THE EFFECTS OF VICARIOUS THERAPY PRETRAINING AND ROLE INDUCTION INTERVIEWS ON BEHAVIOR MODIFICATION IN GROUPS

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ABSTRACT

THE EFFECTS OF VICARIOUS THERAPY
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ON BEHAVIOR MODIFICATION IN GROUPS

By

Thomas Frederick Curran

The present research investigated the effects of Vicarious Therapy Pretraining (VTP) and Role Induction Interviews (RII) on client manifest anxiety, motivation to change and positive therapeutic expectations. Clients were randomly selected from the intakes at Ingham Medical Center Community Mental Health Center during the month of October, 1973. Clients who had been in psychotherapy previously or those whose primary diagnosis was alcohol or drug dependency were excluded from the research, resulting in a total of 21 subjects, who were constituted into three groups. Group A received a pre- and post-test battery in conjunction with VTP/RII, prior to beginning therapy. Group B received only the pre- and post-test battery prior to therapy and Group C received VTP/RII and the post-test battery prior to therapy. All groups utilized the same therapy technique (Lawrence & Sundel, 1971) and the same therapist.

VTP/RII conditions consisted of exposing clients to a thirty minute video-tape of a behavior modification group in progress.

The video-tape was role played by five volunteers using a script provided by the researcher and simulated a segment of a typical behavior modification group following the Lawrence and Sundel (1971) model. The clients were then given an opportunity to react to the video-tape and ask questions. This was followed by a modified version of the Orne (1968) Role Induction Interview which suggested appropriate client behavior in the group and outlined some of the group procedures and their importance.

The first aspect of the study was concerned with the effects of VTP/RII on client manifest anxiety, motivation to change and positive therapeutic expectations. As predicted, groups exposed to VTP/RII exhibited significantly lower anxiety, as indicated by the Taylor Manifest Anxiety Scale (1953). Groups exposed to VTP/RII also showed significantly greater motivation to change, as indicated by the Miskimins Self-Goal-Other Discrepancy Scale (1967) and significantly higher levels of positive therapeutic expectations, as indicated by the Fischer-Turner Attitudes Toward Seeking Professional Psychological Help Scale (1970).

The second part of the study was concerned with the impact of VTP/RII on client and therapist evaluations of success in therapy. Both client and therapist evaluations were found to be significantly higher for those groups exposed to VTP/RII. Similarly, objective outcome measurements disclosed that the VTP/RII groups rated significantly higher than did non-VTP/RII groups, with the exception of the results of the Lawrence scales (parts 1-3) which did not yield

significance, although they did demonstrate a trend in the predicted direction.

The final section of the study is devoted to the analysis of manifest anxiety, motivation to change and positive therapeutic expectations as predictors of successful outcome. Consistent with previous studies, the present research suggests that these three variables are accurate predictors of therapeutic success.

Refinements in design and instrumentation are suggested and implications of the research findings for clinical practice and further study are discussed.

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By

Thomas Frederick Curran

A DISSERTATION

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to my father

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CHAPTER I

INTRODUCTION

Interest in the investigation of counseling and psychotherapy has both a history and an evolution. It is unfortunate, however, that this common and long standing concern in the constructive change of behavior and personality has divided rather than unified the interested parties. As Rogers (1963) points out:

> . . . our differences as therapists do not lie simply in attaching different labels to the same phenomenon. The differences run deeper. An experience which is seen by one therapist as healing, growth-promoting, helpful, is seen by another as none of these things. And the experience which to the second therapist is seen as possessing these qualities is not so perceived by the first. We differ at the most basic level of our personal experience.
>
> Some people may feel that though we differ regarding specific incidents, . . . nevertheless in our goals and in our general directions there is much agreement and unity. I think not. To me it seems that therapists are equally divergent in these realms (p. 7).

The significance of this state of affairs can best be understood by examining the evolution and content of the research representative of the field of psychotherapy.

Historical Perspective

The era prior to the experimental investigation of psychotherapy can best be characterized as one of "academic tribalism". The various schools of psychotherapy which existed were largely organized around

loosely organized theoretical formulations based on biased and unsystematic observations which could not be controlled, and thus repeated, in any reliable manner. Consequently, adherence to any of these theoretical views was based on faith, conviction and personal satisfaction, and loyalties were maintained and perpetuated by identification with a particular set of esoteric rituals (Bandura & Walters, 1963). Blocher (1967) seems to have captured the essence of this historical process when he states:

> Much of the history of change in counseling and psychotherapeutic theory and practice contains elements which closely parallel those which tend to dominate the evolution of religious movements and political ideologies. In both cases a movement tends to be originated by a messianic figure, characterized by a kind of elan vital, who translated a deeply moving personal experience into universalistic terms. This leader quickly attracts a group of worshipful disciples who immediately begin to generalize the precepts promulgated by the master into the most widely applicable terms (p. 4).

With little more than faith and the sheer force of opinion to back untested propositions and doctrinaire assertions, it is not surprising that these so-called coteries or schools existed as factions, often times diametrically opposed to one another in terms of their aims, methods and goals (Arbuckle, 1967; Bandura & Walters, 1963; Rogers, 1963). However, with such a faith in the efficacy of their respective techniques, and its resulting hope, failures in practice engendered only a minimum of what Festinger (1957) has termed "cognitive dissonance".

Both Phillips (1956) and Blocher (1967) have shown how a number of convenient expressions arose to buttress and thus justify these already well developed and deeply held personal convictions; i.e., "the

client is unmotivated", "he lacks ego-strength", "he doesn't have enough working-through anxiety", etc. "The convenience of this type of thinking . . . for counselors who readily lose a third to a half of their clients prematurely, is of course, obvious" (Blocher, 1967, p. 4).

In any case, the net effect of these newly coined rationalizations was effectively to screen out any negative feedback by automatically attributing untoward consequences to defects in the client (Ellis, 1962). When coupled with the enormous resistance to extinction generated by relatively few "successes" delivered on an aperiodic schedule, these factors served only to reduce any dissonance which may have resulted from failures in practice, thus eliminating any reason for change or modification in techniques.

