EXPERIENCING AND OUTCOME IN PSYCHOTHERAPY

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ABSTRACT

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By

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This study investigated the relationship between experiencing, a therapy process variable, and the outcomes of psychotherapy. The outcome criteria used in this research were (a) changes on the Number of Deviant Signs score of the Tennessee Self Concept Scale before and after therapy, (b) changes on Total Positive score of the TSCS before and after therapy, (c) changes in MMPI profiles from beginning to end of therapy, (d) counselor evaluations of therapy, and (e) client evaluations of therapy.

The sample was 20 undergraduate students who sought counseling for personal-emotional problems at the Michigan State University Counseling Center from 1967-1969. Experiencing ratings were made by raters on tapes of these clients' therapy sessions. Two sessions were sampled from the beginning, middle and end of therapy. Four 2-minute segments were sampled from each session. There were 480 segments rated.

The results of the study indicated that (a) EXP level correlates significantly negatively with Tennessee Self Concept scores and the MMPI profile change; (b) EXP level correlates positively but insignificantly with counselor evaluation of outcome, client evaluation of outcome, and with Self-Exploration, another process measure; (c) EXP movement is negligible and unrelated to outcome in our population.

These results fail to confirm several previous studies. This was unexpected, and we qualified our results with a discussion of our client, therapist and outcome samples and their relationship to previous studies. We concluded that for our clients, therapists and outcome measures, high levels of experiencing are not associated with success in psychotherapy.

In addition, we discussed the necessity of differentiating experiencing as a separate strand of process from the whole process concept itself. We pointed out that our findings are less unusual when this distinction is made.

Finally, we presented the possibility that experiencing as a separate strand, and movement of experiencing must be carefully considered before they are researched again. The evidence indicates that this use of EXP data has not revealed promising findings.

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CHAPTER I

INTRODUCTION

A Process Variable in Psychotherapy Research

This study investigates the relationship between experiencing, a therapy process variable, and the outcomes of psychotherapy. Experiencing is a process in the Rogerian sense of the term. It is not, therefore, a term which is used to describe what goes on in therapy. It refers to more than a description of the client's or therapist's activities during the therapeutic hour. Experiencing is a process because it refers to the ongoing movement of feelings within the client. As a client process variable, experiencing refers to movement within the client which Rogers, Gendlin and others hypothesize as causative of therapeutic change.

Rogers' Process Conception of Psychotherapy

For Carl Rogers, the client's process during therapy is an integral part of therapeutic change. If certain conditions exist, then certain processes will occur. In turn, if those processes are working, certain outcomes will result.

The conditions include:

a. Therapist and client have psychological contact, i.e., each makes a difference in the awareness of the other.

b. There is incongruence between experiencing[1] and awareness in the client.

c. The therapist is congruent in the relationship; that is, he communicates to the client his honest feelings.

d. The therapist experiences unconditional positive regard for the client; that is, he values the client as a person without contamination from evaluating his behavior or thoughts.

e. The therapist experiences empathy for the client; that is, he is sensitive to the client's feelings and is able to communicate that to him.

f. The client perceives c. d. and e. above.

The processes include:

a. The client is free in expressing his feelings.

b. The client emphasizes reference to himself; sees himself as the locus of evaluation.

c. The client is more open to his experience; he experiences feelings previously denied to awareness.

d. The client is less defensive.

e. The client accurately symbolizes his experience.

Rogers makes no clear distinction between process and outcome in this context. His outcomes include those qualities we have listed under process. In addition to those, the client will be more mature, accepting of others and realistic.

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[1]Further discussion of this condition, and experiencing in particular will follow.

The process conception described above is most important to the present study. Rogers (1961) sees the ongoing movement within the client as developing from fixity to changingness. Such a process goes through seven stages, which are really stopping points on a continuum of movement. Stage 1 begins with an individual who is rigid and remote and experiences no free flow of his feelings. At Stage 4, there is a gradual loosening of constructs, as well as freer expression of feelings. By Stage 7, the client's changingness and emotional freedom have been fully accepted as his own responsibility.

These stages are applied to seven strands of process. They are: relationship to feelings, degree of incongruence, manner of experiencing, communication of self, construing of experience, relationship to problems and manner of relating to others. At early stages the strands are separate and distinct. By Stage 6, they form a coherent single process. Since so few clients achieve stages six and seven, it is valuable to speak of the separate strands.

The "manner of experiencing" is interwoven with the other strands, and definitions of the other strands include reference to an experiencing process. At the higher levels of the continuum, Rogers refers to it as the "major characteristic of the process of therapy." (Rogers, 1958) Thus, though Rogers' earliest

conceptualizations include experiencing as a separate strand, his bias towards it as a singularly powerful variable is well documented. Eugene Gendlin continued the emphasis of experiencing as a process concept.

Eugene Gendlin and the Experiencing Process

As early as 1958, Gendlin's influence on the process conception was evident. In 1962, he published Experiencing and the Creation of Meaning, and thereby formulated the most comprehensive definition of the experiencing process. In general terms, Gendlin's concept of experiencing refers to that "partly unformed stream of feeling that we have every moment . . . the flow of feeling, concretely, to which you can every moment attend, if you wish." (p. 3) It is an inward sensing which is always present.

Symbolization of experiencing is complex and a concept inseparable from experiencing itself. Without symbolization, experiencing is referred to as preconceptual and implicit. As such, it is also incomplete. For though experiencing may exist in a preconceptual sense, symbolization is needed to complete the experiencing process. The symbols may be words, things, events, situations, behaviors or interpersonal interactions. It is the interaction between these symbols and the unformed emotional experience which is an important part of process and

Rogerian therapy. Since one's experiencing is in continual flux, it is not surprising that symbolization of it at any one time is tentative and subject to change. Several "modes" of interaction have been described (Gendlin, 1962), but the two modes which most concern the psychologically minded reader are "direct reference" and "conceptualization."[2] Direct reference underlies all other ways in which experiencing occurs, though it may also occur alone. (Gendlin, 1962) It employs symbols which function as markers, or pointers. These markers do not represent the experiencing as such, but refer to it: For example, "I don't know what this feeling is, but it sure is strong." At the same time, direct reference is not any inward attention. It is not single, sheer emotions such as the concepts of love, hate, joy and anger. It is the "complex ground of these emotions." (Gendlin, 1964)

Conceptualizations, on the other hand, represent what is symbolized. They are more concrete and content-oriented. Instead of pointing, they clearly represent the feeling to which they refer. For example, "I feel angry." It is not unusual for both direct reference and conceptualization to occur. Gendlin (1964) gives the example of

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[2]In the philosophical discussion of experiencing, Gendlin also describes recognition, explication, metaphor, comprehension, relevance and circumlocution. For our purposes, the two above will suffice.

a client saying, "I always knew I felt angry at such and such, but I had no idea how strong that feeling is." (p. 238)

A client using only conceptualizations as they interact with experiencing will restrict the forward movement of the experiencing process. The experiencing process contains more than the feelings which are being conceptualized at the moment. Since experiencing is a process, it must be investigated with respect for its movement. To be complete, any content which the client defines must include its development or movement as part of the definition, not just its static qualities. Using a process rather than a content frame of reference, we ask different questions. Instead of attempting to define a content, we must describe an ongoing process.

The process which ensues when direct reference is the mode of experiencing is called "focusing." (Gendlin, 1964) This process employs the movement of experiencing, and is a good description of experiencing and its interaction with symbolization. Focusing develops in four phases, which may or may not be found separately.

Direct reference

This phase has been described previously in this paper. It involves an individual pointing to a conceptually vague, but definitely felt, inward referent. He uses pointing words like "this," and "it" when referring to the feeling.

Unfolding

This is the step-by-step process by which the directly felt referent begins to "make sense." It usually involves a sudden awareness of what the feeling "really is." There is not only a shift in defining the feeling, there is a shift in the experiencing of it. The whole multiplicity of feelings change.

Global application

With the experience of unfolding, the individual often remembers other situations which are related to the new and changing feelings. He sees that such feelings have a wide application, and are not restricted to a given moment. As a result of such global application, the person may experience insight and better understanding of many situations.

