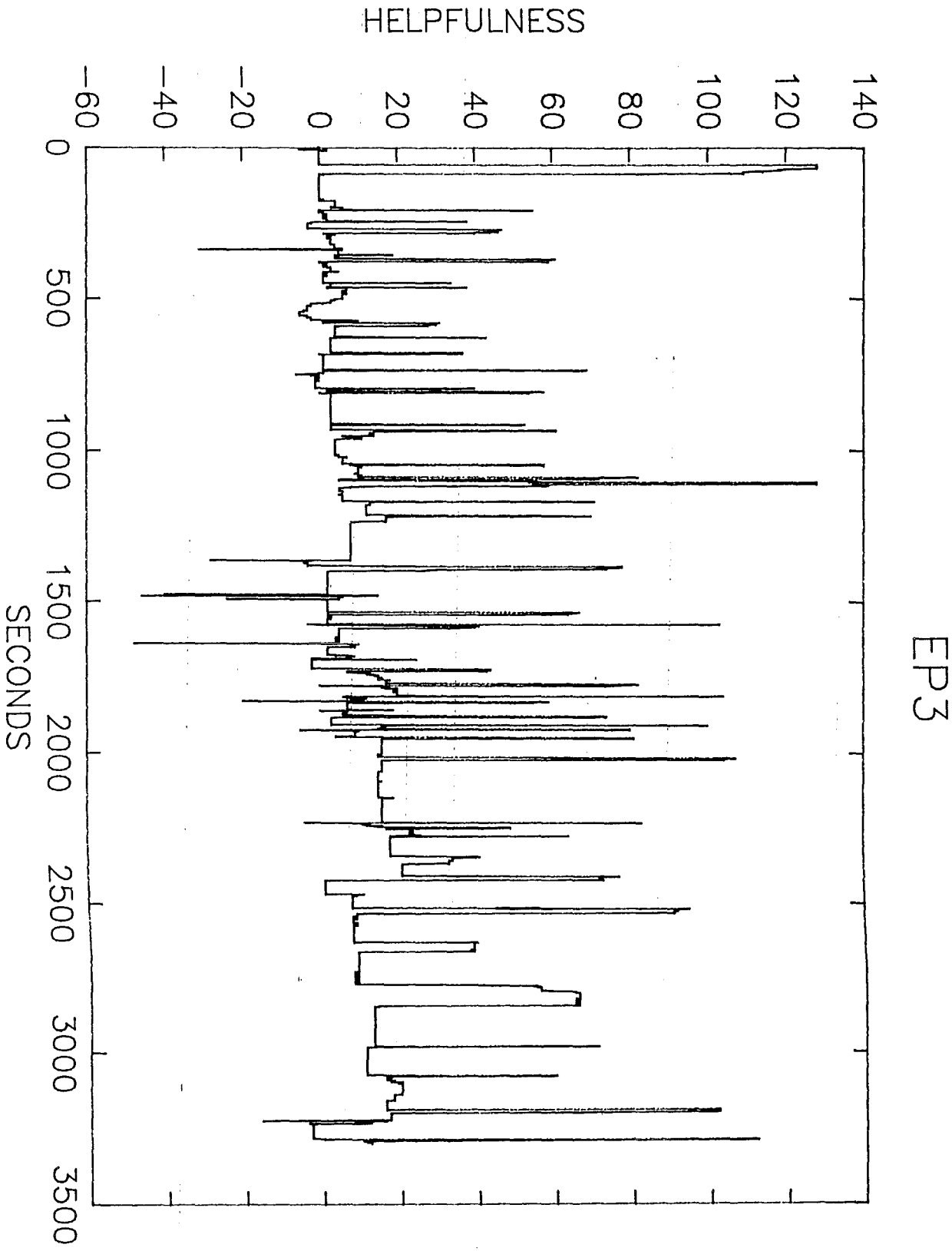


Figure
3-10 Therapist Rating of Helpfulness for Session 3

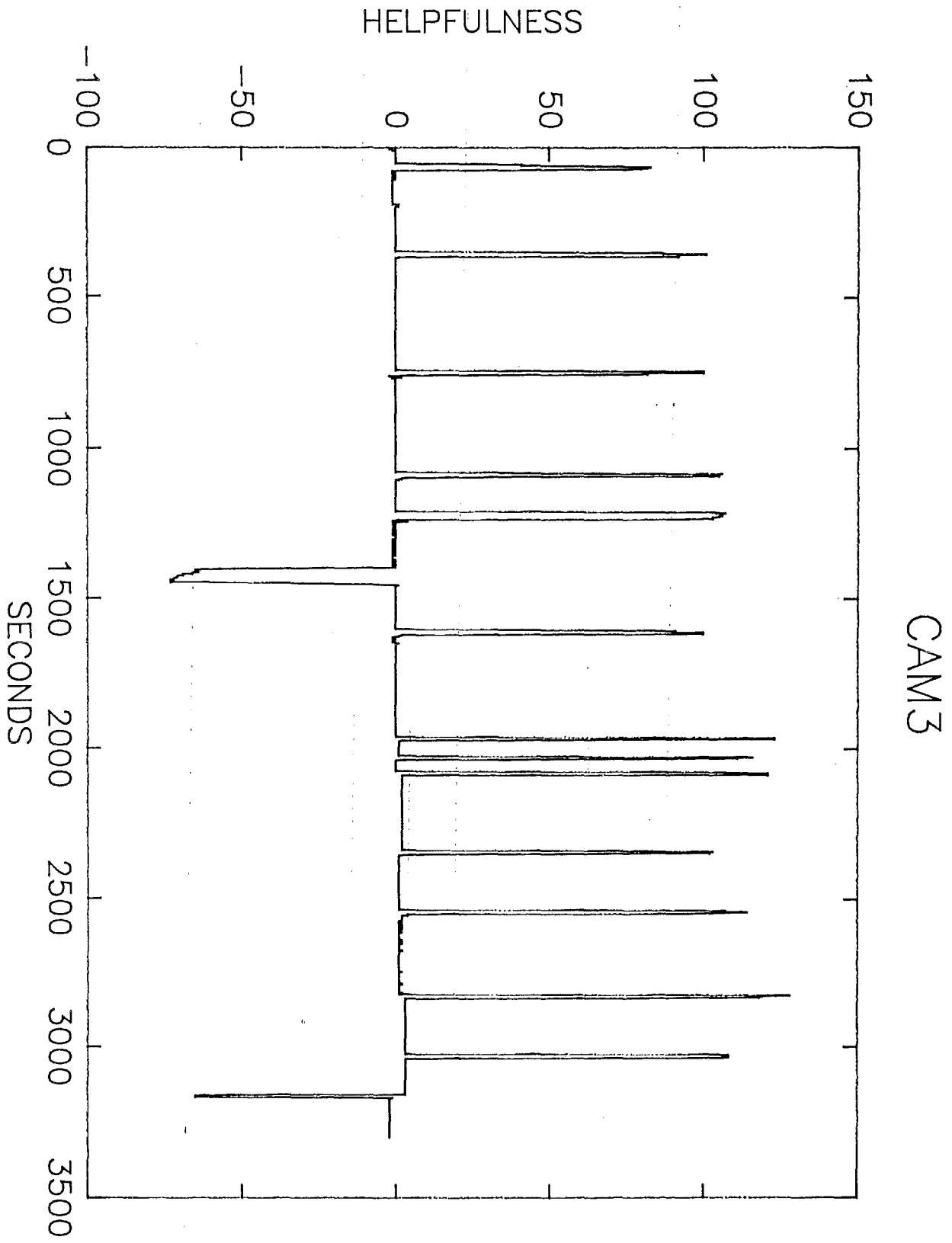
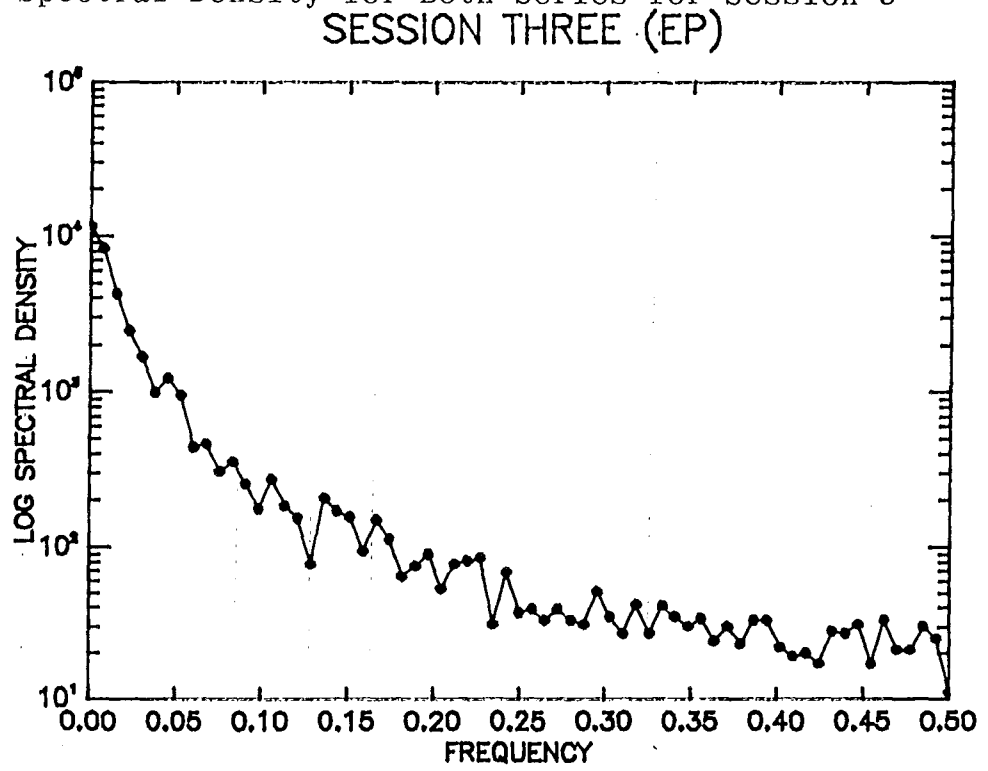