Finally, dissonance between "schools" was further avoided by limiting contacts between members of the dissonant factions. Even when they did interact, the violent polemics which resulted often generated more heat than light. According to Hoskisson (1965):

> . . . they . . . get together to wrangle and defame each other and have a wonderful time, . . . much of specialized scientific publication seems to consist of mutual condemnation of each other's work (p. 29).

With the introduction of the methods of science into this formerly sacrosanct domain, it was hoped that a common core of empirical knowledge would replace the theories based on tenacity, faith and intuition (Campbell & Stanley, 1963). This laudable, but peremptory, waive of optimism soon faded, however, when the predicted rapproachment somehow never materialized.

Current Status of the Problem

In a summary of the overall impact of the past 25 years of research in psychotherapy, Shlien (1966) pointed out that, "Continued subscription to an existing school of psychotherapy is based upon personal conviction, investment, and observation rather than upon general evidence" (p. 125). In a similar vein, Eysenck's[1] figures fail to support the hypothesis that existing forms of psychotherapy facilitate recovery from neurotic disorders (p. 323). His more recent reviews (Eysenck, 1955, 1960, 1961, 1965), as well as those of others (Bailey, 1956; Bandura, 1963; Luborsky, 1969; Levitt, 1957; Strupp & Bergin, 1969), have led to essentially the same conclusions.[2]

The factors contributing to this current state of affairs are many and varied. As the discussion has disclosed, for a number of years this predicament was due to the lack of empirical research. However, as a number of authors have pointed out, the more recent causes stem from the fact that the existing empirical evidence is

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[1]For an explanation of these findings in terms of the therapist variables see Truax and Carkhuff (1967). For an explanation in terms of pre-treatment individual differences in clients see Blocher (1967) and Sprinthall (1967). For a general critique of the validity of Eysenck's interpretations see Kiesler (1966).

[2]Cross (1964) surveyed the literature since Eysenck's 1952 review and found nine studies which used control groups. However, he felt they were so deficient in other respects that the findings still could not be interpreted unambiguously. More recent reviews (Dittman, 1966; Patterson, 1966) have led to essentially the same conclusions.

derived from such poorly organized and controlled research that the findings could be used to support almost anything, and thus nothing (Blocher, 1967; Edwards & Cronbach, 1952; Kiesler, 1966; Paul, 1967; Sprinthall, 1967; Strupp & Bergin, 1969, 1971).

In spite of this, researchers and practitioners alike have not tried to maintain a respectful tentativeness commensurate with their real ignorance of the problem. Rather, there is a tendency among partisans of each of the various positions to apply one standard of adequacy to this inherently poor research when it supports their theoretical position and an entirely different standard to the same type of research when it is contrary to their position (Hunt, 1956).

As Goldstein, et al. (1966, 1971) have pointed out, it is not uncommon for clinically-minded researchers to disqualify and reject unfavorable results by pointing to methodological and control problems, while at the same time citing favorably indentical studies which support the position they advocate. More specifically, Bandura and Walters (1963) have shown how psychoanalysts frequently reject negative findings when the research is based on a translation of psychoanalytic theory into learning terms, citing the inadequacy of translation, or misunderstanding of theoretical positions. Yet, they embrace positive findings with such enthusiasm that the purely psychic dividends which result unite to compel and further seduce their continued belief and increased entrenchment in psychoanalytic theory. As a result of this sort of response to research by many clinicians, the era of academic tribalism is still with us, and shows little evidence of waning

in the near future.

Schools of psychotherapy still exist with little more reliable, empirical foundations than before (Berger & McGaugh, 1965; London, 1964; Luborsky et al., 1971; Rogers, 1963). New schools continue to emerge (Berne, 1965, Ellis, 1962, Eysenck, 1959, 1960, 1965; Salter, 1961; Stamphl, 1967; Wolpe, 1958) as factions radically opposed to traditional psychotherapy. Freshly minted ideas and glimmerings of understanding become so quickly encapsulated into the dogma of a "school" or coterie that they are seldom subjected to the scrutiny and "natural selection" of experimentation (Blocher, 1967; Berger & McGaugh, 1965; Dittman, 1966). In fact, every effort is often made to protect and guard what each deems desirable, should it be "mistakenly confused" with the facts of research, for ". . . non-confirmation of a cherished hypothesis is acutely painful" (Campbell & Stanley, 1963, p. 3).

Similarly, as before, these new schools maintain their autonomy, and thus avoid any potential cognitive dissonance, simply by building new jargons, creating new journals in which to publish (Behavior Research and Therapy, Voices, etc.) and generally divorcing themselves from the rest of the field. Successes by one school are either impugned as palliative, attributed to factors the critic's school deems irrelevant, or blatantly disreputed (Rogers, 1963; Strupp, 1962; Strupp & Bergin, 1971; Wolpe, 1963; Wolpe & Lasarus, 1966). Finally, as before,

> Extremists on all sides have not hesitated in their expenditure of polemic words and ink to discredit each other, even though well-controlled comparative studies are nonexistent (Paul, 1966, p. 1).

Although the collapse of the field into shapeless solipsism and feckless relativism, which is the death of science, is not imminent or pressing, this joint-catharsis-against-a-common-foe makes for little more than personal harmony and satisfaction within each faction. While such procedures effectively protect the members of each coterie from the experience of cognitive dissonance, they contribute little in the way of constructive, cumulative knowledge (Campbell & Stanley, 1963). It is true that these precociously inspired theories often replace one another. However, since this displacement is typically not the result of well controlled, comparative research, the product rarely augments existing knowledge or serves as a sequel to what has gone before (Blocher, 1967). In short, it adds to the history of psychotherapy, but not to its evolution.

The overall effect of this condition is clearly demonstrated in Colby's (1973) analysis of the current predicament in psychotherapy--"Chaos prevails" (p. 347). Similarly, Rogers' (1963) statement graphically portrays the net results of this state of affairs--"The field of psychotherapy is a mess" (p. 10). Finally, London (1964) has conceded that:

> A detailed examination of the surfeit of schools and theories, of practices and practitioners that compete with each other conceptually and economically, shows vagaries which, taken all at once, make unclear what it is that psychotherapists do, or to whom, or why (p. 5).