Referent movement--content mutation

With such global application, the individual is often left with a new direct referent. He finds that there is a new feeling, which needs new symbolization. The implicit meanings are different, and the focusing process may begin again.

Focusing is an especially important concept, for it clearly distinguishes one direction which the experiencing process may take. It is the direction which often occurs when direct reference is the mode of experiencing.

It is also the direction which a successful client will follow in therapy, and to which the therapist seeks to respond. (Gendlin, 1968)

Experiencing and Psychotherapy

Gendlin claims that "experiencing (certain functions of it) is a process that brings about therapeutic change." (Gendlin, 1962) It is in the therapeutic role that certain interactive aspects of experiencing are evident.

Just as experiencing is an interaction between feeling and symbols, the therapeutic process is an interaction between two individuals. More precisely, psychotherapy involves the relationship between a client's experiencing and his therapist's reactions to that experiencing. A client's experiencing changes when it interacts with another person. Some therapists constrict the mode of experiencing. Others allow the client to feel more intensely and freely.

Therapists seek to respond to the implicitly complex experiencing of their clients. (Gendlin, 1968) By attending only to contents, change will not occur. The problems which an individual encounters in his own daily life cannot be solved by merely answering certain content questions. Feelings which occur during a crisis involve experiencing, and to change those feelings one must attend

to the experiencing. Attending only to the contents which define the feelings is not effective. Through attending to experiencing (by therapist and client) the many different feelings accompanying it can be differentiated and worked through. Content awareness can answer certain "why" questions, but change can only occur through a meaningful interaction of experiencing and awareness. In fact, it is the adjusted individual for whom there is complete congruence between experience and awareness. (Gendlin, 1962)

Research on Experiencing and Psychotherapy

Development of EXP scale and reliability

The process concept described above has been researched for the most part by Rogers, Gendlin and C. B. Truax. It was originally studied using the "Process Scale" (Rogers and Rablen, 1958) as revised by Walker, Rablen and Rogers (1959). This included the seven variables mentioned earlier; feelings and personal meanings, manner of experiencing, degree of incongruence, communication of self, construing of experience, relationship to problems and manner of relating to others. By 1962, Tomlinson was using simpler scales of experiencing, personal constructs, problem expression and manner of relating. Since correlations between these scales was high, it was possible to concentrate on only one of these scales. The Experiencing

Scale (EXP) was the most likely cue for the others, so that this scale, as revised by Mathieu and Klein (1963), may be used to study the process conception of experiencing in psychotherapy.

Much of the earliest work with the complete Process Scale involved the investigation of interrater reliability using the scale. Walker, Rablen, and Rogers (1959) rated samples from two early and two late interviews of six cases, and found an r. of .83 between two judges. Tomlinson (1959) did some further study of reliability, and using three judges, found reliability coefficients ranging from .47 to .63. Then Hart (1961) decided to investigate more closely the reliability question. With experienced raters he achieved interrater reliability: r. = .72 to .95. Reliability was increased by using both tape and type-scripts, and using non-time limited ratings (raters could use as much time as they wished to rate the tapes).

Outcome studies

Rogers considered process and outcome to be highly related. As described earlier, in his process conception of psychotherapy, there is little distinction made between the two. Yet most researchers, and the present research design, call for other independent measures of therapeutic outcome. In doing so, we acknowledge the usefulness of such outcome measures as indices of therapeutic change, with only passing consideration for their theoretical

basis. The following studies emphasize the relationship between process and outcome.

Though Walker, Rablen and Rogers (1959) were mostly concerned with a revision of the Process Scale, the study also employs a comparison between process and outcome. Using counselor evaluations of therapy as their outcome criterion, they found that the more successful cases increased their process levels more than the less successful cases. The mean change over therapy for the more successful group was 1.93 on a seven point scale, and for the less successful group it was .69. Positive Process Scale movement and outcome correlated .89 (rank-order correlation). Process ratings were made using typescripts only, and six cases were involved. Gendlin, et al. (1968) include these six cases in their analysis of 38 neurotics to be reported later in this section.

In 1962, Tomlinson and Hart reported on ten cases, using nine 2-minute segments of therapy from one early and one late interview of each client. Again using the seven-strand Process Scale, and outcome criteria of therapist ratings, client rating, and a self-concept Q-sort, the authors summarize their results as follows:

a. The scales can be reliably rated, with interjudge reliability at a minimum of .60.

b. The scale scores distinguish between more successful and less successful cases.

c. The more successful cases begin as well as end therapy at a significantly higher level of process.

d. There is greater movement (process change) on the scale during therapy in more successful than less successful cases.

e. There is a tendency for the second half of each interview to be rated higher on the Process Scale than the first half. (Tomlinson and Hart, 1962)

Rogers, Gendlin, Kiesler and Truax (1967) report similar findings with schizophrenics. In Chapter 10 by Kiesler, Mathieu and Klein there is a discussion of EXP Scale level and outcome, and EXP Scale movement and outcome. Ratings were made by four judges and averaged, utilizing sessions from the beginning, middle and end thirds of therapy. These ratings were on both modes and peaks of EXP level. Modes were the average level for that segment, while peaks were the highest level reached, no matter how briefly, within a segment. The segments were four minutes in length, and the judges used both tapes and typescripts. Fourteen schizophrenic patients were included, and outcome criteria included MMPI subscales, clinical assessments of test batteries, Q-sort, therapist's ratings, Wittenborn DS (depressed state) and hospital status--nine in all for this part of the analysis.

Results were as follows. EXP level was positively related to several MMPI scales, clinical assessment of tests, therapist ratings of outcome and hospital release. It was insignificantly related to other MMPI scales, some

therapist outcome ratings, and amount of hospitalization. It was negatively related to the Wittenborn depressed state subscale. This latter finding was interpreted as an indication of a ceiling effect; that is, the negative relationship was due to a positive relationship between initially low pathology and high EXP level in therapy.

Regarding EXP movement, they found that EXP movement was more monotonically consistent for the more successful therapy group. In general the more successful group improved linearly while less successful clients were lower on the EXP scale in the middle of therapy than at the beginning or end. In addition, there were some differences in correlations with outcome depending on whether modes or peaks were used.

Further examination of EXP results appear in Chapter 13 by Tomlinson. Using twelve cases, and outcomes including therapist rating, MMPI profile change and a Q-sort, the EXP Scale was compared to three other process ratings. They found that positive process change over therapy was greater for more than less successful patients, but that initially high process level does not correlate with better outcome. Correlations between process measures were as follows:

	Experiencing	Personal Constructs	Problem Expression	Relationship
EXP		.85	.71	.57
PC			.83	.68
PES				.66

Ryan (1966) used a sample of 32 clients from the University of Illinois Counseling Center in a study relating EXP level to outcome of therapy. He used 96 eight-minute segments from beginning, middle and end of therapy, rated by four judges. He found EXP level and outcome inconsistently related, and difficult to interpret. He found the trend of ratings to differentiate the best between more and less successful clients. More successful clients began therapy at a low EXP level, rose about .4 level at the midpoint, and dropped slightly at the end of therapy. Less successful clients began therapy at the highest mean EXP level he found, about 3.1, dropped about .6 level at the midpoint, and rose slightly at the end of therapy. Ryan's conclusion is that the trend of ratings differentiate between more and less successful clients, though this movement involves only half a level on the EXP scale.

Finally, a later work (Gendlin, et al., 1968) considers a new analysis of the thirty-eight neurotic cases from Tomlinson (1959, 1962), Tomlinson and Hart (1962), and Walker, Rablen and Rogers (1959), and also includes further analysis of Rogers' et al. (1967) schizophrenic population. Analysis of the neurotic population showed significantly more increase on the Process Scale for the success cases than for the failure cases. But, such movement is not from low to high levels, and does not appear

important to outcome. There is only slight movement which is statistically, but not practically significant.