Figure
3-11 Log Spectral Density for Both Series for Session 3



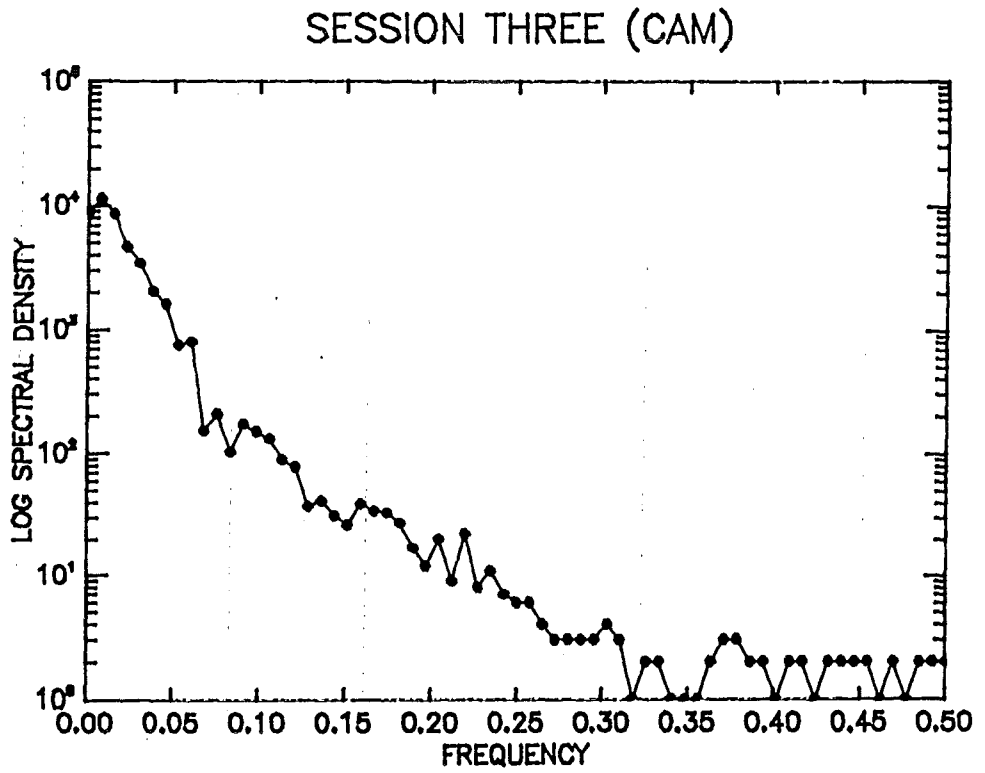
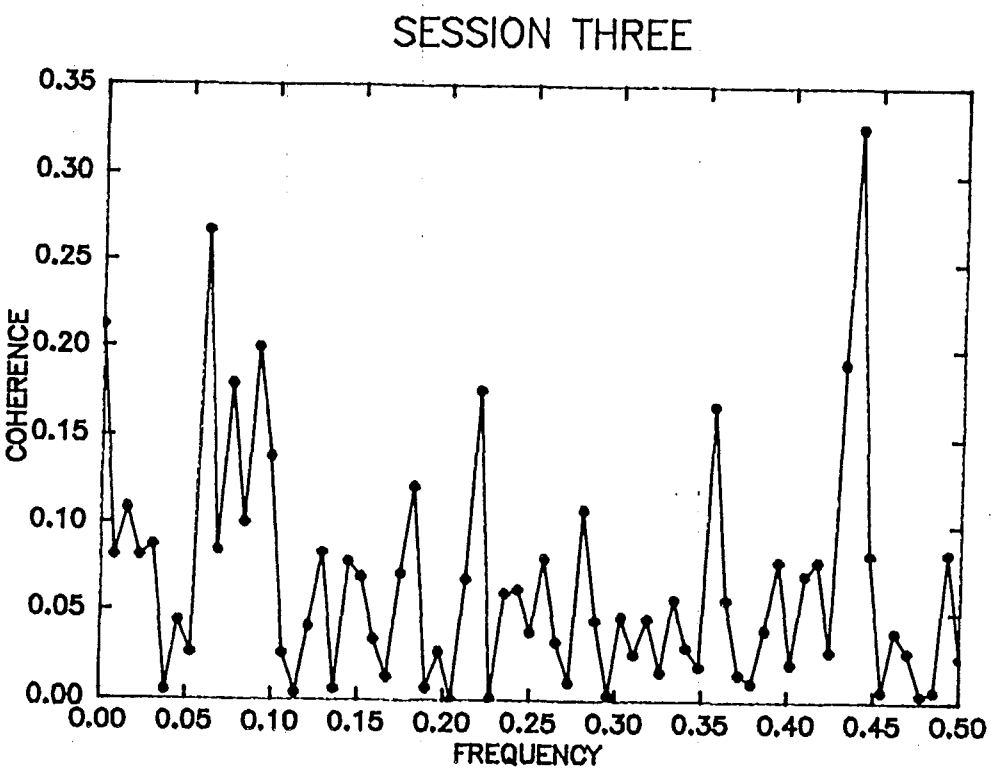