Summary and Prospective

As indicated above, a good portion of this "mess" is due to the fact that most existing schools of psychotherapy are based as

much, if not more, on faith and dogma as on comparatively derived research findings. By transposing flimsy hypotheses into truths and then selecting research to bolster already developed personal convictions, these schools become implacable and categorically indestructable; i.e. immune to dissonant empirical findings (Goldstien, 1969; Matarazzo, 1965). As a consequence, evolution in psychotherapeutic theory takes the form of ". . . a fadish discard of old wisdom in favor of inferior novelties" (Campbell & Stanley, 1963, p. 2).

Nature of the Problem

If, however, psychotherapy is ever to mature beyond the level of ". . . an undefined technique, applied to unspecified problems, with an unpredictable outcome" (Raimy, 1960, p. 93), then experimenters must abandon research models which perpetuate distinctions between existing schools and adopt those models which seek to define techniques, circumscribe limits of applicability and demonstrate efficacy, within limited contexts (Gendlin, 1967; Gilbert, 1952; Bednar, 1970; Gruen, 1973; Kiesler, 1966; Lewis, 1973; Sanford, 1953; Strupp & Bergin, 1969).

In spite of the formidable obstacles created by methodological and control problems and in the face of admonitions to the contrary (Hyman & Berger, 1965; Kiesler, 1966; Strupp, 1962; Strupp & Bergin, 1969) a number of investigators feel that there is an adequate paradigm for research in psychotherapy which follows the above prescription (Blocker, 1967; Edwards & Cronbach, 1962; Frank, 1959; Paul, 1967; Sprinthall, 1967). Such a design would consider simultaneously the

following: (a) client variables, (b) therapist variables, (c) technique variables, (d) outcome variables. The magnitude of such an undertaking is obvious, and much of the remainder of this chapter addresses itself to the obstacles inherent in such an enterprise, and to the potential solutions to the problems that they present.

Client Variables

In terms of research methodology, client variables can be reduced to the dual problem of sample selection and treatment focus. Borrowing his strategy from the research on the effects of drugs, Frank (1959) has suggested a promising approach to this problem, which involves the selection and description of clients in terms of what he calls "target behaviors". In other words, clients who are going to be used as subjects for research are selected on the basis of common or similar distressing behaviors. The description or operational definition of this common presenting problem then becomes the dependent variable in the research design. Furthermore, with this approach, the goal of treatment then becomes change in a specific direction. The efficacy of this approach has been successfully demonstrated by Paul (1966) in his attempts to reduce interpersonal-performance anxiety in college freshmen.

According to Paul (1966), therapy should:

> . . . compare specific techniques in the treatment of an emotional problem that is delimited enough to allow rigorous experimental methodology, but significant enough to allow generalization from the findings and to have implications for further study in the broader field of counseling and psychotherapy (p. 9).

If one views the most important test of the effectiveness of a particular therapeutic treatment as involving (a) change in the client's distressing behaviors as well as (b) change in these behaviors outside of the treatment setting, then these two criteria, in conjunction with client self-reports, go a long way toward achieving this goal. This observation relates itself to the problems of research in psychotherapy in some interesting and challenging ways.

First and foremost is the fact that the founders of nearly all existing forms of psychotherapy derived their theoretical formulations and based their techniques on observations of radically different types of clients (Kiesler, 1966). Secondly, the evidence which does exist, while not entirely satisfactory, in terms of either scope or consistency, suggests that in fact, psychotherapy, as traditionally conceived, is a process which has restricted applicability for only selected subgoups of the population (Blocher, 1967). Considered together, these two factors seem to suggest that perhaps different forms of treatment are needed for differing combinations of personality type and presenting problem (target behaviors).

There is a growing body of evidence which suggests that therapists do in fact behave quite differently with different types of clients (Dittman, 1966; Matarazzo, 1965; Strupp,1962,1971). However, the relationship between this and outcome is unclear. In one study (Truax & Carkhuff, 1965) it was found that "therapist transparency" was positively related to self-exploration in both hospitalized neurotics and delinquent adolescents. However, whereas self-exploration was positively related to client improvement among

the neurotic group it was inversely related to positive personality change in the delinquent population. Such results suggest that, indeed, there is a significant relationship between client types and problems, and further that therapy techniques have a differential impact on divergent populations, a fact that has until recently been largely ignored by clinical researchers.

Therapist Variables

To a great extent the situation observed with regard to client variables holds true for therapist variables and in certain situations the impact of the latter is even more pronounced than that of the former. There are at least three ways in which the therapist variable can be treated. The first approach, which exists predominantly in fantasy, involves using each therapist as his own control. The advocates of this approach (Paul, 1966, 1967) conclude that by having each therapist administer each of the treatments, one can hold the personal-social attributes of the therapist constant across groups, reducing the placebo effects which may masquerade as treatment effects.

Not only is this goal impossible to achieve, but the strategy on which it is based is internally inconsistent. Having therapists objectively indicate their degree of commitment to certain techniques, as Paul (1966) has done, excludes by definition an equal commitment to alternative approaches; the therapist's personality has already entered into his choice and commitment. Once this is done, finding ". . . therapists who are open-minded enough to learn to use contra-

dictory methods without exhibiting attitudes that would greatly affect their approach" (Paul, 1966, p. 6) becomes an axiomatic impossibility.

Even if we were to grant the potential plausibility of this approach, it does nothing to circumvent the original problem, but rather creates an insoluable dilemma. That is, if one uses this approach (Paul, 1966) and fails to achieve its supposed goal, then one is maximizing the differential influence of the placebo effects in the direction of the techniques preferred by the therapist originally. If one, in fact, succeeded in finding such "open-minded" therapists they would most assuredly not be representative of other therapists of the same or similar orientation. As Arbuckle (1967) has so aptly pointed out "Differences in counselors automatically become differences in counseling" (p. 224).