About half the clients begin therapy with moderate level ratings on the Process Scale, and for this group the scales cannot predict outcome. Persons initially rated at middle levels of process are about equally likely to be a success or a failure case. Although those beginning therapy at higher levels tend to be successful and those beginning therapy at lower levels tend to fail, the majority of clients begin therapy at some intermediate level of Process. For this group, it is not clear whether they will succeed or fail. But, looking at overall process level, both neurotics and schizophrenics show a strong relationship between success and high process levels. It appears that "in some people, effective therapy behavior is present all along. In others, a good outcome occurs because they do develop their experiencing capacity as therapy proceeds." (Gendlin, et al., 1968)

Purpose and Hypotheses to be Tested

In many ways psychotherapy research is different from the great majority of psychological study. Specifically, the problem of generalizability is a great one. No two clients or therapists are ever identical, and even within schools of therapy there are differences in technique. Further, different outcome measures may produce

different findings, since we know that different outcome measures may not correlate with each other. Nor can we be certain that any one outcome measure is a valid index of successful or unsuccessful therapy. Therefore any study undertaken with one population may or may not have general applicability to other populations. The necessity for replication of psychotherapy research can hardly be overstressed.

The present study is such a replication, using a new sample of clients and therapists, and several different outcome measures. In addition, this study follows Rogers' and Gendlin's hypotheses regarding the importance of experiencing as an independent strand of process. Though most studies have used the Process Scale, or at least several of the strands of it, the present study concentrates solely on the Experiencing Scale.

For many of the clients used in this study, ratings are now available on Carkhuff's "Self-Exploration in Interpersonal Processes" Scale, which, theoretically, appears to tap a process similar to EXP. We will briefly introduce data comparing these two scales.

Our results will give us some indication of the importance of experiencing as a variable for our population. It will use data which will give us insight into experiencing and outcome, experiencing movement, and the role of experiencing as an independent variable in psychotherapy.

Hypotheses

a. A high level of experiencing (EXP) early in therapy is predictive of success in therapy.

b. The mean EXP level for total therapy will be higher for successful outcomes than for unsuccessful ones.

c. Where a high EXP level early in therapy leads to an unsuccessful outcome, there will be a decrease in EXP level during therapy.

d. Where a low EXP level early in therapy leads to a successful outcome, there will be an increase in EXP level during therapy.

CHAPTER II

METHOD

Subjects

The subjects were 6 male and 14 female undergraduate students who sought counseling for personal-emotional problems at the Michigan State University Counseling Center, between 1967-1969. Their mean age was 20 years. The average number of sessions was 13.6. Prior to therapy, during the course of therapy and at post-therapy, they were requested to complete a battery of tests from which the outcome data were derived for the present study.

Process Measures

A scale for the rating of experiencing (EXP)

Use of tapes

Process data for this research were tapes of interviews compiled by the MSU Counseling Center on the above clients' therapy sessions. Where possible a total of six sessions were sampled from each client. The sessions were two from the beginning (usually 2nd or 3rd), two from the middle and two from the end of therapy. In

only two cases was it necessary to use a last interview. Two four-minute segments were randomly selected from the tape of each session, one from the first half of the session and one from the second half. These four-minute segments were further divided into 2 two-minute segments (a and b). Ratings were made for each two-minute segment, 480 in total.

In this manner we were able to derive a modal and peak rating for the four minute segments. Rogers, et al. (1967) found that modes and peaks differed in their relationship to conditions and outcomes. In this study modal ratings are defined as the mean of the 2 two-minute ratings; peaks are defined as the higher of two consecutive two-minute ratings. This is a somewhat different definition of peak from that used by Rogers, et al. (1967). In that study the peaks were the highest level reached during a four-minute segment, even if for only one statement. By using a full two-minute segment to define "peak" of a 4-minute segment, what we lose in spontaneity, we gain in confidence that such a level is sustained for a short period of time. If Rogers' more instantaneous peak had an important effect on the two minutes in which it occurred, then it was picked up. If, however, it was just a brief excursion into experiencing, then it was not.

For segmenting, each tape had its midpoint determined. Then each half was entered at a random point and

timed for four minutes. Each segment (a and b) was required to have at least two client and two therapist responses to provide a broad enough base for rating. The beginning, end and midpoint were carefully marked. No tape was identifiable to the rater regarding patient success or interview number. Typescripts were not available, but non-time limited ratings were made.

Rater selection and training

EXP ratings were made by a former graduate student, trained as follows:

(1) The rater was presented a copy of the Scale for Rating of Experiencing (as revised by Mathieu and Klein in Rogers, et al., 1967) (see Appendix A-1). "At the lowest stage of experiencing the patient is not able to own his affective involvement in what he says," and "the upper stages of the Experiencing Scale represent the patient's deepening awareness of his feelings, his successful understanding of them, and their investigation into his experiential framework." (Kiesler, Mathieu and Klein, in Rogers, et al., 1967)

(2) The rater and this researcher discussed various segments to give the rater a feel for rating.

(3) The rater was assigned to rate practice material.

(4) When the rater and researcher reached interrater reliability of .70 (Pearson r Correlation

Coefficient) the rater began to rate the research tapes. Reliability was again checked at the conclusion of rating by having the researcher rate actual data segments selected randomly: r. = .69.

Self-exploration in interpersonal processes--a scale for measurement (SX)

Also available to the researchers were ratings of Self-Exploration on 19 of the 20 subjects. These ratings were made from Carkhuff's Self-Exploration in Interpersonal Processes Scale (1967). At the lowest level the client expresses no "personally relevant" material, or there is no opportunity for such material to be discussed. At the highest level is the "inward probing to newly discover feelings or experiences about himself and his world." Like the EXP Scale, the SX Scale has its roots in Rogerian theory. The two appear similar in content, and theoretically should be measuring similar phenomena.

The ratings on the SX Scale were made by two judges on segments different from those used in the EXP data. The judges rated three, 3-minute segments from an early interview and three, 3-minute segments from a late interview. The judges achieved an interjudge reliability of .94 on the ratings (Ebel's, 1951, estimation of interjudge reliability). Some ratings were by a single judge, and some were the average of both judges' ratings.

Outcome Measures

Tennessee self concept scale (TSCS)

Fitts (1964) developed this scale to measure the self concept. "The individual's concept of himself has been demonstrated to be highly influential in much of his behavior, and also to be directly related to his general personality and state of mental health." (Fitts, 1964) The use of such a scale for clients in a counseling center is advantageous. The scale is easy to administer and has several sub-scales which are valuable for outcome research. This research used Positive Scores (P) and the Number of Deviant Signs Score (NDS). The latter has been used by Ashcraft and Fitts (1964), with the difference between pre and post-therapy NDS scores as an indication of improvement in psychotherapy.

Total positive score (P)

This is the "most important single score on the Counseling Form." (Fitts, 1965) It reflects overall level of self-esteem. Zax and Klein (1960) reviewed several studies indicating that the more successful cases of therapy also show an increase in self-respect. Therefore, if total P increases from pre to post-therapy testing, positive client change could be inferred. The difference between pre and post-therapy P score was used as a measure of therapy outcome.

Number of deviant signs (NDS)

This is a purely empirical measure, a count of the number of deviant features on all other scores. Berg's (1957) "deviation hypothesis" states that "individuals who deviate sharply from the norm in minor behaviors are likely to be deviant in more major aspects of behavior." (Fitts, 1965) It is the scale's best measure of psychological disturbance, having identified deviant individuals with 80% accuracy. (Fitts, 1965) The differences between pre and post-therapy NDS scores was used as a measure of therapy outcome in the present study.

Minnesota multiphasic personality inventory (MMPI)

The MMPI has been used extensively by researchers in psychotherapy (Walsh and Dahlstrom, 1965; Rogers, et al., 1967). Rogers, et al., (1967) used the MMPI as a measure of outcome in their study with experiencing in schizophrenics. Our study with experiencing in neurotics gives us some opportunity to compare the diverse populations regarding experiencing and outcome.