Figure
3-12 Coherence & Phase Results from Bivariate Analysis for Session 3



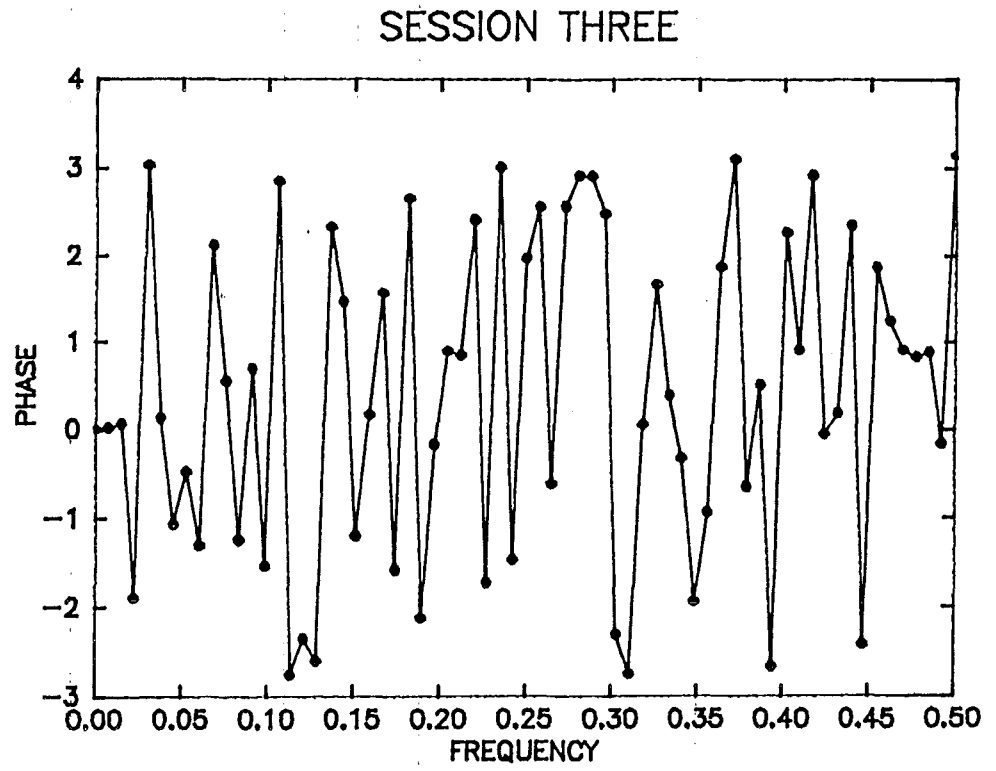


Figure
3-13 Client Rating of Helpfulness for Session 4

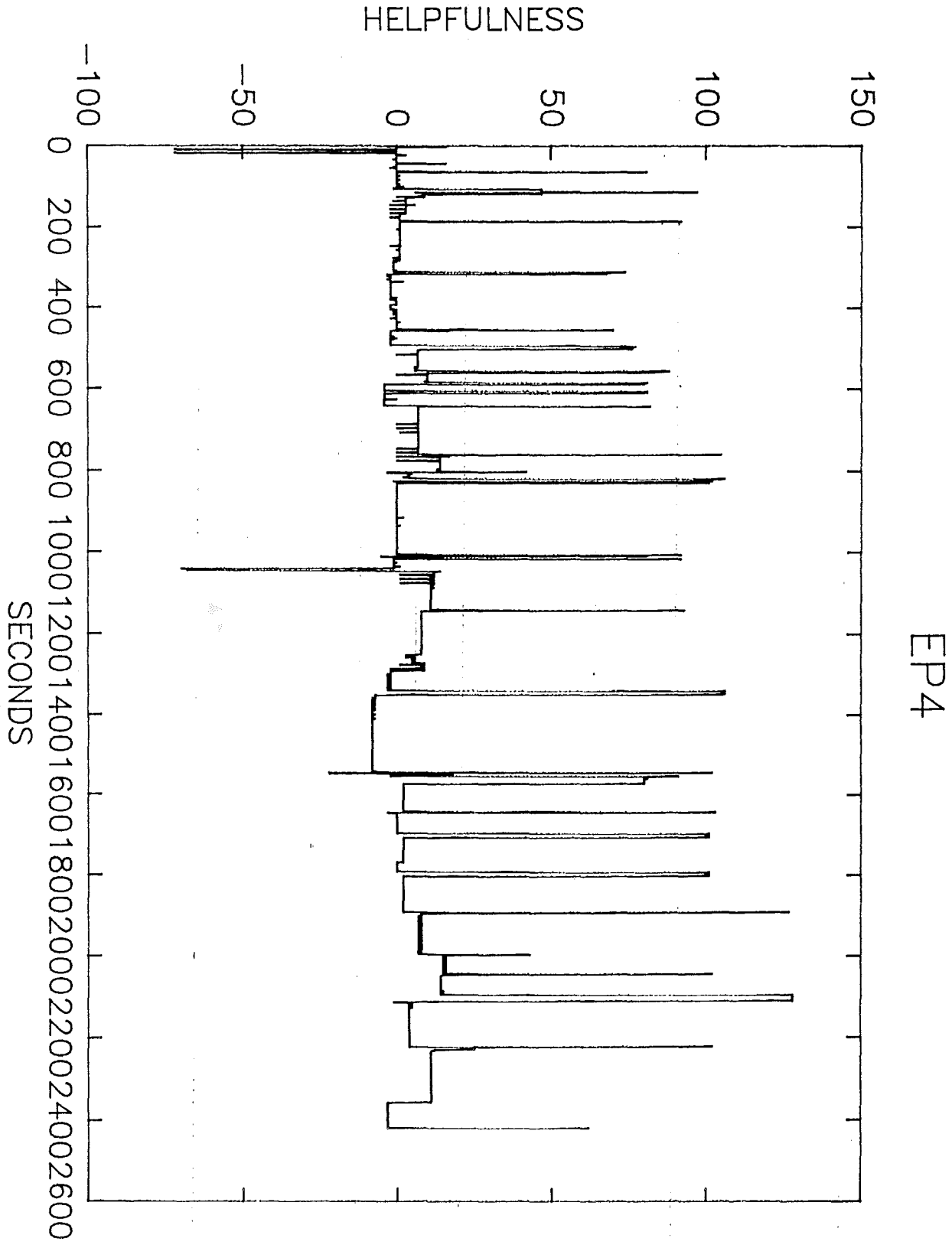


Figure 3-14 Therapist Rating of Helpfulness for Session 4

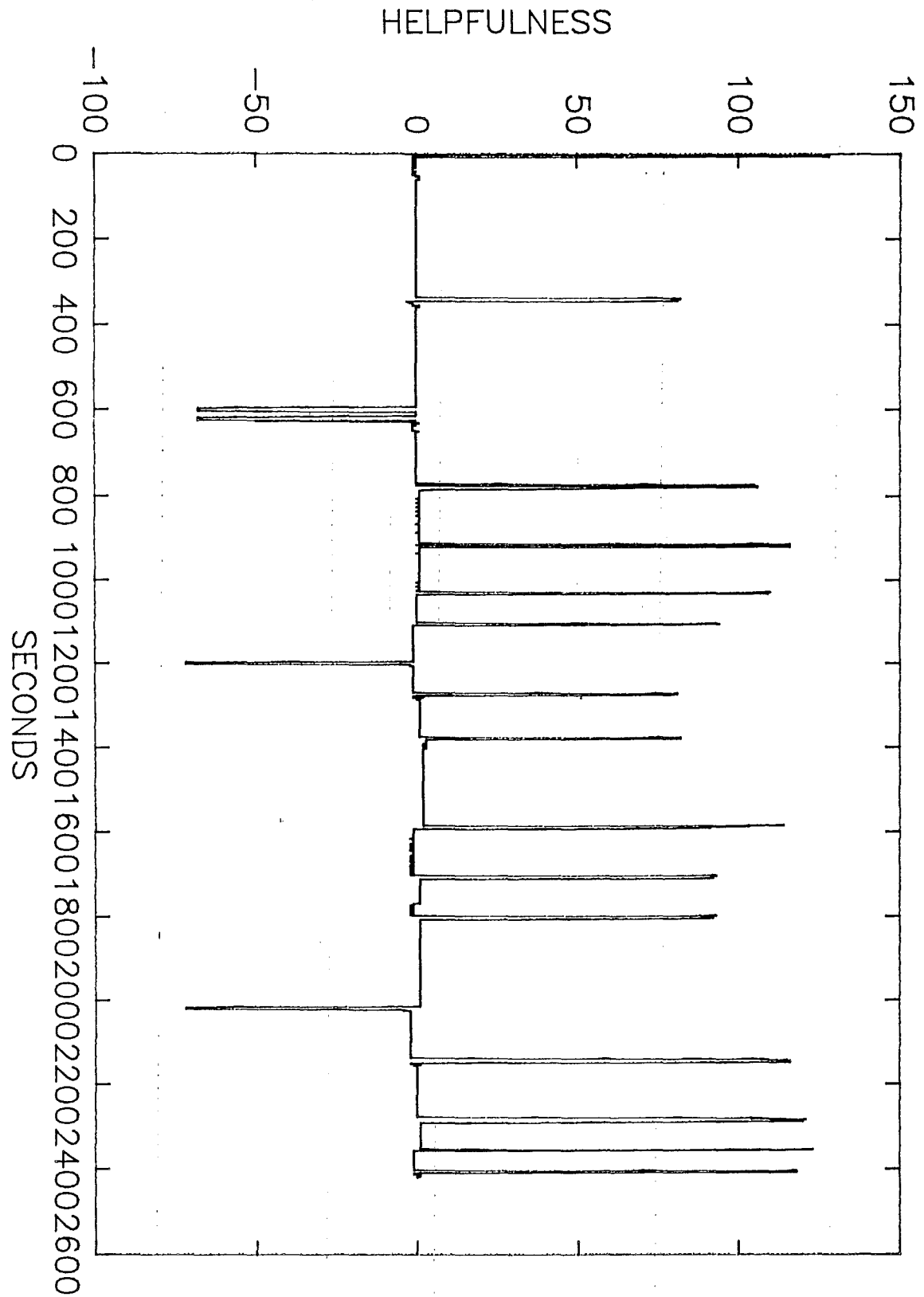
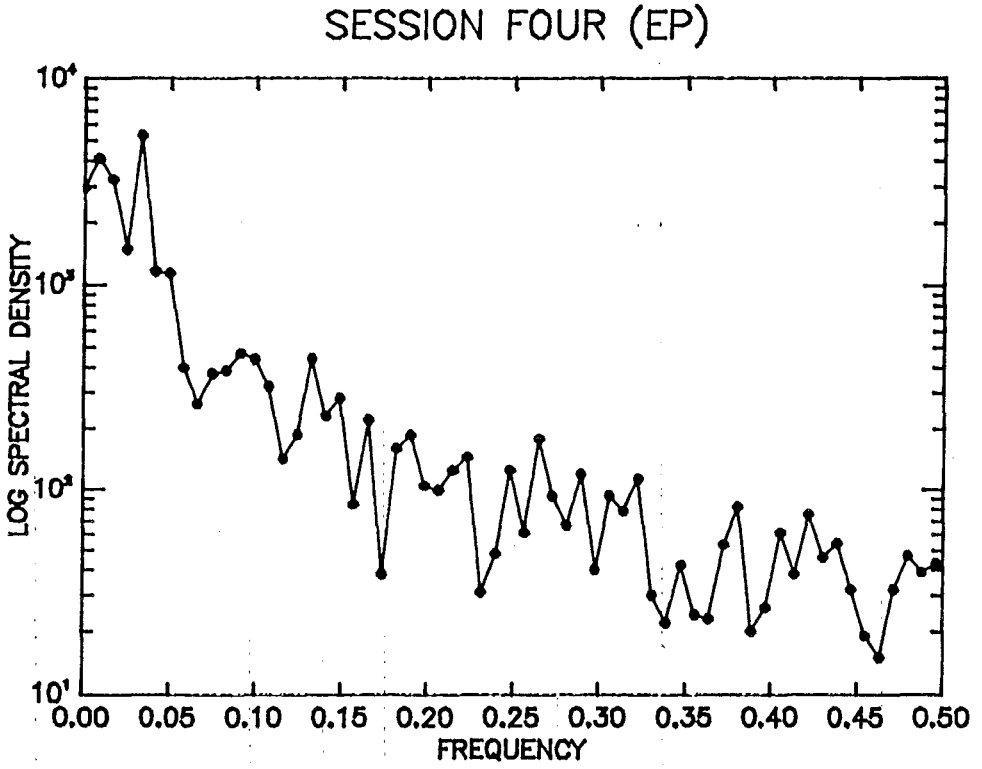


Figure
3-15 Log Spectral Density for Both Series for Session 4



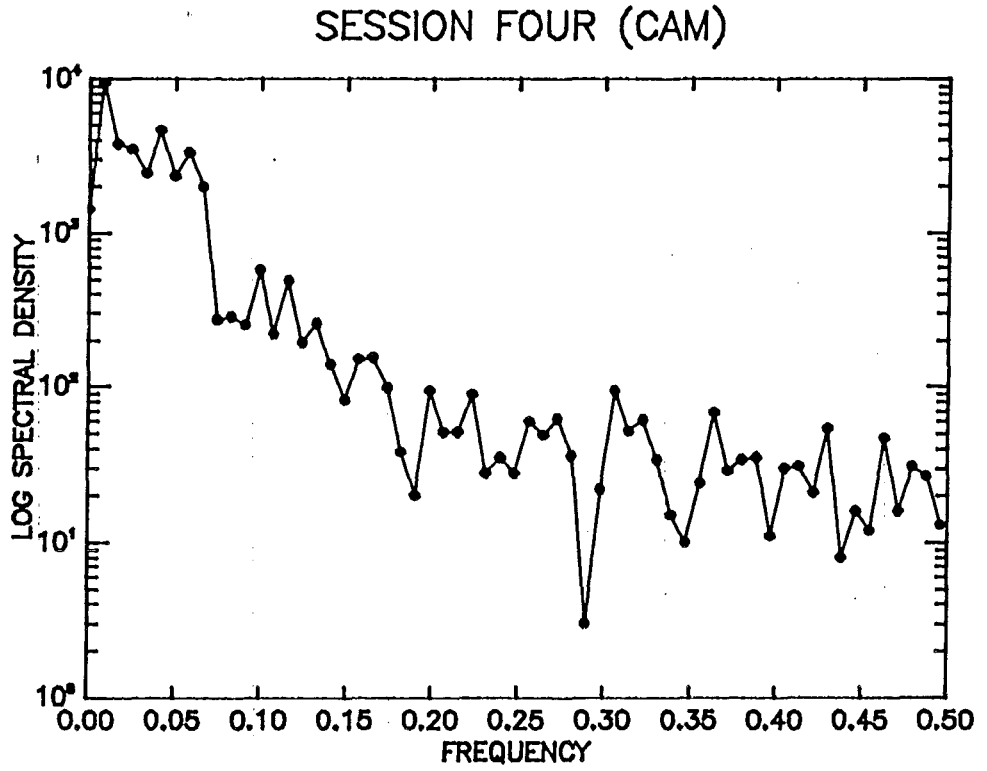
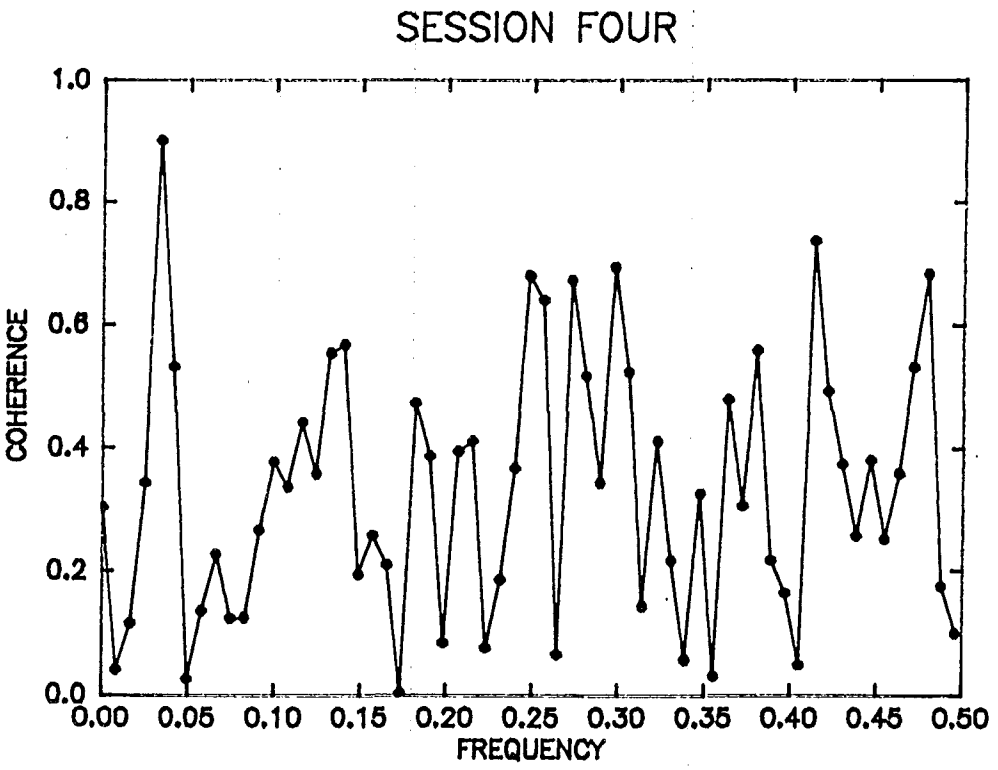


Figure
3-16 Coherence & Phase Results from Bivariate Analysis for Session 4.