Perhaps the clearest statement regarding the inseparable nature of therapist and therapy variables has been offered by Frank (1959) who states:

> It is obvious that the therapist and therapy variables cannot be completely separated. It is unlikely that a therapist can conduct different types of treatment with precisely equal skill or that his attitudes towards them will be identical. Therefore, differences in results obtained by two forms of therapy conducted by the same therapist may be due to therapist rather than treatment variables, especially since the faith of a therapist in a form of treatment may account for much of its efficacy. (p. 7).

> In our psychotherapy study the psychiatrists disliked minimal treatment. They gave it reluctantly and felt that they were shortchanging the patients. The patients remained just as long in this type of treatment as in the other two, suggesting that they were not as lacking in confidence in it as the doctors. (p. 17).

An alternative, and even more absurd, approach is to attempt to get counselors effectively to role play confidence in techniques they regularly do not use or in which they do no believe (Snyder, 1963). This method, if effective, simply adds any placebo effects back in again, in haphazardous and uncontrollable amounts, mitigating the entire purpose of this circuitous approach. If ineffective, the researcher has, once again, introduced placebo effects, this time systematically and in such a way as to maximize the differential impact of the treatments being examined. The primary problems here, as above, is that one never really knows when and if he has or hasn't failed. In addition, in view of Rogers' (1963) and Frank's (1959) observations, it becomes difficult to imagine a Client-Centered therapist, for example, doing Rational Emotive Therapy or trying to roleplay confidence in such an approach. This is to say nothing of the inequity created by attempting to train seasoned veterans of Client-Centered therapy to do Rational Emotive Therapy in a week or less (Strupp, 1967, 1968).

Finally, both of these strategies lend an air of artificiality to the research treatments which is not present in the clinical treatment setting in which these techniques are usually administered. This latter fact serves only to reduce the external validity or generality of the findings even further. Clearly, then, both of these approaches commit the error of misplace precision.

A partial solution to this problem can be achieved by assuming, as Arbuckle (1967) does, that certain therapists choose

certain techniques because they are certain kinds of people -- i.e. that the therapist's personality and his treatment techniques are integrally and inseparable linked. Then, by securing therapists who are committed to techniques which one wishes to compare, and having each administer the techniques they respectively deem effective; and comparing what they do (by means of video or audio tape); one is in a much better position to assess treatment conditions as they are most often administered with little or no loss of scientific rigor. Unfortunately, this approach incurs problems due to the greater variability of the treatments administered by different therapists (Paul, 1966, 1967), and consequently, is not the answer to the problem of therapist variables.

A compromise approach is available, however, one which captures the desirable characteristics of those reviewed above without incurring the liabilities attending their utilization. One has simply to examine the impact of a therapy variable that does not significantly effect the theoretical or technical orientation of the therapist(s) in question. By utilizing the same therapists in both conditions, (one in which the variable in question is present and another in which it is absent) the experimenter can successfully control for the relationship between therapist personality and technique, so that the results can safely be attributed to the presence or absence of the dependent variable. This method allows for large scale replication, without the necessity of using hundreds of subjects in the initial study; it circumvents the absurdity of having each therapist role play confidence in methods

in which he has little or no faith and at the same time retains the desirable factors of having each therapist act as his own control. Additionally, it serves to eliminate the ethical question of offering services perceived to be inferior, to a client population.

Another distinct advantage of this approach is that one may check on whether or not the assumptions of this model are met, an advantage not found in the previously discussed strategies. In addition to comparing what therapists say they do with what they actually do, by means of tape recordings, objective assessment of the therapist's personal-social characteristics can be made and similarities and differences noted. When client variables are sorted in the manner described earlier, the data on therapist personal-social characteristics can be compared with the data on client personal-social characteristics, since, in many cases, assessment can be made by many of the same measurement instruments. This is especially true of such personal-social characteristics as personality type, socio-economic status, age, sex, etc.

This does not mean, however, that outcome results are simply a measure of therapist personal commitment. One can be strongly committed to walking to the moon, even though the efficacy of this technique (walking) can be proven virtually useless. The compromise approach attempts to hold personal commitment as a constant, then, by using uniform outcome criteria for all treatment and control groups, the results can be interpreted as commitment to either effective or ineffective treatment, whichever the case may be.

It should be remembered that Paul's (1966) conclusions, strictly speaking, are relevant only to insight oriented therapists practicing systematic desensitization, and at last count, there doesn't seem to be an over-abundance of these individuals in the field. This of course, assumes that Paul's (1966) initial distinction between therapist personal-social characteristics and treatment techniques is accepted, and since most of the research (Arbuckle, 1967; Frank, 1959; Strupp, 1962,1969) seems to be supportive of this stance, it seems a reasonable distinction to employ in the present research.

The approach offered above, however, allows us to conclude that a therapist's personal commitment is either too powerful or relatively impotent, in modifying therapy behavior, whatever the results support. In concluding this section on input variables then, discussion has shown that selecting, describing and classifying both clients and therapists on the basis of pretreatment individual differences makes for better controlled, more easily interpretable and thus more legitimately generalizable research, provided that such classification can be done with the instruments that are presently available for such measurement. Lacking such instrumentation, the next best alternative is to use random selection with respect to client populations and to use therapists as their own controls, whenever the research design allows the utilization of such an alternative. The importance of clearly defining the variables within these two broad domains has been exhorted by Garfield and Afflick (1961) who maintain that the time to begin outcome studies is prior to intake. Similarly, Strupp (1962) has noted the potential value

of this area when he states; "research might make an important contribution by refining the selection of particular patients for particular therapists and for particular therapeutic methods" (p. 471).

In this manner, we may begin to bury the myths which, according to Kiesler (1966), have retarded progress in both the research and practice of counseling and psychotherapy; namely the assumption that clients, therapists, and treatments are homogeneous entities. In so doing, research will simultaneously give birth to the area of "individual differences" within the fields of counseling and psychotherapy; an area which gave to psychology, generally, some of its earliest and most important discoveries (Sprinthall, 1967).