Profile ratings of pre and post-therapy MMPI scores were made by three experienced MMPI judges. They used the nine common scales (He + 5K, D, Hy, Pd + 4K, Mf, Pa, Pt + 1K, Ma + 2K and Sc + 1K). Each client's MMPI was rated for change from pre to post testing as follows: 5-satisfactory, 4-partly satisfactory, 3-no change, 2-partly

unsatisfactory, 1-unsatisfactory. Interjudge reliabilities were established: $r_{.} = .74$; and average ratings between judges, $r_{.} = .90$. (Kurtz, 1970)

Counselor evaluation form (CE)

At termination, each therapist evaluated the therapy outcome on the following scale: 4-successful, 3-partly successful, 2-partly unsuccessful, 1-unsuccessful.

Client evaluation form (CL E)

Each client filled out an evaluation of therapy at termination. They evaluated the therapy outcome on the following scale: 7-extremely helpful, 6-helped quite a bit, 5-helped somewhat, 4-indifferent, 3-harmed somewhat, 2-harmed a lot, 1-extremely harmful.

CHAPTER III

RESULTS

Relationship between Process Level and Outcome

The primary purpose of this research is to investigate the relationship between EXP level and outcome of psychotherapy. Table 1 gives the correlation coefficients between the scores on outcome measures and process measures.

Table 1. Correlations between process measures and outcome measures.

	TSCS Total P Difference	TSCS NDS Difference	MMPI Profile Change	CE	CL E
EXP peak	-.31	-.49**	-.55**	.20	.18
EXP mean	-.25	-.42*	-.42	.28	.23
EXP I (early)	-.49**	-.48**	-.56**	.29	.21
EXP II (middle)	.12	-.04	.05	.15	.10
EXP III (late)	-.20	-.30	-.39	.19	.21
SX	.03	.02	-.28	.50**	.22
N =	18	18	16	19	19

*Significant at .10 level

**Significant at .05 level

Several of the scores are significant at the .05 level, but only one in the expected direction. That was Self Exploration with counselor evaluation of therapy. Those who are higher in SX level are judged more successful by their counselors. Other measures of outcome correlate insignificantly with SX level.

The EXP ratings consistently correlate negatively with the Tennessee Self Concept and the MMPI ratings, five of these fifteen correlations are significant at $p < .05$. This would indicate that those who rate higher in EXP, are less likely to improve in therapy as determined by the TSCS and the MMPI. Both counselor evaluation and client evaluation correlate positively with EXP level, but are not significantly so. Both hypotheses 1 and 2 are unconfirmed.

There are differences in correlations with EXP level depending on whether peaks, modes or different parts of therapy are reported. Peak ratings and early ratings show the highest negative correlations with the TSCS and the MMPI ratings. The middle ratings (EXP II) are distinguished by their complete failure to correlate above .15 with any of the outcome measures.

The correlation coefficient between mean modal EXP and mean SX is .19, which is non-significant. This finding was unexpected and will be discussed in Chapter IV.

Process Movement in Therapy

Although level of EXP has been an important issue to process researchers, its movement during therapy is also important. Rogers' hypothesis about EXP level was that they would increase from lower to higher levels as therapy progressed. But he found little consistent evidence for this. (Rogers, et al., 1967; Gendlin, et al., 1968)

The analyses relating process movement to outcome are given in Tables 2 and 3 and Figures 1 and 2. The cases were classified as successful or unsuccessful as follows: For counselor evaluation (Table 2), more successful cases were defined as those receiving rating "4" on the CE form, less successful cases as those rating "3" or below. For the MMPI (Table 3), successful cases were those above the median, failure cases those below the median. We present the CE and MMPI data as indications of EXP movement. Other outcome criteria yielded similar results.

Process movement fails to distinguish between the successful and unsuccessful cases, and thus hypotheses 3 and 4 are disconfirmed. With both CE and the MMPI as the outcome criteria, we find that clients start at similar levels of EXP and their movement during therapy is similar, whether they are more or less successful cases.

Table 2. EXP movement--counselor evaluation as outcome criterion.

Change in EXP level from EXP I to EXP III	Process Starting Point								
	2.0 - 2.49		2.5 - 2.99		3.0 - 3.49				
	more successful	less successful	more successful	less successful	more successful	less successful	Tm	Tl	T
-.9 to -.5			1				1	0	1
-.49 to 0	1	1	1	5	2	1	4	7	11
.01 to .49		1	2	1			2	2	4
.50 to .99		2		1			0	3	3
1.0 and above							0	0	0
	1	4	4	7	2	1	7	12	19

Table 3. EXP movement--MMPI profile as outcome criterion.

Change in EXP level from EXP I to EXP III	Process Starting Point: 2.0 - 2.49 more successful	2.0 - 2.49 less successful	2.5 - 2.99 more successful	2.5 - 2.99 less successful	3.0 - 3.49 more successful	3.0 - 3.49 less successful	Tm	Tl	T
-.9 to -.5			1				1	0	1
-.49 to 0		1	2	1	1	3	3	5	8
.01 to .49	1		1	2			2	2	4
.50 to .99	2			1			2	1	3
1.0 and above							0	0	0
	3	1	4	4	1	3	8	8	16

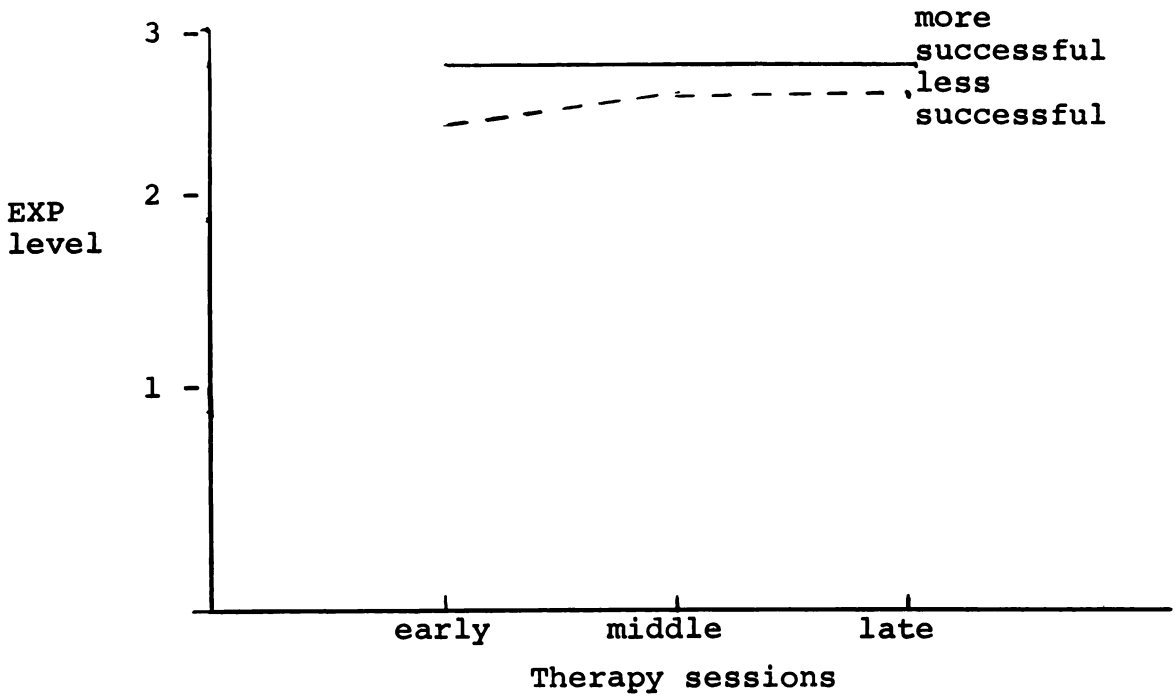

Figure 1. Movement of mean EXP level over therapy--CE as outcome criterion.