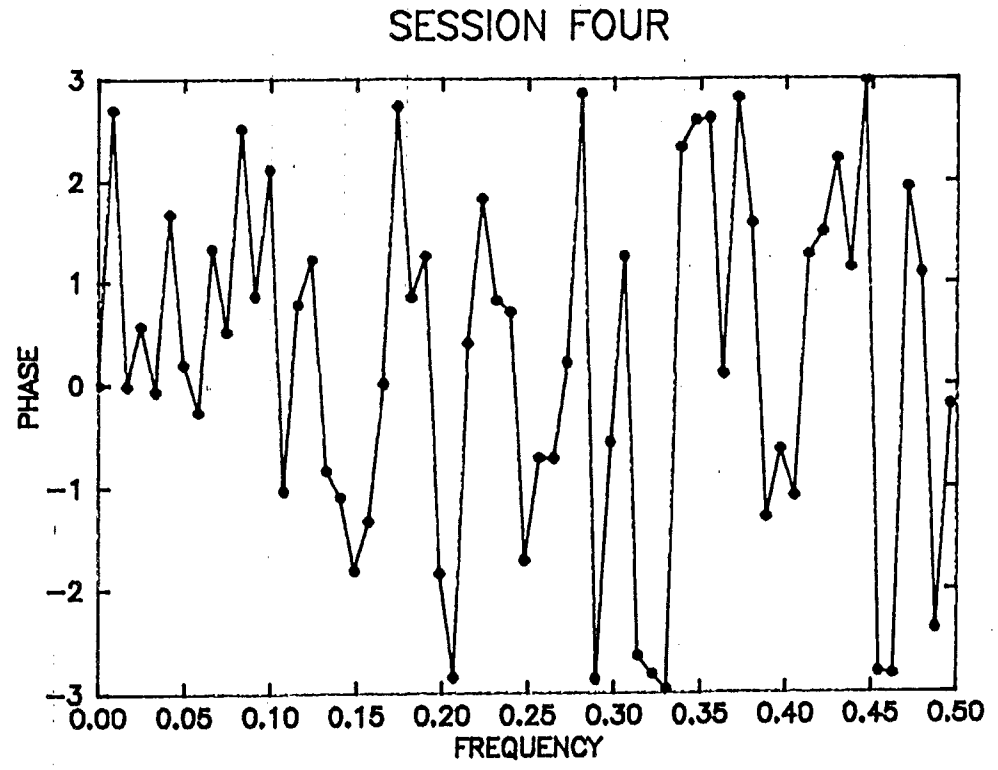


Figure
3-17 Client Rating of Helpfulness for Session 5

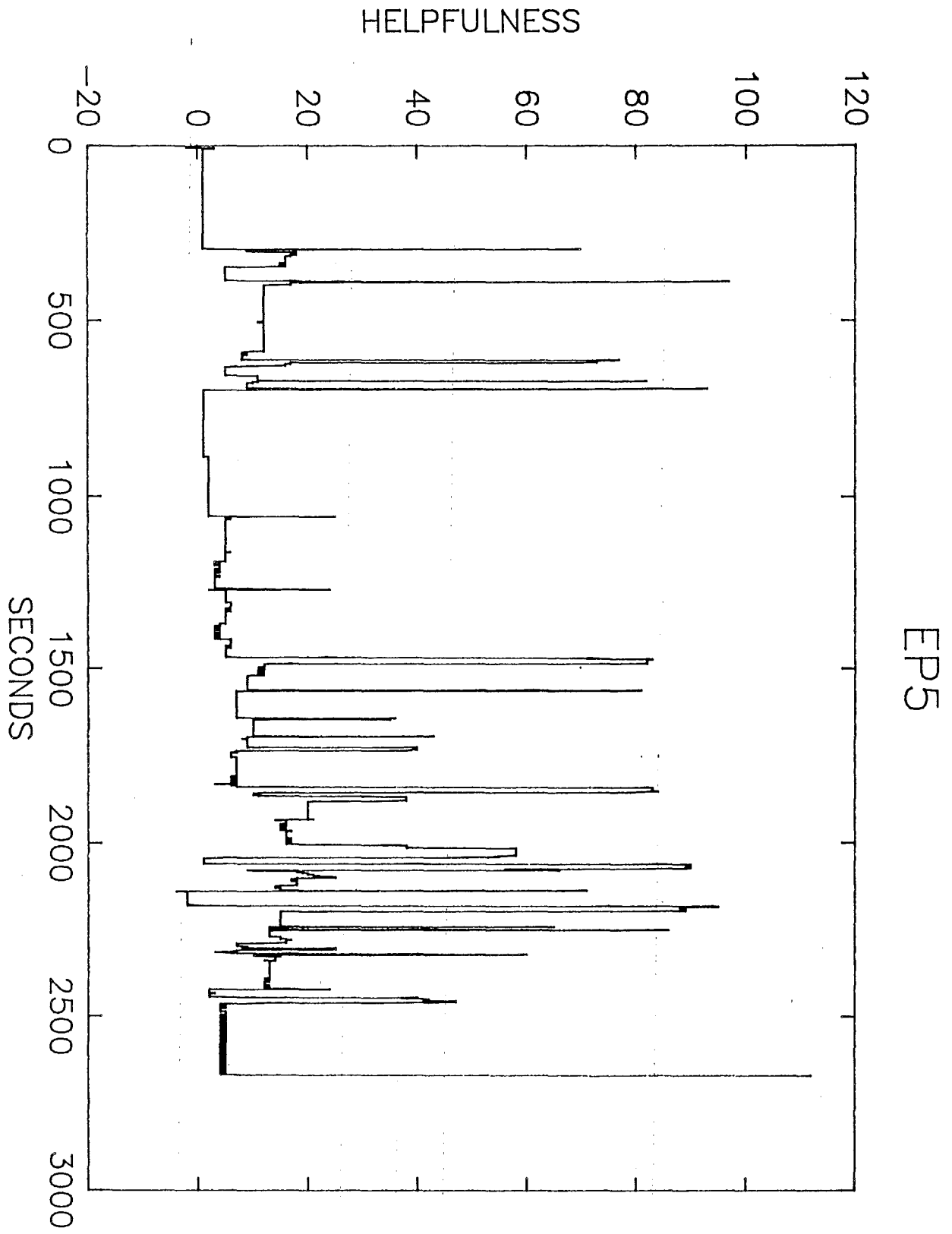


Figure 3-18 Therapist Rating of Helpfulness for Session 5

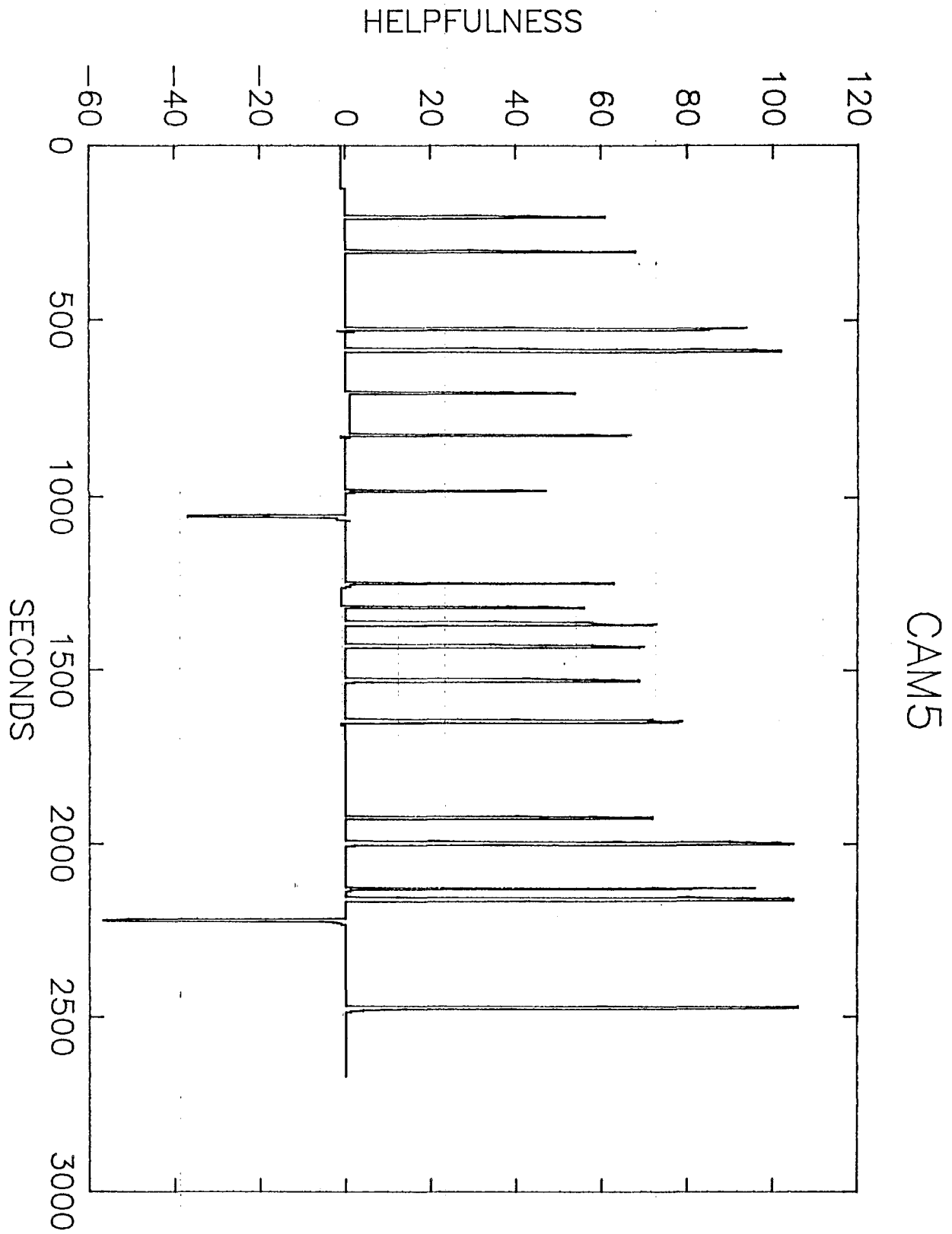
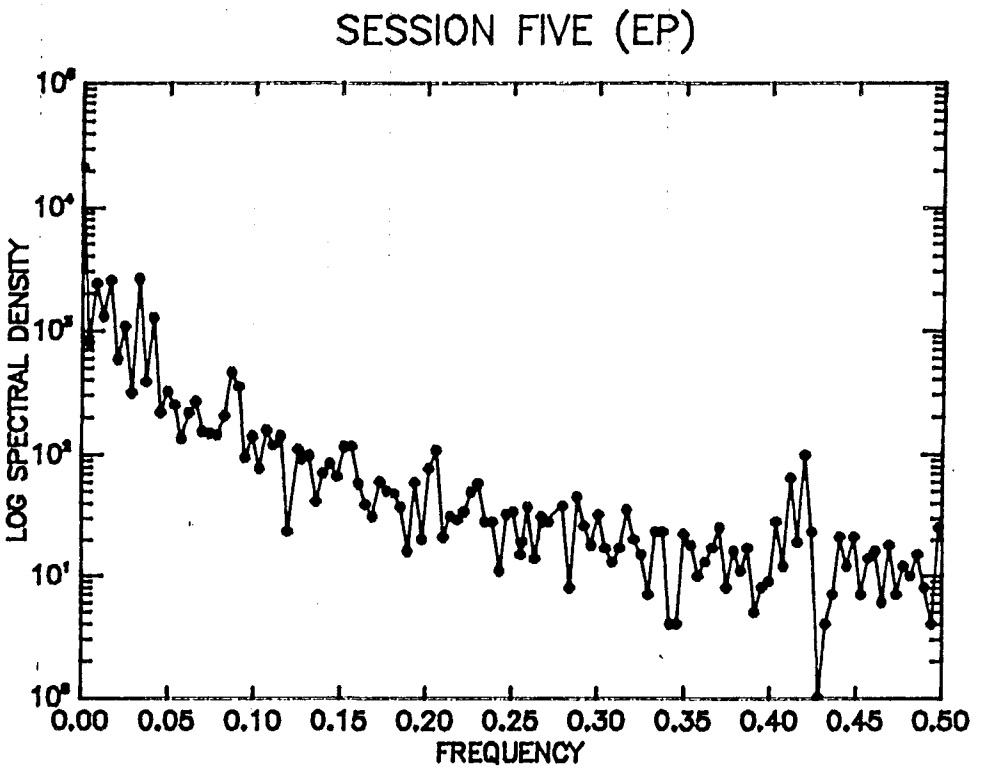


Figure
3-19 Log Spectral Density for Both Series for Session 5



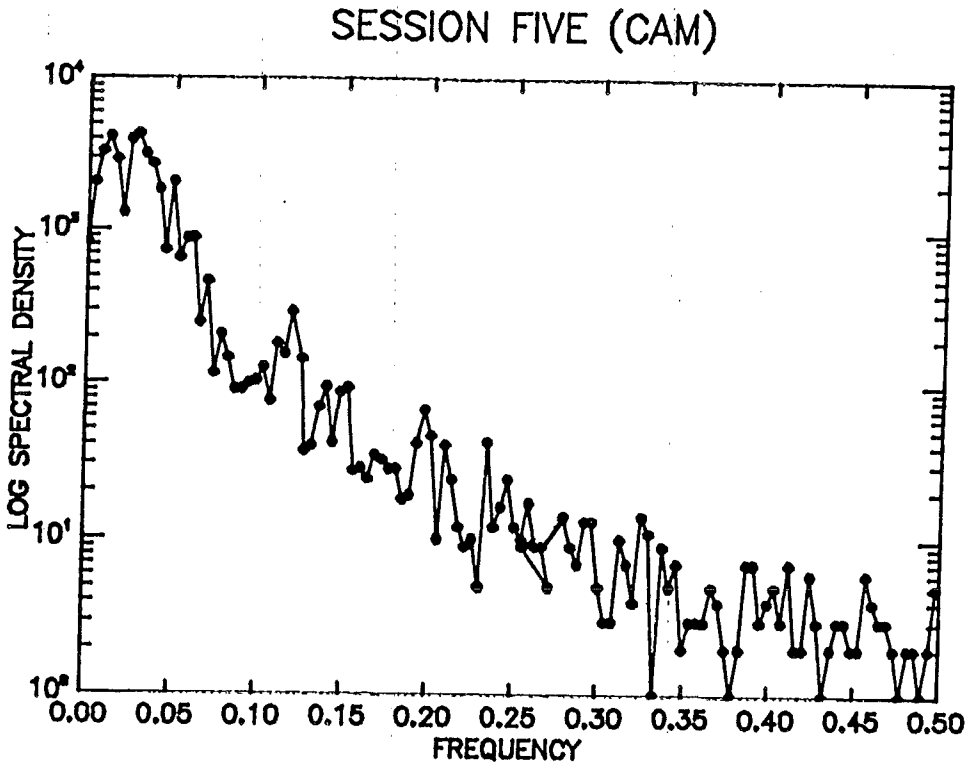
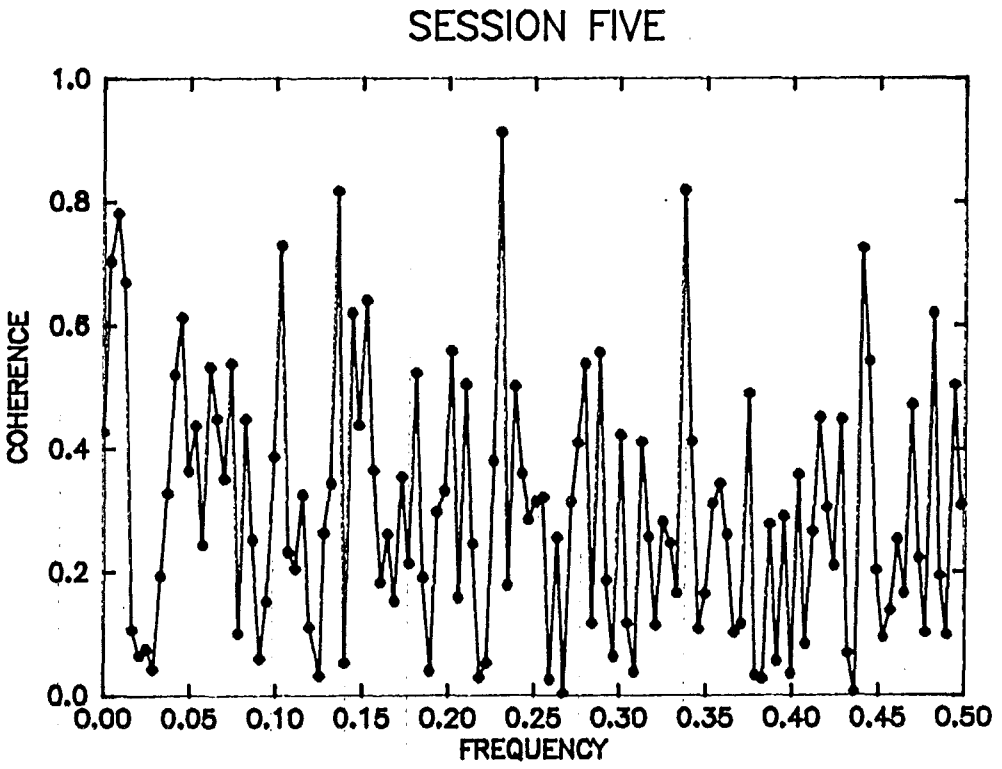