Research in Group Psychotherapy

The above discussion has noted a number of research problems and cautions, all of which are equally true for research in group psychotherapy, albeit with some additions imposed by the nature of the field. Recent reviews of research in group psychotherapy (Bednar & Lawlis, 1971; Goldstien et al., 1966; Gundloch, 1967; Yalom, 1970) have clearly indicated the need for improvements in the quality of the research being done. Keisler (1966) noted that research in individual psychotherapy has been disorganized and methodologically unsophisticated, but an even worse state of affairs has existed in the group psychotherapy area. One of the main reasons for this is that the many conceptual and methodological problems inherent in group psychotherapy research have been insufficiently delineated. Recent reviews of the literature (MacLennan &

Levy, 1971; Lubin, Lubin, & Sargent, 1972; Lubin & Lubin, 1973) show an increase in the volume of production from 327 articles in 1970 to 500 in 1972, and proportionately the number of articles which can safely be called research, has risen from only 25 in 1969 to over 80 in 1972. It is clear, however, that the preponderance of articles still are those which might be called theoretical or case study papers. The same criticism holds true here as in the earlier analysis of the individual psychotherapy literature; it simply has not made any significant contributions to the cumulative body of knowledge upon which practice is based.

A proper evaluation of group psychotherapy must begin by determining those advantages and disadvantages which distinguish it from individual psychotherapy. If the greater number of participants in group psychotherapy leads only to a greater complexity of dyadic therapeutic processes, then extensive research into group psychotherapy is likely to be far more expensive in terms of time, resources, and personnel than would the aquisition of an equivalent amount of information gathered in the field of individual psychotherapy research.

Truax (1966) measured the levels of accurate empathy, non-possesive warmth and genuineness expressed by group therapists, and found that members of groups in which levels of these therapeutic conditions were high showed greater personality and behavior change than members of groups in which levels of these therapeutic contitions were low. This was so even for group members who were not themselves the recipients of the warm, empathic and genuine remarks made by

the therapist. Thus, rating the therapeutic conditions characteristic of the group proved to be a better predictor of individual change than rating of the magnitude of these conditions offered to individual group members. Lieberman (1970) reported similar findings; a group therapist who systematically prompted and reinforced cohesive statements was able to significantly increase the amount of cohesion in his group over that of a control group. Further, the frequency of therapist reinforcements for cohesion in the group as a whole was more predictive of early improvement than was the frequency of reinforcements received by particular group members. Lieberman (1970) suggests that the level of cohesion within the group is more significant in producing change for a member than is the amount of reinforcement directed to any individual members.

Both of the above studies support the notion that there are group variables which significantly influence individual outcomes in group psychotherapy. Group psychotherapy does not seem to be merely a more complex version of individual psychotherapy, but rather, to be a seperate entity differing in some extremely significant ways. The task of the researcher then, is carefully to specify that which he may borrow from the individual psychotherapy literature, and clearly seperate it from that which may be used exclusively in the analysis of dyadic relationships.

For research purposes, group psychotherapy, like individual psychotherapy, can be conceptualized as a complex array of client variables, therapist variables, situational variables, and outcome variables. The methodological issues associated with these

variables have been described by a number of researchers (Bednar, 1970; Bednar & Lawlis, 1971; Bergin & Strupp, 1970; Kiesler, 1966, 1971; Meltzoff & Kornriech, 1970; Pattison, 1965). Briefly, they can be summarized as follows.

1) Uniformity myths (Kiesler, 1966, 1971). There is clearly a need for increased specificity in group psychotherapy research. Researchers need to stop evaluating the effects of something called "group psychotherapy" on somebody called "patients", "out-patients" or "schizophrenics". Group psychotherapy is not a homogeneous treatment condition; group psychotherapists differ from one another in a multitude of ways, and so do psychotherapy patients. As Bednar and Lawlis (1971) have pointed out, different kinds of group psychotherapy have differential effects on different kinds of patients. It is clear that we are not going to learn a great deal about group psychotherapy until we begin to specify relevant patient characteristics, therapist characteristics and treatment differences.

2) Evaluating Outcome (Paul, 1967; Strupp & Bergin, 1969). Outcome criteria as used in different studies differ to a degree that makes comparison impossible and consequently significantly reduce the utility of such research. Furthermore, typical outcome criteria, such as therapist rating of improvement, self report questionnaires, attendance records and symptom checklists are not good estimators of the change in individual patients, which constitutes the goals of psychotherapy research (Gruen, 1973). Checklists, therapist rating, attendance and discharge rates all sample behavioral domains which are poorly related to one another

(Strupp & Bergin, 1969) and which are quite different from the domain of behaviors involved in the process of group psychotherapy. As such, these criteria are not capable of clarifying the relationship between therapeutic process and outcome and thus of showing us how to increase the power of our intervention procedures.

3) Inadequacy of present theories (Lewis & McCants, 1973). As is the case in individual psychotherapy, theories of group psychotherapy do not lead us to useful research paradigms. Present theories do not offer the precise definitions of relevant patient therapist, and treatment variables required for meaningful research in group psychotherapy. An adequate theory would generate propositions delineating these variables as well as suggesting the form of their interactions. Such a theory would also direct researchers to appropriate process and outcome dimensions. (Dozier Thornton, personal communication, Jan. 1974).

In response to the methodological problems outlined above and the paucity of information concerning the interactions among significant variables in psychotherapy, researchers have allied themselves with one of two basic camps (each encompassing a number of off-shoots that will be considered later). Some researchers have suggested undertaking large-scale multivariate studies, in which therapist, patient, treatment and environmental variables are all present in adequate numbers to allow for precise interactional analysis. Statistical analysis is given the burden of sorting out the crucial interrelationships (Goldstien et al., 1966; Kiesler, 1966, 1971). Unfortunately, the usefulness of this approach

depends upon selecting for analysis those variables which have impact on individual change. It is precisely the identification of these variables which neither our theoretical models, outcome and process research, nor case study literature has in fact accomplished. Statistical analysis cannot delineate meaningful relationships among irrelevant or poorly defined variables. Inadequate categories are no more likely to provide fruitful research results in large-scale studies than in small ones. At present the large scale multivariate approach is impractical and requires a degree of scientific understanding about group psychotherapy which we simply do not have.