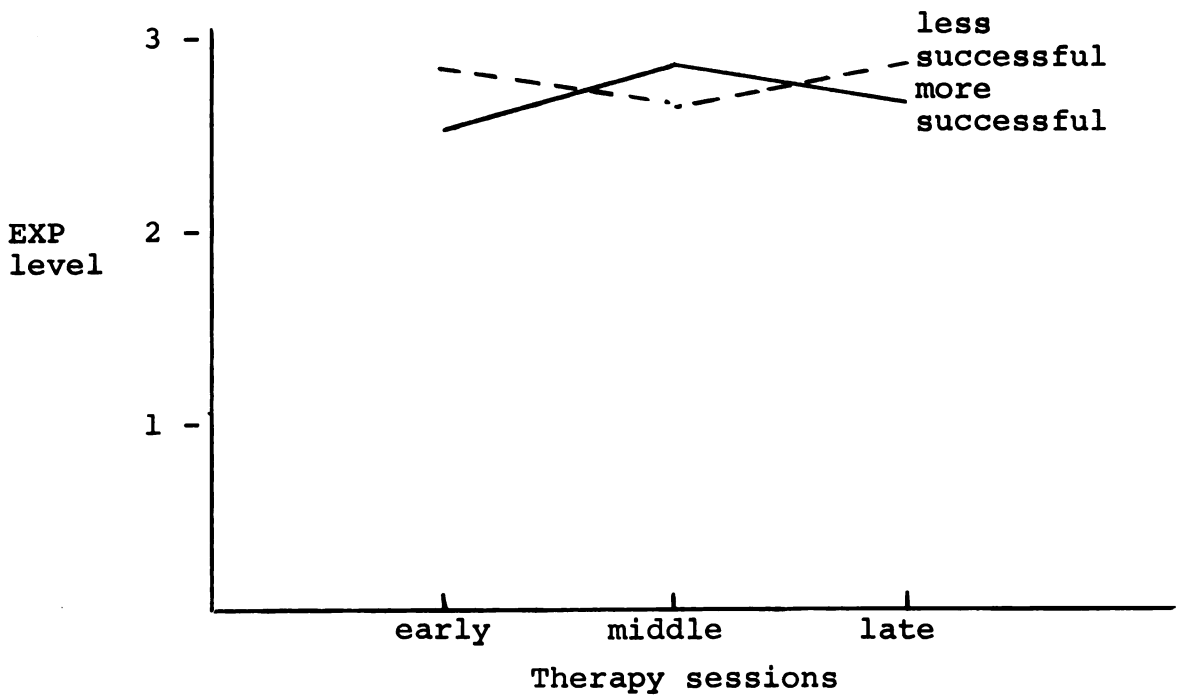

Figure 2. Movement of mean EXP level over therapy--MMPI as outcome criterion.

Although the counselor evaluation indicates that clients do improve, 12 of 19 clients decline in EXP level. With the MMPI as criterion, it is 9 of 16. Examining the relationship between EXP movement and CE more closely, we find that the three clients who increased EXP by more than .5 level, were all less successful cases. What slight movement there was, occurs in less successful, not more successful, cases.

The range in both level and movement of EXP data should also be considered. Only 4 of the clients change more than .5 of an EXP level in both tables. Most change little, if at all. In addition, our tables need only include the range from 2-3.49, to include all our clients. This restricted range of EXP level was found in Rogers' study with schizophrenics, but Gendlin found a much wider range for his neurotic population.

Using either the CE or MMPI measure as the outcome criterion, the difference between more and less successful cases is minimal, at most .34 level. Using CE both more and less successful cases change little across therapy. Using the MMPI there is slightly greater change, with more successful cases beginning at 2.48, rising to 2.78 in the middle and falling to 2.66. Less successful cases begin at a mean of 2.81, fall to 2.59 and then recover to 2.86. This latter pattern is similar to that found by Ryan (1966).

CHAPTER IV

DISCUSSION AND CONCLUSIONS

The distinction between level of EXP and movement of EXP appears throughout this paper, and this distinction provides the organization for Chapter IV. We will first discuss the relationship between level of EXP and outcome and then between movement of EXP and outcome. Most previous research found either level or movement to be an important variable in psychotherapeutic success. Our findings reveal some new, and confirm some old discoveries.

Relationship between EXP Level and Outcome

Six of the ten correlations predicted to reveal a positive relationship between EXP level and outcome are negative. Of these, three are significantly negative at $p < .05$, and a fourth is significant at $p < .10$. Thus we find no support for the prediction that high levels of experiencing are associated with success in psychotherapy; in fact, we find the opposite to be true.

A further analysis reveals that seven of the fifteen additional correlations obtained between EXP level and outcome are negative; and two of these are significant

at $p < .05$. Of the total of twenty-five correlations obtained, all but two of those between EXP level and both the MMPI and Tennessee Self Concept Scale measures are negative. The correlations between EXP level and both counselor and client evaluations are positive, but insignificant. These findings fail to confirm most previous research, and offer new evidence for the value of this measure of experiencing in psychotherapy.

Because of these unexpected findings, we must qualify interpretation of our data by considering our outcome, client and therapist samples. The limitations of such samples affect interpretation and generalization to other populations.

As for outcomes, we were limited by the measures which were available on our client population. We can generalize only to these specific measures. These measures include the instruments most often used in EXP research, the MMPI and a counselor evaluation scale. We did not have access to another primary measure of client-centered therapists, the self concept Q-sort; but another self concept instrument, the Tennessee Self Concept Scale, was employed. The number and variety of outcome measures in this study are comparable to most previous research.

Our client sample was limited only by number of sessions, availability of taped sessions, and completion of outcome criteria. The latter limitation decreased our

original sample from 20 to 16 for the MMPI results, 18 for the TSCS and 19 for counselor and client evaluations. But even these N's compare favorably to previous research, and only Gendlin, et al's (1968) analysis, which combines several studies, and Ryan (1966) have larger samples.

In addition, our client sample must show improvement in therapy as a group, before we can expect to find a relationship between experiencing and psychotherapeutic change. There must be change in therapy for EXP level to actually show an important relationship. As a group, these clients did show improvement on all outcome measures. T-tests performed on the TSCS scores show a significant difference between the means for pre and post-therapy measures of both total P and NDS. The mean MMPI change was 3.57 on a scale of 5, where 5 indicates improvement. Finally, all 19 clients, and 16 of 19 therapists indicated that therapy had been at least partially successful.

The range of client outcome scores must also be considered. The counselor and client evaluations are limited in that they are mostly at high levels of success, and this restricted variance may account for the lack of significant findings for these outcomes. The other outcome measures vary considerably between clients; NDS differences range from -11 to +40, total P differences from -23 to +103, and MMPI from 1.33 to 5.00.

Our client sample did change during therapy, and also showed a considerable range of outcome scores. If such changes were sensitive to high levels of experiencing, the EXP levels would have shown the appropriate positive correlations.

Finally, one other outcome consideration was introduced by Kiesler, Mathieu and Klein (Rogers, et al., 1967) in their examination of negative findings. In their analysis, the Wittenborn depressed state subscale was correlated negatively with EXP level. They hypothesized that this finding was a result of a ceiling effect; that is, those clients showing least improvement on this measure do so because they have less to improve. An analysis of our NDS data reveals a similar interpretation of our data. The correlation between pre-therapy NDS level and EXP overall level is -.45, significant at $p < .05$. Those clients identified by high EXP level, were those clients with the least pathology prior to therapy. Consequently, those who show lower levels of EXP also show the greatest pathology and are more likely to have room for improvement in therapy. Although this is a post-hoc type of analysis, it cannot be completely discounted.

Another qualification of our data concerns the therapists involved. Therapists at the MSU Counseling Center, though influenced by client-centered techniques,

are probably more confronting than the strict Rogerian therapists found in previous research. This is a clinical judgment based on experience at the Counseling Center, and discussions with several senior staff members of the Center. Therapists in most previous EXP research (Ryan, 1966 is an exception) were either working with Rogers at the time, or indicated in reporting their work that the orientation of their co-workers was predominantly client-centered.

Therefore, in previous research, Rogerian process concepts were important to the therapists involved. This may have influenced findings in two ways. On the one hand, if the therapists' expectations of client behavior were not met, the therapists may have found their effectiveness lessened. When clients do not show high levels of experiencing, client-centered therapists may not perform effectively. As a result, experiencing and outcome will be correlated only because of the effect low experiencing levels have on the therapist, not as they directly relate to outcome. A further study investigating client-centered vs. non-client centered therapist differences and experiencing levels is needed to confirm or disconfirm this proposition.