Figure
3-20 Coherence & Phase Results from Bivariate Analysis for Session 5



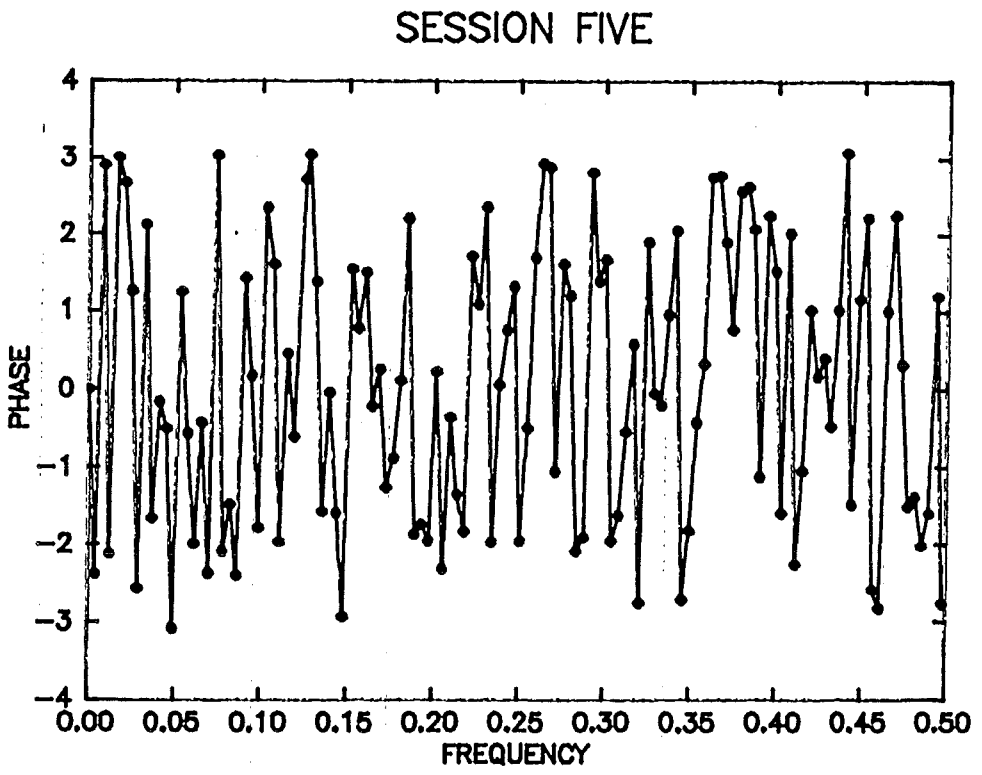


Figure
3-21 Client Rating of Helpfulness for Session 6

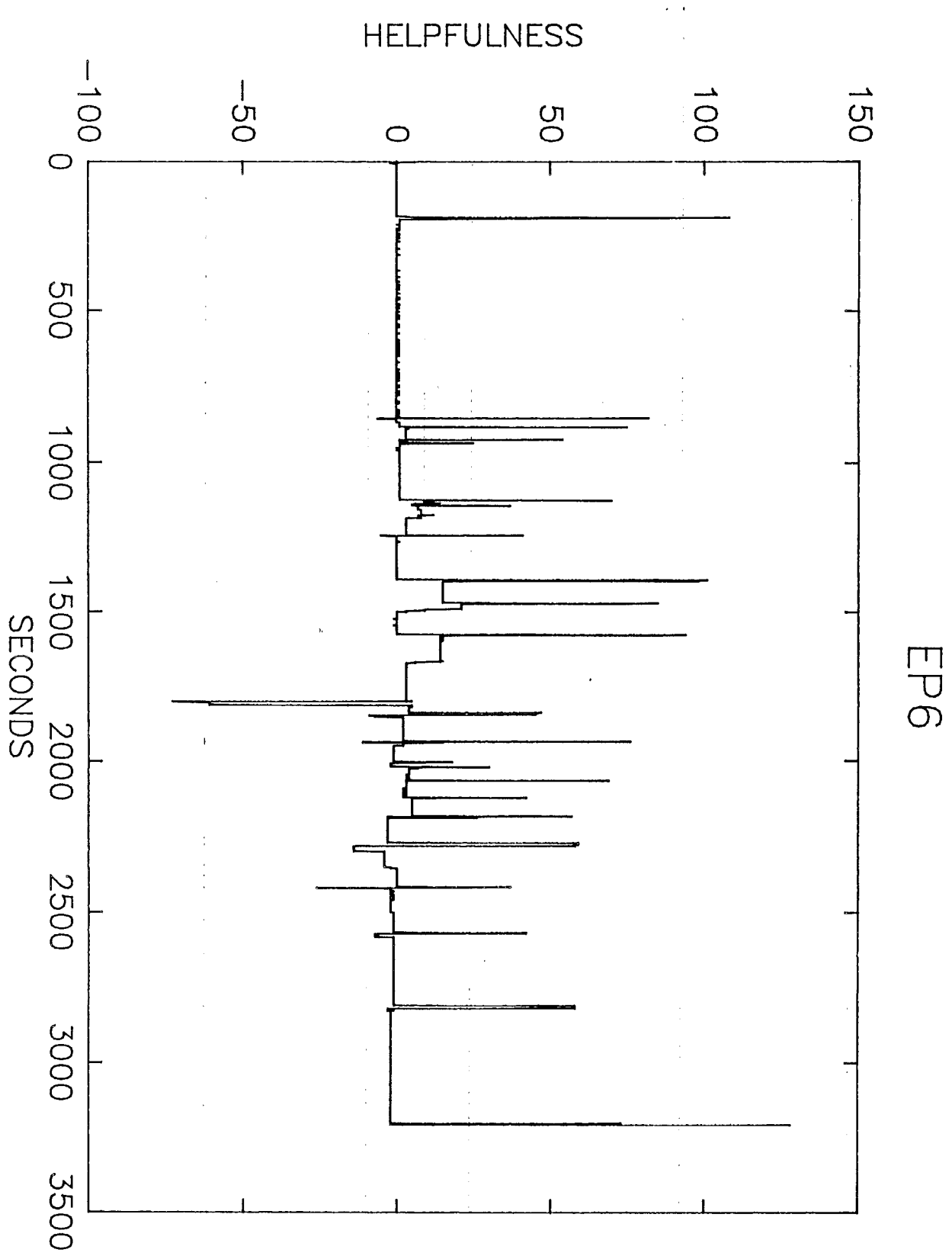
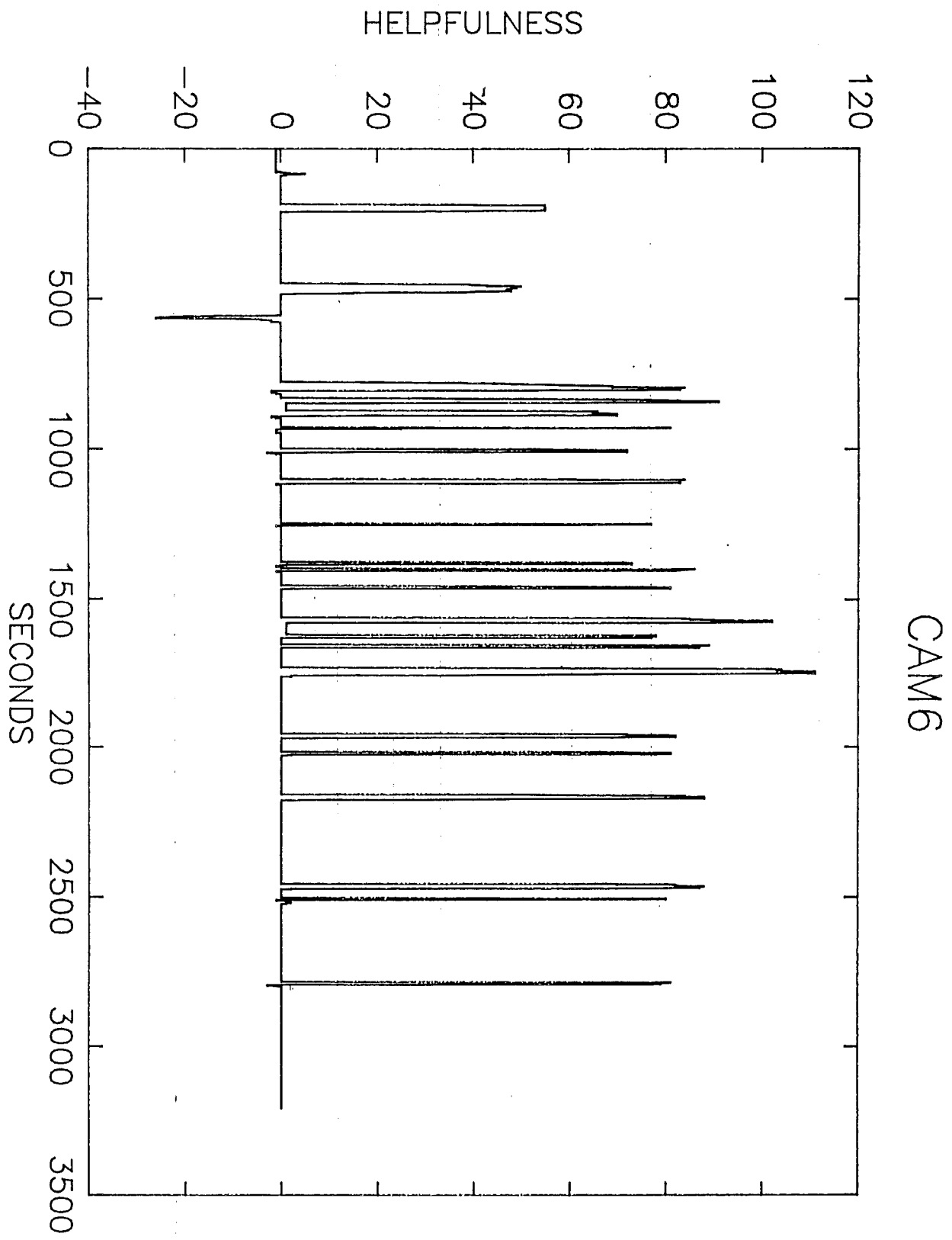