The other camp, seemingly, more aware that we have a low level of knowledge about psychotherapy in groups advocates a greater reliance upon naturalistic observation and experimental case studies (Strupp & Bergin, 1970; Meehl, 1964; Verplanck, 1970). These procedures are designed to identify variables relevant to individual change in the clinical setting and to record in detail the process of intervention and change which leads to individual growth.

Naturalistic observation refers to observation of the target phenomenon as it occurs naturally rather than abstracted from its usual environment in a laboratory setting. The execution of meaningful research in group psychotherapy requires observation in the clinical setting. These observations must be precise and replicable if they are to offer more powerful information than the clinical case study approach has provided. Kiesler et al., (1967)

found that the therapist's evaluation of intratherapeutic events correlated negatively with evaluation both by patients and trained observers, which may account for the fact that our rich case study literature has had such a low yield with respect to identifying the vital variables in the psychotherapy process. Unfortunately, a precise, replicable, and reliable method for observing interpersonal interchange systems is yet to be developed. Bales' system (Bales, 1950) is innappropriate as its content based emphasis does not allow utilization in an essentially dyadic interchange network. Promising advances are being made by Lewishon (Lewishon, 1969) at the University of Oregon, but as yet his system remains inadequately developed to meet the challenges posed.

Given that the observational system, prerequisite for the proper utilization of the case study approach, has yet to be developed; and that the definitional and theoretical system, prerequisite to the large-scale multivariate approach, is nonexistent, it is readily understood why there is such a relative paucity of "good" research in group psychotherapy. By and large, researchers have attempted to follow Strupp and Bergin's (Strupp & Bergin, 1969) suggestions for coordinated research in psychotherapy. The resultant product, while far from the coordination that Strupp and Bergin have called for, has at least contributed significantly to our knowledge of what methods of design and analysis tend <u>not</u> to be useful in group psychotherapy, which at least puts the group researcher on equal footing with the individual psychotherapy researcher. There is very little "hard" evidence of what works in either area, but there

is a wealth of information regarding those methods of analysis that have not proven fruitful, and perhaps this is sufficient to provide a glimpse of the light at the end of the tunnel--or at least an indication as to which directions might be most profitable.

CHAPTER II

REVIEW OF THE REVELANT LITERATURE

Frank (1969) has identified what he believes to be the common factors which account for the success of psychotherapy. He believes that:

> . . . It is probable that at least three processes are involved in the production of attitude change, which may vary independently. The first is the production of change; the second, its duration; and the third its generalizability (1969, p. 123).

Continuing along the same lines he makes the isolation of relevant factors even clearer;

> . . . the most effective ingredients in psychotherapy lie in those aspects of the therapeutic relationship which raise the patients morale and inspire him with courage to try new ways of coping with the stresses that beset him (Frank, 1969, p. 126).

At the risk of seeming overly simplistic, with respect to the previous chapter, it seems that the factors which contribute most significantly to the patient's inspiration and morale are: 1) Anxiety (Bergin & Jasper, 1969; Distler, 1964; Gallagher, 1954; Gottschalk, 1967; Katz, 1958; Kirtner & Cartwright, 1958; Hamburg et al., 1967; Luborsky, 1963); 2) Expectations (Brady et al., 1970; Conrad, 1960; Goldstein & Shipman, 1961; Lipkin, 1954; Uhlenhuth & Duncan, 1968); and 3) Motivation (Cartwright & Lerner, 1963; Conrad, 1962; Schroeder, 1960; Strupp et al., 1963). All of these factors have been shown to be

significantly related to therapeutic outcome by the above authors, and yet very little has been done by way of relating the combination of all three to the outcome of psychotherapy.

Distler (1964), in a study conducted with hospitalized patients at the Camarillo State Hospital in California, concluded initially that manifest anxiety (rated by the Taylor, 1953 and Bareson, 1953 scales) was not significantly effective in predicting the length of hospitalization or the outcome of psychotherapy. When the sample was broken down according to sex however, both predictors were found to be significant, although in opposite directions for men and women, suggesting a sex differential related to perceived sex-appropriate models of behavior.

Katz (1958) raised the question of whether and how anxiety was related to the premature termination rate of 30 to 65%, nationwide, and concluded, for the outpatient population which he studied, that there seemed to be some discrepancy between the variables accounting for the subsequent improvement of the client and the variables which seemed to be related to the patients' continuation in therapy. This raises an intriguing question; if Katz's (1958) results are valid, they seem to suggest that we are dealing with two types of anxiety, one which seems to be related positively to the liklihood of improvement and another, underlying or "durational anxiety" which seems to be positively related to the patients' continuation in therapy, but negatively related to the liklihood of improvement. The first, "working anxiety" comes perilously close in definitional terms, to the "need to change" or motivation which

will be discussed later. The latter, "durational anxiety" comes much closer to a useful operational definition of anxiety. It seems to be closely related to the individual's willingness or unwillingness to expose his faults or what he believes to be his "deepest and darkest secrets", and consequently accounts for the divergence or differential impact on the therapy process of the two types of anxiety. Gallagher (1954), utilizing the Rorshach and MMPI scales, and client centered psychotherapy techniques, concluded that:

> . . . unless the client is motivated by some overt anxiety to change his perceptions and unless he is able to give of his perceptions freely with the counselor, then client-centered methods of counseling will produce a minimum of change (p. 413).

These results are supported by Cartwright and Lerner's (1963) study which suggest again a differential impact of anxiety. Schematically the resulting relationship between the variables is presented below:

Length/improvement	Need to change	Empathy
short/improved	high	high
long/improved	high	low
short/unimproved	low	low
long/unimproved	low	high

Figure I

Results of Cartwright & Lerner's 1963 Research

Although the instrumentation used by Cartwright and Lerner was not capable of differentiating between working anxiety and durational anxiety their results suggest that it is this differential which accounts for the differences in terms of length of therapy and improvement. Studies by Truax (1965,1967) have indicated that a high

level of empathy is effective in producing positive results in short term therapy, which would account for the differences between the short/improved and long/improved populations. However, the differences between the short/improved and long/unimproved populations cannot be adequately accounted for by the empathy level of the therapist and the researchers conclude that it may be due to the antithetical nature of working anxiety and durational anxiety--i.e. one tends not to exist in the presence of the other, or at least present instrumentation is not capable of determining the relative levels of each if they can or do exist simultaneously. If this is in fact the case, the question relevant to the researcher is how to bring "working anxiety" up to productive levels while at the same time, reducing "duration anxiety" to a level at which it does not impede the process of psychotherapy.