Similarly, our therapists may define success independently of a client's experiencing. Therefore, the evaluation of successful therapy will not depend on a

client's experiencing as it is likely to for the client-centered therapist. The insignificant correlations found between counselor evaluation and EXP level are then, in fact, correlations between two independent factors and more reliable than if EXP level influences a counselor's evaluation of therapy.

With the preceding discussion in mind, the interpretation of our data is still appropriate. For our clients, therapists and outcome measures, high levels of experiencing are not associated with success in psychotherapy, if anything, high levels of EXP are negatively related to outcome.

Relationship between EXP level early in therapy, peak EXP level, and outcome

Gendlin's idea of early prediction of successful outcome by utilizing high beginning levels of EXP is not warranted by our data. In fact, if we looked at our data alone, we would conclude the opposite to be true; high beginning levels of EXP are predictive of failure in therapy. At this time, no prediction is possible from early ratings.

Peak EXP level ratings reveal a pattern similar to beginning EXP ratings; they are significantly negative. The similarity is informative, since peak ratings theoretically tap a somewhat different use of experiencing by

the client than modal ratings. Modal ratings reveal the average level of EXP during a four-minute segment; the peak rating is a measure of less sustained, but increased experiencing.

The negative correlations between peak EXP ratings and outcome are subject to the same qualifications presented earlier. In addition, there is one qualification specific to the nature of peak ratings. Our clients may be described as reasonably well-motivated and functioning individuals. A total reorganization of their thought processes is not the goal of therapy, and they may purposely defend against probing which seems aimed at such a goal. On the other hand, the schizophrenics who have shown positive relationships with peak levels (Rogers, et al., 1967), may require frequent examples of peak experiencing for such reorganization to occur. With neurotics only very occasional high levels of EXP may be adequate. Our sampling procedure for tape segments may fail to reveal these infrequent high levels of EXP, if indeed they exist in the interviews.

Relationship between EXP Movement and Outcome

Our data gives no support to the hypothesis that movement of EXP over therapy is associated with success in therapy. Tables 2 and 3 indicate that more and less successful cases were for the most part equally divided

regarding EXP movement during therapy. In fact, five of seven clients who moved towards higher levels in the counselor evaluation table were less successful cases.

The restrictions placed on our samples of clients, therapists and outcomes in the last section also apply to discussion of EXP movement; they need not be repeated here. But the range of EXP values in this study does require some discussion, since movement refers to the range of values from beginning to end of therapy.

Our clients do not move from low to high levels of EXP. There is some change from beginning to middle to end of the therapy, but this change is slight. For example, counselor evaluated more successful cases change from a mean of 2.875 at the beginning of therapy to 2.821 at the end; counselor evaluated less successful cases change from 2.531 to 2.625.

A further investigation of Gendlin, et al.'s (1968) analyses reveals that the lower level of EXP in that study includes most of our sample. Thus, just as Gendlin indicated in his analysis, the prediction for this group shows a trend toward failure. Our sample encompasses a range of EXP for which Gendlin has predicted failure.

In addition, our data with the MMPI as outcome criterion reveals results similar to those of Ryan (1966). Figures 3 and 4 indicate this similarity.

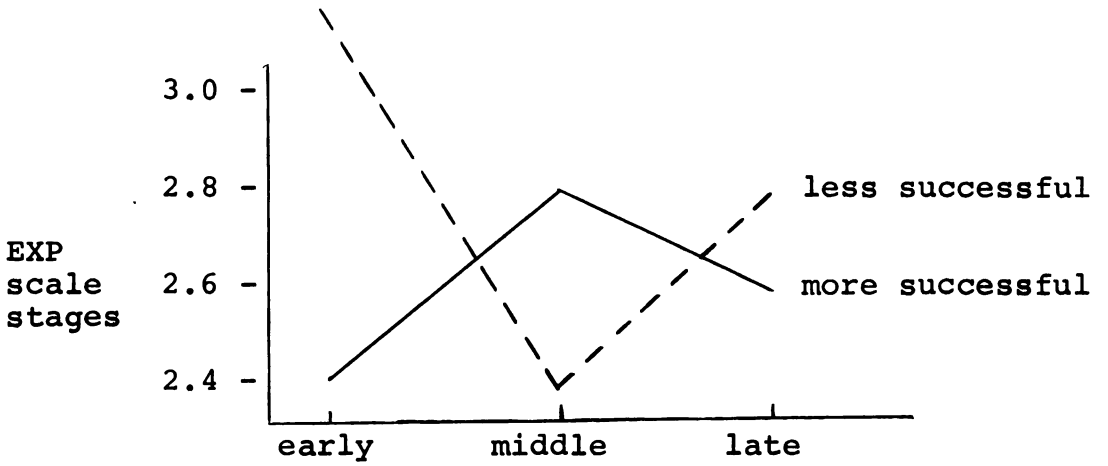

Figure 3. Mean movement of EXP level over therapy (Ryan, 1966).

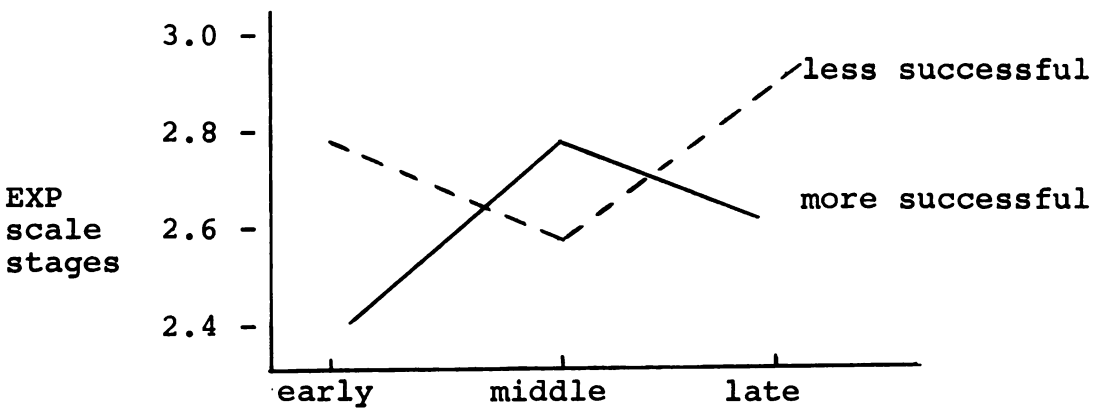

Figure 4. Mean movement of EXP level over therapy (present study).

Ryan concluded that trend of EXP ratings over therapy differentiated between more and less successful clients. The figure above confirms that finding, only if one considers such small changes in EXP level to be significant. Gendlin is skeptical of such small changes. The "EXP Scale has not been tested for reliability of very small differences or movement over very small intervals." (Gendlin, et al., 1968) Gendlin argues that reliability of rating governs the usefulness of movement figures, and that a reliability of .70 is not high enough to "support a very microscopic use of half-stage differences."

This lack of range of EXP levels may be due to several factors. Our sample may in fact exhibit generally lower and less varied EXP levels than those reported by Gendlin. This possibility is supported by Ryan's (1966) EXP levels. Our raters may have interpreted the EXP Scale differently from previous raters. For example, if our raters expected more from the clients in order for them to reach even middle levels of EXP, then the lack of ratings above 4 is understandable.

Our findings on the relationship between EXP movement and outcome confirms much of the previous research. Both the present study and previous research reveal EXP movement as an unimpressive variable in distinguishing between more and less successful cases. These findings should cause researchers to consider carefully the benefit of studying EXP movement.

The use of EXP as an Independent Strand

The distinction between the process concept as a whole and experiencing as an independent strand within that concept is not generally discussed. But this distinction is important in a study in which data measuring both whole process and a strand within that process are presented. Our findings do not dispute Rogers' process theory and its importance in therapy; but only that EXP as an independent strand, is not associated positively with success in therapy for our sample.