Figure
3-22 Therapist Rating of Helpfulness for Session 6



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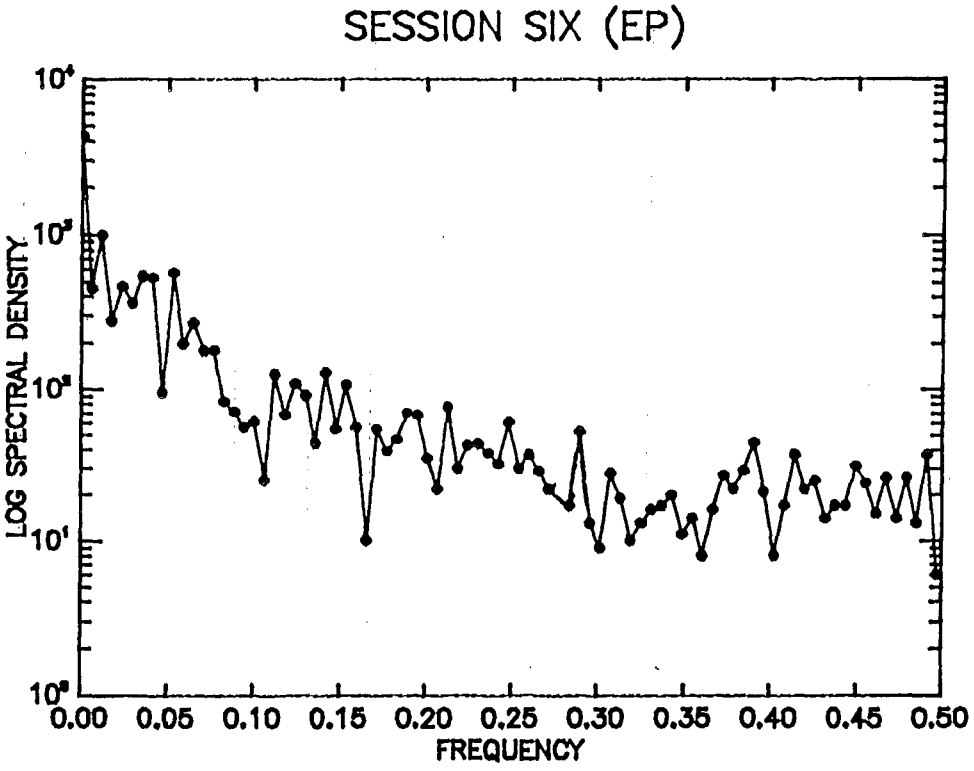
3-23 Log Spectral Density for Both Series for Session 6



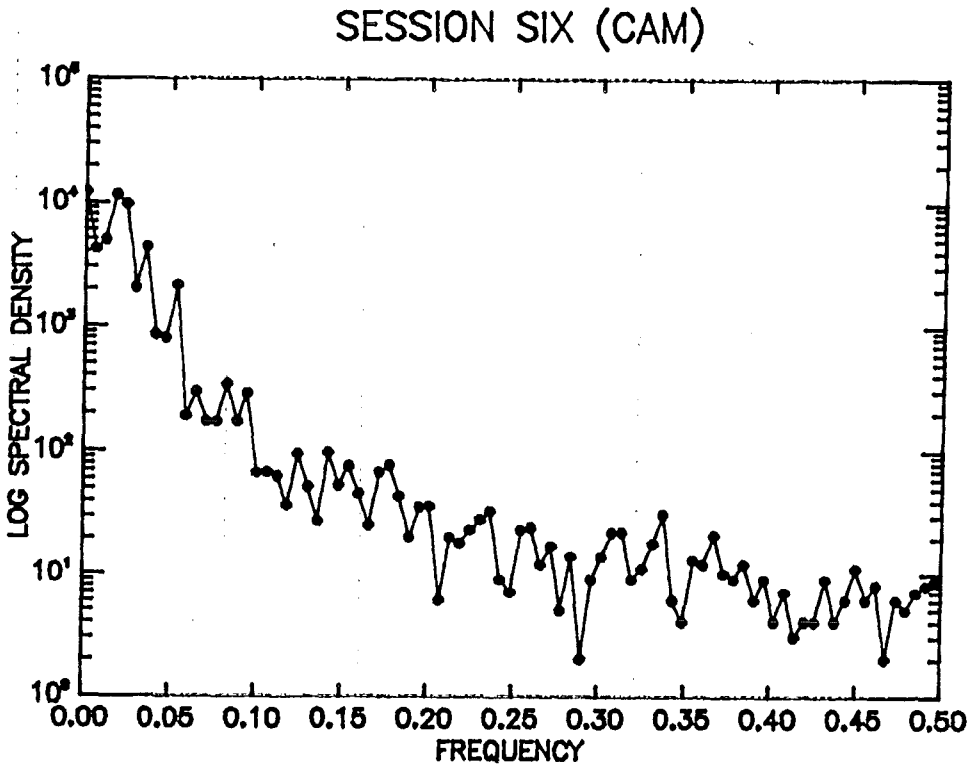
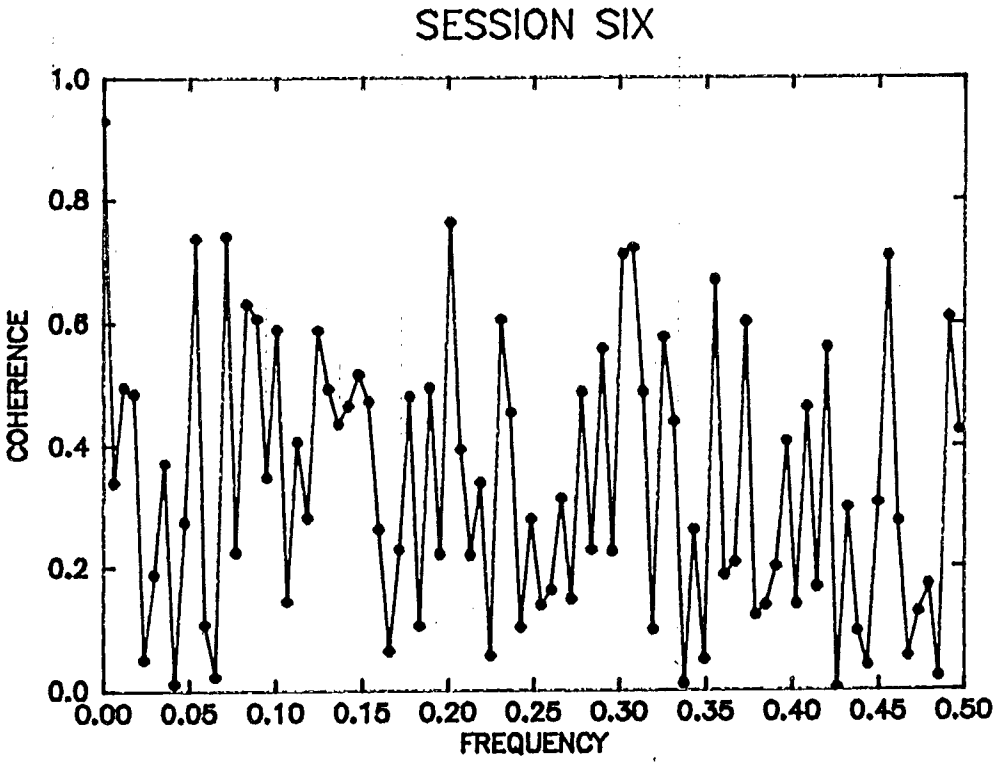
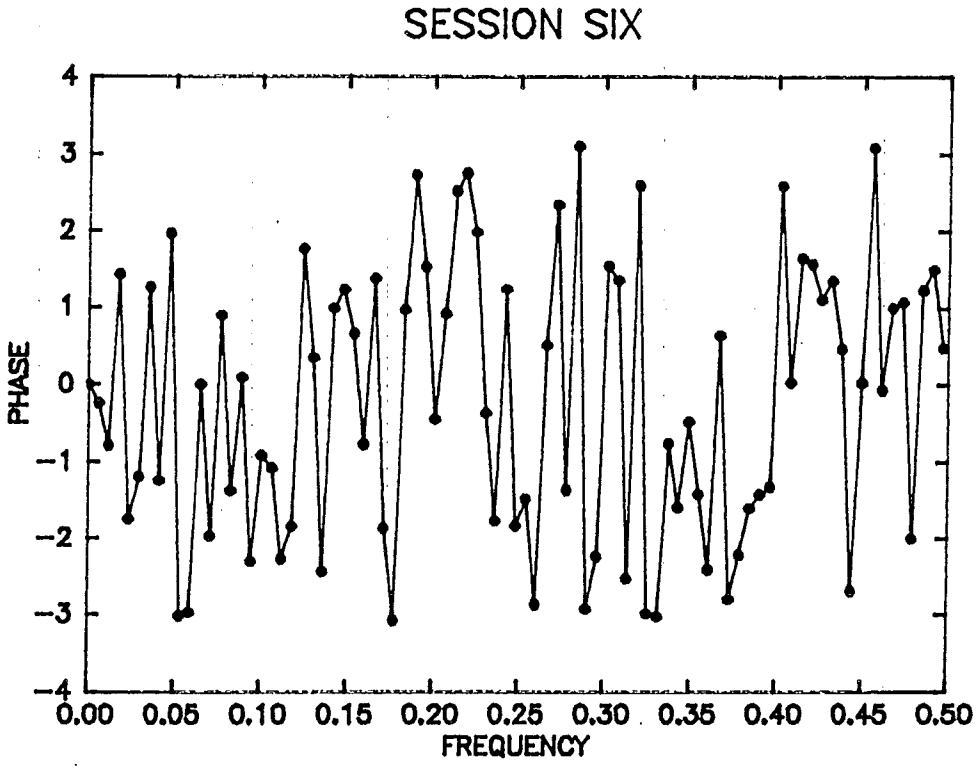


Figure
3-24 Coherence & Phase Results from Bivariate Analysis for Session 6





CHAPTER FOUR - DISCUSSION

4 - 1 Methodological Limitations

4 - 1 - 1 Qualitative Analysis

The limitations of the N=1 study design have already been discussed in Chapter One. These can be summarised by saying that the single case design has low external validity, and its internal validity can be seriously challenged by several factors (e.g. confounding of variables, practice effect, history etc).

Some of the specific methodological limitations of the current study are: a) The reliance on self-report and the consequent sujectivity of the data collected (the inclusion of the dial analogue measure with the subsequent spectral analysis of the data generated, was seen to be a validating measure for the subjectivity of the qualitative material. While also being a product of self-report, it did not suffer from constraints of existing definitions and categories. Thus it left subjecive decision-making less hindered by externally imposed parameters). b) The `self-selecting' popluation from which the therapist and client were drawn (i.e. the willingness to exposure that both participants showed may differentiate them from many other therapists and clients and thus make them less like the `normal' population of therapists and clients. c) The close and necessary participation of the author with both client and therapist during post-session video viewing was yet another influence on the responses of both participants, and possibly contaminated or biased those responses. d) The study failed

to take account of context and patterns of interaction (Greenberg, 1986; Russell & Trull, 1986). The coding of therapist responses required a certain degree of contextual consideration, but this was more to do with whether or not new material was being introducted than with looking at the overall picture of client-therapist interaction, and identifying patterns and themes. As well, the design of the study did not relate process sub-outcome to final outcome of therapy. This happened for two reasons: 1) the focus of this study was on identification and description of helpful events in therapy, not outcome, and 2) implicit in the aims of he study is the belief that intra-therapy outcome (i.e. experienced helpfulness) is as important to identify and describe as final therapy outcome. e) The verbal response mode taxonomy which was used (Hill, 1978) did not always discrimate as finely in practice as in theory (e.g. between the categories of minimal encourager and approval/reassurance). More importantly, quite a degree of subjective judegment was required in order to distinguish between a `simple restatement of what the client had already said' and a response that `goes beyond what the client has overtly reconised'. A specific stumbling block for the research question of this thesis was that categories did not distinguish between the type of response and the content of the response (e.g. the response `what are you feeling?', is actually a response which involves an affective emphasis but would be coded in the category of `open question'. On the surface this is not an affective-oriented category but the question itself does in fact respond to the client at a `feelings' level). f) The nature of the research quesion -

`what do you experience as most helpful?' - has inherent difficulties. For example, a therapist who reinforces existing helplessness of a passive, dependent client may be seen by the client as `helpful'. On the other hand, the same therapist who challenges the beliefs and actions of that client may be experienced as critical and uncaring. Which response is truly more helpful for the client? (A suggestion for future research may be to ask the client in what way could he best describe his experience of the process of therapy. A better question for the client may have been, `tell me in what way is this response helpful/unhelpful'? These are the kinds of enqiries made during Elliott's (1985) study of Helpful and Nonhelpful Events, which were later used in the formation of the Therapeutic Impact Content Analysis System (Elliott et al, 1985). This kind of enquiry made of the client would go some way toward establishing a context for the experience of that helpful/unhelpful response.