A somewhat similar situation exists with regard to motivational levels or the "need to change". Several authors (Cartwright & Lerner, 1963; Conrad, 1962; Schroeder, 1960; Strupp et al., 1963) have concluded that there exists a strong positive relationship between the individual's need to change and the actual probability that he will change. Intuitively, this seems a perfectly logical conclusion, and in fact some of the research (Schroeder, 1960) seems to be more intuitive than it is empirical; however, the question is more relevantly how can motivation be modified in such a way as to increase the probability of success in psychotherapy, rather than is there a relationship between motivation and change? Cartwright and Lerner (1963) suggest that there is a clear relationship between the therapist's

understanding, experience, etc. and the outcome of therapy, regardless of motivation. Cartwright and Cartwright (1958) also arrive at the same conclusion, leading to the suggestion that the therapist's ability to clarify what the therapy relationship is all about and his ability to assist in setting and attaining therapy goals combine to increase the probability of successful psychotherapy by simultaneously increasing the client's motivation to change and his acceptance of the possibility of change. If this is an accurate perception of the process, it is reasonable to assume, then, that endeavors to clarify the client's perception of what psychotherapy is and how it works should increase his positive expectations, while at the same time increasing his motivation to change.

Authors addressing themselves to the relationship of a client's and therapist's expectations (Brady et al., 1960; Conrad, 1960; Goldstein & Shipman, 1961; Lipkin, 1954) have uniformly concluded that positive expectations are highly correlated with positive outcome. Tien-Teh-Lin (1973) suggests that the quality of the counseling relationship is largely a function of the counselor's self confidence and consequently the positive expectations for improvement which he projects, while Clemes and D'Andrea (1965) conclude that the patient's anxiety is a function of expectations and the degree of initial interview ambiguity. In analyzing the data on the 85 subjects in their study, they suggest that if initial interview ambiguity can be reduced, then positive expectations will be increased. The data also clearly indicates that positive expectations are highly correlated

with positive outcome, leading to the conclusion that a reduction in initial interview ambiguity will be met by more positive outcomes.

Brady et al., (1960) have discovered a similar positive relationship between expectation of improvement and actual improvement with a hospitalized population, suggesting that this relationship is not isolated to certain client populations but is in fact found in all investigated cross sections of the population.

Goldstein and Shipman (1961) found correlations of .405 and .530 respectively with regard to expectations and perceived symptom reduction and symptom intensity, replicating the results of an earlier study (Goldstein, 1960) concerned with the effects of expectation on an undergraduate population at a university counseling center. Finally, Overall and Aronson (1963) have found that lower class clients tend to have expectations of psychotherapy which are closely allied to their expectations of the medical profession in general. Overall and Aronson conclude that perhaps a good deal of the ineffectuality of psychotherapy with lower class clients can be accounted for by observing the discrepancies between their expectations and the actual process which typifies psychotherapy.

By way of summation then, it is noted that there is a considerable amount of evidence pointing to the relationship of positive psychotherapy outcome and the client's initial degree of anxiety or ambiguity, motivation or need to change and his degree of positive expectations with regard to psychotherapy. It should also be noted that this general trend has been present without regard to the specific client population being considered, nor was the trend

significantly affected by varying settings or theoretical orientations, suggesting that it is generalizable and not dependent upon idiosyncratic situational determinants.

The above discussion suggests that the process of psychotherapy may be significantly enhanced by attempting to direct the client's anxiety, promote his motivation and clarify his expectations. Yet a review of the literature discloses only five articles (Martin & Shewmaker, 1962; Hohn-Sardic et al., 1964; Truax et al., 1970; Pierce et al., 1970; and Warren & Rice, 1973) which have been written on the effects of planned preparation for psychotherapy, and of that number, only two (Martin and Shewmaker, 1962; Truax et al., 1970) have been directly relevant to group psychotherapy. All have been plagued by methodological problems, resulting in a gaping hole in the body of knowledge relevant to improving the effectiveness of the process of psychotherapy in general and group psychotherapy in particular.

Martin and Shewmaker (1962) review the effects of written instructions in group psychotherapy remarking that:

> One of the first tasks of a prospective patient is to obtain a minimum comprehension of what he can expect of psychotherapy and what will be expected of him. One of the initial problems confronting the therapist, accordingly, is to acquaint the person with the therapeutic procedure (1962, p. 24).

They attempt to achieve this introduction to the therapeutic procedure by distributing a two page synopsis of group psychotherapy to the participants in their groups. Unfortunately, at this point their study severely suffers, at least from a methodological point of view. Their utilization of one "relatively unbiased" therapist and

one group as the subjects hardly lends to the credence or replicability of the study and the utility of the project is further handicapped by their use of informal observation and clinical notes to assess the impact and effectiveness of the written instructions.

After a similar fashion, Orne and Wender (1968) present an intuitively sound but empirically untested case for the use of "anticipatory socialization" in psychotherapy. The authors state that:

> There is a strong positive relationship between a patient's perception of psychotherapy and its ultimate success. Some patients who appear to lack motivation for treatment may be capable of profiting from psychotherapy if they are taught what to expect--if they understand the "rules of the game" (1968, p. 1202).

While there is a fair amount of clinical evidence to support their statement (Frank et al., 1957, 1964; Hoehn-Saric et al., 1964) the authors, in this case, provide little more than additional buttressing to the already overly abundant case study literature, while providing little in terms of verification for their claims.