Gendlin, et al. (1968) discuss their analyses as if they bear directly upon the EXP Scale and its importance in therapy. In fact, Gendlin's review and reanalyzation of 38 neurotic cases does not include studies where EXP is used independently. All but one of the studies analyzed by Gendlin used the original Process Scale. The other study used experiencing in conjunction with several other scales. Any discussion of those results should not imply that experiencing is valuable as an independent strand; except as a theoretical extension of the presented data.

Kiesler, Mathieu and Klein (in Rogers, et al., 1967, Chapter 10) used the EXP Scale independently, and revealed mixed findings. EXP level was positively related to some outcome criteria, insignificantly related to others, and negatively related to the Wittenborn DS subscale. These results are inconclusive, although they show

a trend toward a positive relationship between EXP level and outcome of therapy with schizophrenics.

Tomlinson (in Rogers, et al., 1967, Chapter 13) considered the EXP Scale independently and with regard for its relationship to other independent strands. None of the strands, analyzed independently, revealed significant main effects with success. Three process ratings did increase over time for the more successful cases, and decreased for less successful cases; but even here, the EXP Scale was less powerful than the two other scales. These results, which also revealed high correlations between the four process measures, indicate that independently the process strands do not confirm previous research employing the original Process Scale.

A close examination of the studies confirming the importance of process level on success in therapy, reveals that the present findings employing a single strand are not as unusual as they first appeared. When EXP is used as an independent strand the results are confusing and inconclusive. We must not confuse process results with the more narrow experiencing results.

Relationship between EXP Level and SX Level in Psychotherapy

Experiencing and Self-Exploration (Truax and Carkhuff, 1968; Carkhuff and Berenson, 1967) were derived from

Rogers' process conception of psychotherapy as independent measures of parts of that process. Experiencing was included as one of Rogers' original process strands; Self-Exploration has mostly grown out of Truax and Carkhuff's association with Rogers' work. Theoretically the two scales appear similar. They both investigate the clients' self-exploration, his attention to inward feelings. The actual rating scales are also similar. The lowest level of the Self-Exploration Scale (Carkhuff and Berenson, 1967) says the client "does not discuss personally relevant material . . . and avoids any direct expression of feelings that would lead him to reveal himself to the therapist." Similarly, the Experiencing Scale (Gendlin and Tomlinson, in Rogers, et al., 1967) says the client gives, "a narrative of events with no personal referent used . . . he does not use himself as a reference point--he says nothing about himself, or his feelings, attitudes, or reactions." Other levels of the two scales are also similar.

The correlation between ratings on the Experiencing Scale and the Self-Exploration Scale is only .19. This finding disconfirms our expectations that ratings on the two scales would be highly correlated.

Methodologically, ratings on the scales were made in different ways. The clients rated were the same in both analyses, but the ratings were made from different segments, and often from different tapes. The raters for

the SX Scale were experienced psychotherapists; the EXP rater was a relatively naive judge.

The theoretical differences between the two concepts need to be carefully evaluated. In addition, a more controlled methodology must be employed in examining the relationship between the two scales. At this point our finding is only exploratory.

Conclusions

The present study failed to confirm the majority of previous findings, and directly contradicted several others. The necessity for replication of psychotherapy research is thus apparent. If a replication confirms previous findings, generalizability and confidence in those findings is increased. But if a replication fails to confirm, and in fact contradicts, previous findings, such generalizability and confidence is diminished. Future researchers can learn from both those studies which confirm and those which disconfirm prior research.

Our conclusions are as follows:

1. For our clients, therapists and outcome measures high <u>levels</u> of experiencing are not associated with success in psychotherapy. In addition, high early levels of EXP are not predictive of success in psychotherapy.

2. For our clients, therapist and outcome measures, movement of experiencing involves changes too small to be significant, and is not related to outcome.

3. Findings regarding experiencing as an independent strand of Rogers' process conception must not be confused with findings involving the whole Process Scale.

4. In exploratory findings, the EXP Scale is not related to the Self-Exploration Scale.

The analysis of our data, and a careful examination of previous research reveals that there is less evidence for experiencing as an important variable than has been indicated in previous reports. It is not clear at this point exactly what status EXP has as an important therapeutic variable. This is especially true of experiencing as an independent strand of process and the value of movement of experiencing during therapy. The present findings agree with much previous research indicating the lack of clear evidence for the importance of these latter two concepts.

CHAPTER V

SUMMARY

This study investigated the relationship between experiencing, a therapy process variable, and the outcomes of psychotherapy. The outcome criteria used in this research were (a) changes on the Number of Deviant Signs score of the Tennessee Self Concept Scale before and after therapy, (b) changes on Total Positive score of the TSCS before and after therapy, (c) changes in MMPI profiles from beginning to end of therapy, (d) counselor evaluations of therapy, and (e) client evaluations of therapy.

The sample was 20 undergraduate students who sought counseling for personal-emotional problems at the Michigan State University Counseling Center from 1967-1969. Experiencing ratings were made by raters on tapes of these clients' therapy sessions. Two sessions were sampled from the beginning, middle and end of therapy. Four 2-minute segments were sampled from each session. There were 480 segments rated.

The results of the study indicated that (a) EXP level correlates significantly negatively with Tennessee Self Concept scores and the MMPI profile change; (b) EXP

level correlates positively but insignificantly with counselor evaluation of outcome, client evaluation of outcome, and with Self-Exploration, another process measure; (c) EXP movement is negligible and unrelated to outcome in our population.

These results fail to confirm several previous studies. This was unexpected, and we qualified our results with a discussion of our client, therapist and outcome samples and their relationship to previous studies. We concluded that for our clients, therapists and outcome measures, high levels of experiencing are not associated with success in psychotherapy.

In addition, we discussed the necessity of differentiating experiencing as a separate strand of process from the whole process concept itself. We pointed out that our findings are less unusual when this distinction is made.

Finally, we presented the possibility that experiencing as a separate strand, and movement of experiencing must be carefully considered before they are researched again. The evidence indicates that this use of EXP data has not revealed promising findings.

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APPENDICES

APPENDIX A

PROCESS MEASURES USED IN STUDY

A SCALE FOR THE RATING OF EXPERIENCING[1]

Eugene T. Gendlin and T. M. Tomlinson
Revised by Phillipa L. Mathieu and Marjorie H. Klein

Stages

Stage 1

There is simply a narrative of events with no personal referent used. The client may be telling a story that he is connected with in some way but he does not use himself as a reference point--he says nothing about himself, or of his feelings, attitudes, or reactions. The story told is not "his" story.

If a personal referent is used, the content is such that the client reveals nothing private or tender about himself but merely describes the public aspects of his life. The manner of expression would tend to be matter of fact or to have a rehearsed quality.

Stage 2

The client establishes the association between the narrative told and himself by the use of personal referents, but he is involved in telling the story and does not go beyond it. Any comments he offers about the story do not contain personal reference but function only to "get the story across." Any emotions mentioned are described as part of the story, not the client, and are not elaborated beyond the level of pure description. There is no personal "ownership" of a reaction to the story.

The manner of expression at this stage may be less mechanical and more spontaneous than at stage 1. In some cases, however, the client may seem to be emotionally aroused or involved, but the level of this arousal will remain constant throughout and will not be referred to specifically.

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[1]From Rogers, et al., The Therapeutic Relationship and Its Impact, Madison, Wisconsin: University of Wisconsin Press, 1967, pp. 589-592.

Stage 3

The client is primarily involved in telling a story in which personal referents are used. He goes beyond the story at times to make parenthetical comments about his reactions and responses, but these associations are based on the external events only. Such comments can be an account of his feelings about the story, his feelings at the time of the events described, or comments about the personal significance of the events to him. These parenthetical comments must contain personal referents. The person's focus is upon telling his story "better" or elaborating upon it, but he does not use the story to show what he is like as a person.

Stage 4

The client is now clearly telling something about himself (his feelings, his image of himself), using himself as the referent for his comments. While these comments may be made in the context of a specific story, their function is not to modify the story but to describe the self. In some cases, the client may have great difficulty finding ways to describe himself and the expression of this difficulty alone is sufficient basis to rate 4.

The client is now aware of his feelings and reactions and is able to express them. He is doing this in order to communicate what he is like; he is not engaged in a struggle to explore himself nor is he using his feelings as the basis for self-understanding.