In terms of the more general methodological problems with single case studies, researchers can employ strategies that help to overcome these, such as a) specifying the dependent and independent variables under study; b) using reliable and systematic measures of dependent variables; c) taking repeated measures of the dependent variable, and d) providing accurate descriptions of the participants and procedure so that the study becomes replicable. The current study has attempted to meet this criteria. The possibility that this study has good external validity is implied by the fact that the results are similar to those gained by experimental studies already cited (Elliott et al, 1985; Fuller & Hill,

1985; Hill & O'Grady, 1985). Nevertheless, it is an uneasy feeling when results yield no large group of figures to be statistically analysed. It is with this insight that the dirth of N=1 qualitative studies in the literature is more easily understood. However, requests for qualitative research continue (Elliott et al, 1982; Elliott, 1985; Elliott et al, 1985).

The strengths that this study has are that it closely represents the actual clinical situation, whole counselling sessions were analysed, specific in-therapy measures of impact, intention and independently coded therapist responses were made of the same event in relation to perceived helpfulness, (this procedure seems to combine the aims of several stdies cited), and finally it follows the recommendation of Greenberg (1983) that good description of therapy events should precede explanation and prediction.

4 - 1 - 2 Spectral Analysis

Bivariate spectral analysis offers a way of describing cyclicity in data series, and identifying coherence and phase between the two sets of data.

However, the pattern of frequency detected in psychotherapy sessions (see Figures 3-1, 3-2, 3-5, 3-6, 3-9, 3-10, 3-13, 3-14, 3-17, 3-18, 3-21, and 3-22) takes more of pulse form than a cyclical form. Therefore, Spectral Analysis, which detects cyclical patterns, may not be the technique of choice to analyse such data.

4 - 2 Interpretation of Results

4 - 2 - 1 Qualitative Analysis

The impact category of felt understood together with the intention of clarify and the response mode of interpretation were associated with client perceived helpfulness. These categories appear complimentary and suggest that 'helpfulness' seems to be associated with the experience of both feeling understood and understanding oneself with greater clarity than before.

However, in terms of perception of therapist intention, client and therapist differed. The client perceived the most helpful events to be associated with the therapist intentions of clarify. The therapist identified the most helpful events to be associated with his intentions of feelings. These results suggest that while the client experienced the most helpful therapist responses as those which attended to the emotional content of his communication, he perceived a different therapist intention to be associated with that response.

In actuality, the client's perception of the therapist's intention could be a sample of his general view of others. This is skewed toward an intellectual/cognitive appraisal of his own and others behaviour. And yet he seems to derive benefit (or at least rate highly) those therapist responses which by-pass his natural rational-intellectual way of responding, and emphasises the emotional aspect of his functioning. This analysis of therapist-client interaction

can be viewed as a microcosm of this client's habitual way of responding, and his misperception of that in interaction.

4 - 2 - 2 Spectral Analysis

Spectral Analysis was used to analyse data which reflected perceived helpfulness. It was a redundant measure in one sense in that the Helpfulness Rating Scale had already provided a measure of helpfulness. However, the self-rating dial analogue with the use of spectral analysis provides much more information than the self-rating Helpfulness Scale. It is able to identify cyclicity within a data series, and coherence and phase between parallel data series. This statistical technique is promising in its potential to identify patterns of interaction in psychotherapy sessions between the two members of the dyad, and their influences on each other. In this sense, it may provide the much needed evidence to support researchers' current interests in identifying and describing the important change events, and patterns in psychotherapy (Greenberg, 1986; Russell & Trull, 1986).

The results of the Spectral Analysis show a change occuring across the six sessions, indicating a shaping or learning process resulting in increased oherence between the therapist and client's view of helpful therapy events. How this occured, and which direction the influence was in, are questions which require further research. The possibility that longer length frequency patterns were not detected by the Spectral Analysis suggests that further examination of longer cycle (5-10 minutes) be explored.

4 - 3 Future Studies

In the opinion of the author, future studies would benefit from the following changes. 1) Prior to the study proper taking place, familiarise participants with measurement devices e.g. rating scales, analogue measuring instruments etc. Far from distorting the subject's recall and ability to accurately describe thoughts, events and feelings, this would provide an opportunity for participants to use these instruments to the full potential of their descriptive and identifying power. 2) That more emphasis in process research be given over to obtaining details from both client and therapist as to the invisible decision-making processes which both engage in during therapy. By identifying these processes two advancements may be made. Firstly, choices of intervention made by the therapist at all the decision points along the course of therapy are made covert and thus it may become possible to pinpoint the decisions and interventions which lead to successful outcome. As well, by requesting the client to make covert her experiencing of these interventions and how they effect her choices in therapy, it may be possible to match up the most helpful experiences that clients have with particular decisions and interventions utilised by therapists. Secondly, once these invisible processes are brought to light, it then becomes possible to incorporate the approriate information into psychotherapy training programmes, and, on the other side of the coin, begin to work with clients at an almost `pre-therapy' level,

to maximise the opportunity for the best therapeutic conditions to be created for this client. 3) Following on from 2), that the use of video be employed as frequently as possible both during psychotherapy, and in the training of psychotherapists. Client and therapist appeared to benefit from viewing videotapes of previous sessions before engaging in the next (Walz & Johnston, 1963; Alger, 1969; Marks, Montgomery & Davis, 1975; Sanborn III, Pyke & Sanborn, 1975).

4) The most appropriate analysis of frequency patterns generated from the viewing of psychotherapy sessions, may be gained by collapsing the existing data into 10 second averages and reanalysing using Spectral Analysis. This would give better discrimination at lower frequencies.

The current facilities available for the permanent recording of psychotherapy sessions makes possible the description and analysis of vast amounts of data rich in information about the complex process of therapy. With the science of psychology in its present state of emphasising measurement, definition and precision, it takes courage to engage in qualitative, descriptive studies. However, as was pointed out in an earlier section of this thesis (1 - 2 - 8 Methodology and Design), single case studies are complimentary to experimental group designs and both contribute to the stages of scientific investigation (Russell & Trull, 1986).

4 - 4 A Final Word

The following topics are a mixture of those which are less central to the process of psychotherapy practice and research, and some final comments on research into psychotherapy. They are: the role that values play in psychotherapy; the research-practice gap; implications for training; a philosophy for psychotherapy research; and future directions for psychotherapy research.

Psychotherapy research is about human beliefs and experiences, desires and behaviours. It deals with human subjects who challenge the ability of human investigators to define, measure, prescribe and predict the processes involved and eventual outcome of the therapeutic endeavour.

Despite the progress made in refining research strategies, measuring devices and statistical procedures, some decisions and assumptions will be made on the basis of societal values with regard to the feelings and actions of patients and subjects (Strupp, 1978). Values are inherent in therapeutic practice and research yet rarely recognised. Cognizance of the ways in which values influence the selection of outcome criteria, for example, may lead to more accurate and specific measurements in the assessment of psychotherapy efficacy.

The purpose of psychotheray research is to effect change in the practice of psychotherapy and yet the gap between researchers and practitioners has been well acknowledged. It is obvious that an integration of the two is both desirable and necessary (Bergin & Strupp, 1972; Strupp, 1978), but researchers have been accused of studying what is convenient

to study, rather than what would be truly helpful for practitioners (Luborsky, cited in Bergin & Strupp, 1972). Researchers could work more closely alongside practitioners, studying those aspects that clinicians experience difficulty with, and feeding back results of clinical trials to be put into practice in clinical settings (Strupp, 1978). This would not mean that existing research programmes need be abandoned; the two forms of research could proceed in parallel. Other suggestions for narrowing the gap between research and practice have been to make more use of the clinical practice by utilising the single case study design (Hayes, 1981) or to survey therapists, or observe what is actually done in therapy (Kazdin, 1984) and use the resulting information as a basis for further research. However, the reality for the practitioner can be that there is seldom enough time to keep pace with client caseloads, session notes and reports, let alone making time for the setting up of research measures and recordings. The researcher/clinician schism is showing signs of breaking down with the current emphasis in training of psychologists using the scientist/practitioner model. However, as is the case with many psychotherapy research dilemmas, the theoretical solutions are pragmatically troublesome, as illustrated above. The pressures on psychologists, psychiatrists, physicians etc, as helping professionals leaves little time or opportunity for therapists to divide their workload between therapy and research, or training. A more human element underrides this dilemma as well. The scientist/practitioner division seems to arise out of the inherent differences in persons. That is, some training professionals are drawn toward doing

psychotherapy; others toward research. Seldom does one person embrace both challenging practices. Thus the resolution of the researcher/clinician dilemma represents an ideal. It seems most helpful to a) be aware of this idealism, and b) not to stop striving for it because of its idealistic qualities.

In the same way that the results of psychotherapy research need to be fed back into the arena of clinical practice, they also need to be integrated into training programmes for psychologists, psychiatrists, psychotherapists etc. A review of the literature by this practitioner-author reaped much knowledge which is complementary to ongoing theoretical learning, and experience. As stated in section 4 - 3, videotape recordings of therapy sessions are rich sources of information about what actually transpires in therapy. Researchers are beginning to recognise the utility of examining the `subprocesses' of therapy, with regard to the therapy efficacy question (Greenberg, 1986), and this is so ably done by the use of videotaping and subsequent review. In some cases researchers are beginning to close the practitioner-researcher gap by recommending their findings to practitioners (Russell & Trull, 1986).

If results of current psychotherapy process study are yielding such valuable knowledge about the therapeutic interaction, then this should be the domain of all those involved in its practice, including the newly-recruited trainees of psychotherapy. Thus, along with a closing of the gap between practitioners and researchers, there needs to

occur a similar closure between reseachers and trainees in psychotherapy.

A current philosophy of psychotherapy research needs to take account of the concepts and ideas in the following areas: 1. the increasing refinement of scientific knowledge in the fields of psychiatry, psychopharmacology, neuropsychology, social and cognitive psychology and behavioural psychology; 2. advances in statistical procedures and increasing precision in the development of research designs; 3. the rapproachment of those involved in psychotherapy research in several areas: proponents of different schools; researchers and practitioners; outcome and process research investigators; individual researchers; 4. the development of more precise definitions and measurements, and the willingness to acknowledge the variability in therapeutic process. This has led to more concentrated research in the area of microprocesses or events of psychotherapy, the current study being an example of this trend.

It is the duty of a researcher to familiarise herself with the available knowledge base. While a formidable task, the very existence of a knowledge base represents an advancement on the state of psychotherapy research of 30 years ago.