Stage 5

The client is now using his feelings in a struggle to explore himself. This may take several directions. The client may start with his feelings in a given area and work to understand these feelings, to differentiate them, or to understand how and in what situations they arise. The client may also start with some assumption he has about himself and work to understand how this assumption came about or clarify the implications that this assumption has for him.

The client at stage 5 is clearly engaged in a process of self-exploration in order to achieve self-understanding; this process may be extremely difficult for the client and may not be maintained throughout the segment. The expression of difficulty in achieving

self-understanding is sufficient basis to rate 5 as long as the client is able to express and elaborate his feelings or to present clearly his self-image (as in stage 4).

Stage 6

The client is clearly examining the significance of his feelings or self-concept and is able to arrive at conclusions about them, or to use the results of this self-assessment as the point of departure for further self-exploration. His formulations about himself provide the links between any elaborations of events or expressions of feeling. In stage 6 the client is able to use the results of self-examination in specific areas to arrive at a deeper and more comprehensive self-understanding.

Stage 7

The client does not need a narrative as a point of departure. He can travel freely among feelings and understands them quickly. The client has no difficulty in tying together what he is saying and presenting a clear picture of himself--what meaning his thoughts, actions, and feelings have for him. He moves easily from one inward reference to another and is able to integrate them into his experiential frame of reference.

SELF-EXPLORATION IN INTERPERSONAL PROCESSES

A SCALE FOR MEASUREMENT[1]

Robert R. Carkhuff

Level 1

The second person does not discuss personally relevant material, either because he has had no opportunity to do such or because he is actively evading the discussion even when it is introduced by the first person.

Example: The second person avoids any self-descriptions or self-exploration or direct expression of feelings that would lead him to reveal himself to the first person.

In summary: for a variety of possible reasons, the second person does not give any evidence of self-exploration.

Level 2

The second person responds with discussion to the introduction of personally relevant material by the first person but does so in a mechanical manner and without the demonstration of emotional feeling.

Example: The second person simply discusses the material without exploring the significance or the meaning of the material or attempting further exploration of that feeling in our effort to uncover related feelings or material.

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[1]The present scale "Self Exploration in Interpersonal Processes" has been derived in part from "The Measurement of Intrapersonal Exploration" (Truax, 1963) which has been validated in extensive process and outcome research on counseling and psychotherapy (Carkhuff & Truax, 1965, 1965a, 1965b; Rogers, 1962; Truax, 1963; Truax & Carkhuff, 1963, 1964, 1965). In addition, similar measures of similar constructs have received extensive support in the literature of counseling and therapy (Blau, 1953; Braaten, 1958; Peres, 1947; Seeman, 1949; Steele, 1948; Wolfson, 1949).

In summary, the second person responds mechanically and remotely to the introduction of personally relevant material by the first person.

Level 3

The second person voluntarily introduces discussions of personally relevant material but does so in a mechanical manner and without the demonstration of emotional feeling.

Example: The emotional remoteness and mechanical manner of the discussion give the discussion a quality of being rehearsed.

In summary, the second person introduces personally relevant material but does so without spontaneity or emotional proximity and without an inward probing to newly discover feelings and experiences.

Level 4

The second person voluntarily introduces discussions of personally relevant material with both spontaneity and emotional proximity.

Example: The voice quality and other characteristics of the second person are very much "with" the feelings and other personal materials which are being verbalized.

In summary, the second person introduces personally relevant discussions with spontaneity and emotional proximity but without a distinct tendency toward inward probing to newly discover feelings and experiences.

The present represents a systematic attempt to reduce the ambiguity and increase the reliability of the scale. In the process many important delineations and additions have been made. For comparative purposes, Level 1 of the present scale is approximately equal to Stage 1 of the early scale. The remaining levels are approximately correspondent: Level 2 and Stages 2 and 3; Level 3 and Stages 4 and 5; Level 4 and Stage 6; Level 5 and Stages 7, 8, and 9.

Level 5

The second person actively and spontaneously engages in an inward probing to newly discover feelings or experiences about himself and his world.

Example: The second person is searching to discover new feelings concerning himself and his world even though at the moment he may be doing to perhaps fearfully and tentatively.

In summary, the second person is fully and actively focusing upon himself and exploring himself and his world.

APPENDIX B

SCORES ON PROCESS MEASURES

Table B-1. Scores on EXP scale.

Client	Counselor	Total Mean Score	EXP I Mean	EXP II Mean	EXP III Mean	Peak
801	05	2.580	2.375	3.00	2.375	2.92
808	08	2.580	2.00	2.875	2.875	2.83
812	12	2.880	3.125	2.375	3.125	3.08
815	18	2.250	2.5	2.125	2.125	2.67
818	26	2.540	2.875	2.50	2.25	2.78
823	19	2.960	2.875	2.75	3.25	3.33
828	15	3.120	2.625	3.375	3.5	3.42
829	25	2.920	3.25	2.375	3.125	3.25
830	27	3.120	2.875	3.375	3.25	3.42
831	04	2.960	3.125	3.00	2.75	3.42
834	35	3.00	2.75	3.25	3.00	3.33
838	03	2.670	2.625	3.00	2.375	2.92
843	06	2.500	2.50	2.00	3.00	2.75
845	44	2.375	2.375	2.125	2.625	2.75
846	13	2.625	2.75	2.625	2.5	3.00
848	43	2.375	2.0	2.5	2.625	2.50
849	49	2.830	2.875	3.0	2.625	3.08
855	24	2.420	2.25	2.75	2.25	2.67
859	40	2.670	2.75	2.875	2.375	2.83
861	38	2.330	2.50	2.25	2.25	2.58
		$\bar{X}$ = 2.685				

Table B-2. Scores on SX scale.

Client	Counselor	Average Score
801	05	3.08
808	08	2.10
812	12	2.25
815	18	
818	26	2.50
823	19	2.00
828	15	2.17
829	25	3.10
830	27	1.46
831	04	2.83
834	35	2.75
838	03	2.54
843	06	2.17
845	44	1.41
846	13	1.83
848	43	2.25
849	49	2.83
855	24	1.75
859	40	2.00
861	38	2.33
		$\bar{X}$ = 2.28

APPENDIX C

OUTCOME MEASURES USED IN STUDY

COUNSELOR AND CLIENT EVALUATIONS

C-1. Counselor evaluation form

Therapist Criterion Information

Code: Number_____ Code Name:_____

I consider the above case to be:

Successful	(4)
Partially successful	(3)
Partially unsuccessful	(2)
Unsuccessful	(1)

Check the appropriate description.

Signed_____

C-2. Client evaluation form

Student Evaluation of Counseling

Place an (x) at the point on the scale that best describes your feelings about whether counseling helped you to solve your problems.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
was extremely harmful	harmed me quite a lot	harmed me somewhat	indifferent-- neither helped nor harmed me	helped me somewhat	helped me quite a lot	very much-- was extremely helpful

APPENDIX D

SCORES ON OUTCOME MEASURES

Table D-1. Scores on outcome measures.

Client	Counselor Evaluation	Client Evaluation	MMPI Profile Average	Tennessee NDS Difference (Fewer)	Tennessee P Difference (Gain)
801	4	7	3.67	20	57
808	3	5	5.00	40	103
812	4	7	3.50	2	40
815	3	6	3.33	-4	0
818	4	7	5.00	17	12
823	2	5	1.67	-11	-20
828	3	7	4.17	-5	13
829	4	6	1.33	-10	-23
830	4	6	3.00	0	-3
831	3	5	1.67	2	16
834	4	7	--	8	34
838	3	5	--	11	34
843	-	6	2.33	9	-4
845	3	6	5.00	22	63
846	1	-	--	--	--
848	3	6	5.00	33	55
849	4	6	4.33	20	60
855	2	5	3.33	-9	-9
859	3	6	4.83	13	38
861	3	5	--	--	--
	$\bar{X}$ = 3.16	$\bar{X}$ = 5.94	$\bar{X}$ = 3.57	$\bar{X}$ = 8.72	$\bar{X}$ = 25.89