Future directions for psychotherapy research have been posed in a recent paper (Gendlin, 1986). Eighteen problems were presented together with a fresh approach toward their resolution. They are summarised below as follows. a) Outcome: Records should be made of successful therapy

outcomes and stored by one central organisation. Later analysis should reveal clusters of variables associated with positive outcome. More critical analysis of outcome data is required. b) Process: More direct analysis of what occurs in therapy is required, rather than assuming equivalence of processes and schools. The therapist-patient interaction deserves special attention rather than separate study for each. Gendlin (1986) advocates separate outcome and process measures, in order to identify the incidence of `process in the absence of successful or helpful bits'. It seems important to endeavur to identify the unique and potent elements within a specific therapy style. Targeting microprocesses for study would take research out of the therapy room and into other contexts. c) Research Design: More exploration of hypotheses developed in the laboratory and less investigation of theoretical ideas is suggested. Gendlin (1986) challenges the `trait' assumption. That is, are the valuable parts to identify and measure inherent characteristics of persons or are they to be found in the interactions of those persons? Study results should not stop at just delineating successes and failures but at raising the level of the performance of the 'failed' group. d) Measures: Researchers must be clear that the concept they are researching is operationally defined in a way which is directly relevant to the hypothesis. Specify numerous subprocesses rather than one overarching variable. e) Variables: The systems of the individual's psychological and physical functioning, together with the societal dimension in which she acts need to be investigated together. Study of combinations of treatments (e.g. drugs and psychotherapy)

cannot be done additively. The combined treatments will result in something different to the methods which make it up. Different schools of therapy emphasise different aspects of an individual's functioning, yet all are relevant and important for study. Combination of many different therapies is impossible; smaller components of different therapies are able to be synthesised into a qualitatively improved whole.

This final section of this thesis has briefly reviewed the areas of values in both psychotherapy and research, the research-practice gap, training for psychotherapists, a philosophy for psychotherapy, and lastly, future directions in psychotherapy research.

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APPENDIX 1

HELPFULNESS RATING SCALE (Elliott, 1985)

Event Helpfulness

HINDERING.....Neutral.....HELPFUL

1 2 3 4 5 6 7 8 9

1 = Extremely Hindering; 2 = Greatly Hindering;

3 = Moderately Hindering 4 = Slightly Hindering;

5 = Neutral; 6 = Slightly Helpful; 7 = Moderately Helpful

8 = Greatly Helpful; 9 = Extremely Helpful

APPENDIX 2

INTENTIONS LIST (Hill & O'Grady, 1985)

Intentions

1. **Set limits:** To structure, make arrangements, establish goals and objectives of treatment, outline methods to attain goals, correct expectations about treatment, or establish rules or parameters of relationship (e.g., time, fees, cancellation policies, homework).
2. **Get information:** To find out specific facts about history, client functioning, future plans, and so on.
3. **Give information:** To educate, give facts, correct misperceptions or misinformation, give reasons for therapist's behavior or procedures.
4. **Support:** To provide a warm, supportive, empathic environment; increase trust and rapport and build relationship; help client feel accepted, understood, comfortable, reassured, and less anxious; help establish a person-to-person relationship.
5. **Focus:** To help client get back on the track, change subject, channel or structure the discussion if he or she is unable to begin or has been diffuse or rambling.
6. **Clarify:** To provide or solicit more elaboration, emphasis, or specification when client or therapist has been vague, incomplete, confusing, contradictory, or inaudible.
7. **Hope:** To convey the expectation that change is possible and likely to occur, convey that the therapist will be able to help the client, restore morale, build up the client's confidence to make changes.
8. **Cathart:** To promote relief from tension or unhappy feelings, allow the client a chance to let go or talk through feelings and problems.
9. **Cognitions:** To identify maladaptive, illogical, or irrational thoughts or attitudes (e.g., "I must be perfect").
10. **Behaviors:** To identify and give feedback about the client's inappropriate or maladaptive behaviors and/or their consequences, do a behavioral analysis, point out games.
11. **Self-control:** To encourage client to own or gain a sense of mastery or control over his or her own thoughts, feelings, behaviors, or impulses; help client become more appropriately internal rather than inappropriately external in taking responsibility for his or her role.
12. **Feelings:** To identify, intensity, and/or enable acceptance of feelings; encourage or provoke the client to become aware of or deepen underlying or hidden feelings or affect or experience feelings at a deeper level.
13. **Insight:** To encourage understanding of the underlying reasons, dynamics, assumptions, or unconscious motivations for cognitions, behaviors, attitudes, or feelings. May include an understanding of client's reactions to others' behaviors.
14. **Change:** To build and develop new and more adaptive skills, behaviors, or cognitions in dealing with self and others. May be to instill new, more adaptive assumptive models, frameworks, explanations, or conceptualizations. May be to give an assessment or option about client functioning that will help client see self in new way.
15. **Reinforce change:** To give positive reinforcement or feedback about behavioral, cognitive, or affective attempts at change to enhance the probability that the change will be continued or maintained; encourage risk taking and new ways of behaving.
16. **Resistance:** To overcome obstacles to change or progress. May discuss failure to adhere to therapeutic procedures, either in past or to prevent possibility of such failure in future.
17. **Challenge:** To jolt the client out of a present state; shake up current beliefs or feelings; test validity, adequacy, reality, or appropriateness of beliefs, thoughts, feelings, or behaviors; help client question the necessity of maintaining old patterns.
18. **Relationship:** To resolve problems as they arise in the relationship in order to build or maintain a smooth working alliance; heal ruptures in the alliance; deal with dependency issues appropriate to stage in treatment; uncover and resolve distortions in client's thinking about the relationship that are based on past experiences rather than current reality.
19. **Therapist needs:** To protect, relieve, or defend the therapist; alleviate anxiety. May try unduly to persuade, argue, or feel good or superior at the expense of the client.

APPENDIX 3

THERAPEUTIC IMPACT CONTENT ANALYSIS SYSTEM (Elliott, James, Reimschuessel, Cislo & Sack, 1985)

A. Helpful Impacts:

1. Realised Something New About Self: I got an insight about myself or understood something new about me. I saw a new connection or saw why I did or felt something. (Note: There must be a sense of "newness" about yourself.)

2. Realised Something New About Someone Else: I got an insight about another person; understood something new about someone else or people in general. (There must be a sense of "newness" about someone else.)

3. Awareness-Clarification: I got more in touch with my feelings, thoughts, memories or other experiences. I became more aware of experiences which I had been avoiding. What I was really feeling or trying to say became clearer. (Note: Refers to becoming clearer about what one is feeling, rather than why one is feeling something.)

4. Definition Of Problem For Me To Work On: I got a clearer sense of what I need to change in my life or what I need to work toward; what my goals are.

5. Progress Towards Knowing What To Do About Problems: I figured out possible ways of coping with a particular situation or problem. I made a decision or resolved a conflict about what to do; I got up the energy to do something differently.

6. Felt Understood: I felt my therapist really understood what I was saying, or what was going on with me at that moment in the session, or what I'm like as a person.

7. Felt Supported: I felt supported, reassured, confimred or encouraged by my therapist. I felt better about myself, or started to like myself better.

8. Felt More Comfortable: I felt relieved from uncomfortable or painful feelings; I felt less nervous, depressed, guilty or angry about the session or in general.

9. Felt More Involved in Therapy: I got more involved in what I have to do in therapy; my thinking was stimulated; I started working harder. I became more hopeful that what I have to do in therapy will help. I felt I could be more open with my therapist.

10. Felt Closer To My Therapist: I came to feel that my therapist and I are really working together to help me. I was impressed with my therapist as a person, came to trust, like, respect or admire her/him more. We overcame a problem between us.

B. Hindering Impacts:

11. Unpleasant Thoughts - Avoidance: It made me think of uncomfortable or painful ideas, memories, or feelings that weren't helpful. It made me push certain thoughts or feelings away or avoid them.

12. Too Much Pressure - Not Enough Direction: I felt too much pressure on me to do something, either in the therapy session or outside of it. I felt abandoned by the therapist or too much left on my own.

13. Felt Misunderstood: I felt misunderstood; that my therapist just doesn't or can't understand me or what I'm saying. I felt misunderstood just then for a moment, or generally.

14. Felt Attacked Or That My Therapist Doesn't Care: I felt

criticised, judged or put down by her/him. I felt she/he was cold, bored or didn't care about me.

15. Distracted Or Confused: I felt thrown off or side-tracked from the things which were important to me. I felt confused by what he/she said or did. My therapist interfered with what I was thinking or talking about.

16. Impatient - Doubting Value Of Therapy: I felt bored or impatient with the progress of therapy or with having to go over the same old things over and over again. I started to feel that my therapy is pointless or not going anywhere.

17. Other Helpful Or Hindering Impacts:

THESE INTENTIONS COULD BE RATED:

1 = not at all; 2 = slightly; 3 = somewhat; 4 = pretty much; 5 = very much

APPENDIX 4

COUNSELOR VERBAL RESPONSE CATEGORY SYSTEM

(Hill, 1978)

Counselor Response System

1. *Minimal encourager:* This consists of a short phrase that indicates simple agreement, acknowledgement, or understanding. It encourages but does not request the client to continue talking; it does not imply approval or disapproval. It may be a repetition of key word(s) and does not include responses to questions (see information).

2. *Approval-reassurance:* This provides emotional support, approval, or reinforcement. It may imply sympathy or tend to alleviate anxiety by minimizing client's problems.

3. *Information:* This supplies information in the form of data, facts, resources, theory, and the like. It may be information specifically related to the counseling process, counselor's behavior or arrangement (time, place, fee, etc.). It may answer direct questions but does not include directions for what the client should do (see *direct guidance*).

4. *Direct guidance:* This consists of directions or advice that the counselor suggests for the client, or for the client and counselor together, either within or outside the counseling session. It is not aimed at soliciting verbal material from the client (see *closed* or *open question*).

5. *Closed question:* This is a data-gathering inquiry that requests a one- or two-word answer, a yes or no, or a confirmation of the counselor's previous statement. The possible client responses to this type of inquiry are typically limited and specific. If statements are phrased in the form of a closed question but meet the criteria for another category, they should be put in the other category.

6. *Open question:* A probe requests a clarification of feelings or an exploration of the situation without purposely limiting the nature of the response to a yes or no or a one- or two-word response. If statements are phrased in the form of an open question but meet the criteria for another category, they should be put in the other category.

7. *Restatement:* This is a simple repeating or rephrasing of the client's statement(s) (not necessarily just the immediately preceding statements). It typically contains fewer but similar words and is more concrete and clear than the client's message. It may be phrased either tentatively or as a statement.

8. *Reflection:* This is a repeating or rephrasing of the client's statement (not necessarily just the immediately preceding statements). It *must* contain reference to stated or implied feelings. It may be based on previous statements, nonverbal behavior, or knowledge of the total situation. It may be phrased either tentatively or as a statement.

9. *Nonverbal referent:* This points out or inquires about aspects of the client's nonverbal behavior, for example, body posture, voice tone or level, facial expressions, gestures, and so on. It does not interpret the meaning of these behaviors.

10. *Interpretation:* This *goes beyond* what the client has overtly recognized. It might take one of several forms: It might establish connections between seemingly isolated statements or events; it interprets defenses, feelings, resistance, or transference (the interpersonal relationship between counselor and client); it might indicate themes, patterns, or causal relationships in the client's behavior or personality. It usually gives alternative meanings for old behavior or issues. If a statement also meets the criteria for a confrontation, it should be put in confrontation.

11. *Confrontation:* This contains two parts: The first part may be implied rather than stated and refers to some aspect of the client's message or behavior; the second part usually begins with a "but" and presents a discrepancy. This contradiction or discrepancy may be between words and behavior, between two things the client has stated, between behavior and action, between real and ideal self, between verbal and nonverbal behavior, between fantasy and reality, or between the counselor's and the client's perceptions.

12. *Self-disclose:* This usually begins with an "I"; the counselor shares his or her own personal experiences and feelings with the client. Note that not all statements that begin with an "I" are self-disclosure; it must have a quality of sharing or disclosing.

13. *Silence:* A pause of 5 seconds is considered the counselor's pause if it occurs between a client's statement and a counselor's statement or within the client's statement (except after a simple acceptance of the counselor's statement, e.g., "yes," pause).

14. *Other:* These include statements that are unrelated to client's problems, such as small talk or salutations, comments about the weather or events; disapproval or criticism of the client; or statements that do not fit into any other category or are unclassifiable due to difficulties in transcription, comprehensibility, or incompleteness.