Fortunately, this sort of intuitive hypothesizing does not characterize all of the literature relating to psychotherapy pretraining, and the following examples, while suffering from methodological problems of their own, show a trend in the right direction.

Sloane et al., (1970) utilized a methodologically sound design to evaluate the impact of preparation and expectation of improvement on the outcome of psychotherapy, by using a design that called for the random assignment of 36 psychoneurotic outpatients to four groups, each of which received a different indoctrination by

the research psychiatrist. Group A was assigned to a psychotherapist without further explanation. Group B was told firmly that they should feel and function better after four months of psychotherapy and then they were assigned to a therapist. Group C had the process of psychotherapy explained to them by means of Orne's anticipatory socialization interview and were then assigned a therapist. Group D had the process of psychotherapy explained to them and in addition were firmly told that they should be feeling and functioning better within four months. Sloane (1970) reports that at the end of treatment the patients who received an explanation of psychotherapy improved slightly but significantly ($p < .05$) more than those who did not receive it. The simple suggestion that the patient would improve within four months appears to have had no effect on outcome, leading Sloane to suggest that it is the anticipatory socialization interview alone, that was responsible for the outcome differentials. At this point, however, Sloane's study begins to suffer from methodological problems, the first of which is the fact that his psychotherapists consisted of nine psychiatric residents with a minimal amount of psychiatric training and experience. Goldstein (1967) has emphasized the importance of therapist differences as they relate to outcome, and a design which utilized nine different therapists and makes no attempt to control for the differences in their techniques, experience, personality or approaches to therapy is clearly in violations of his precautions. At the same time, there is the question of the therapeutic competence of residents and if the results obtained by an

inexperienced group of therapists, using uncontrolled techniques, can be generalized so as to be useful to the experienced clinician. Karon's (1971) research would tend to suggest that the experience differential between experienced and inexperienced therapists alone is sufficient to cause outcome discrepancies of a magnitude that may invalidate any study in which they are not contolled for. Furthermore, Sloane has failed to use any sort of reliable outcome measures, relying instead on his own clinical judgements in the initial and in a final interview to determine the relative success or failure of therapy. Sloane also asked the residents and the patients to rate their improvement in therapy, a procedure which as was pointed out earlier, is something less than purely scientific. When these criticisms are combined with the fact that almost 50% of the subjects in his study had been in psychotherapy before, and that no attempt was made to either screen them out of the study or to distribute them evenly among groups, Sloane's claims of improvement with anticipatory socialization must be viewed with a certain degree of incredulity.

An earlier study (Nash et al., 1965) while not completely eliminating the criticisms leveled against Sloane, has attempted to deal with the problems of therapist differences and to combine the analysis of these differences with the systematic preparation of patients to yield a seemingly much more reliable set of conclusions. Nash has attempted to control for therapist differences by rating each group of clients seen by each therapist separately as well as combining them for overall outcome evaluation. This procedure disclosed significant differences in the way the therapists presented

themselves to their clients, in the ratings that they received from their clients, and in the scores that they were given by a group of naive raters listening to tape recordings of all of the therapy sessions. These differences were also reflected in the outcome scores of both experimental and control groups; the clients of the experienced and highest rating therapist scoring significantly higher than the clients of the lowest rated therapist in either condition. The results from the client groups of the other two therapists showed no definitive trends, leading the researchers to conclude that perhaps the therapists' experience, and capability of sustaining relationships, is of greater importance in the determination of outcome than the presence or absence of the role induction interviews. The analysis of the combined factors (therapist, patient attractiveness/unattractiveness, and presence or absence of role induction) however, indicates that each can, to a degree, compensate for one or both of the other variables, the results indicating that the probable prognosis of positive outcome declines relative to the rated decline of the other three factors.

An earlier study by the same research team (Hoehn-Saric et al., 1964) supports the same conclusions, although this study lacks the sophistication of the later attempts. The 1964 study again uses psychiatric residents as therapists, lacks controls for therapist techniques and relies on the clinical evaluations of the researchers for outcome criteria; detracting further from the credibility of the study, however, are the facts that all clients dropping out of therapy prior to the fifth session were excluded from the data,

and that clients serving as controls and those who received the role induction interviews were placed in the same groups, leading to suggestions that the experimental subjects may well have influenced the control subjects, consequently contaminating the results.

Perhaps the best study in the area of therapy pre-training is one done by Truax et al., (1966) who employed a sample size of eighty and a 2x2x2 factorial design. Truax employed eight groups of ten clients each, four of the groups being hospitalized mental patients and four institutionalized juvenile delinquents. The researchers utilized both alternate therapist-present, therapist-absent sessions and vicarious therapy pre-training in the factorial design and obtained pre-and post-measures by means of five Q-sort measures relating to self- and ideal-self-concept measures and self and ideal-adjustment scores. The results clearly support the hypothesis that there will be a lack of differential changes in the vicarious therapy pre-training, non-vicarious therapy pre-training and alternate-regular sessions in the two different populations. The hypothesis regarding the use of vicarious therapy pre-training received less than overwhelming support; although patients receiving VTP showed improvement on all five of the self concept measures from pre- to post-therapy, and patients not receiving VTP showed deterioration on four of the five measures and a minimal gain on the self adjustment measure, none of the ideal-expert and ideal-adjustment scores were statistically significant. This leads the authors to conclude that:

> . . . if any concrete benefit did accrue it is probably in the form of potential in that the patient's goals toward

> which they are seeking to change appear to be, after therapy, more in keeping with societal expectations as a result of this treatment (Truax et al., 1966, p. 31).

It is noteworthy that the results of this investigation are at variance with those presented in the earlier studies. It may be suggested that the use of more objective measures of pre-and post-therapy change account for the loss of significant differences between the VTP and NVTP groups, but it is equally possible to suggest that the lack of significance is due to the confounding effects of the factorial design and to find some support in the fact that four of the interactions in the design were not interpretable. A suggestion which supports the earlier observation that while the factorial design has a good many advantages, most researchers concur that, at this point in time, investigation into the effective ingredients of psychotherapy does not have the requisite specificity for its most profitable implementation.

Statement of Problem

The problem to be examined in the present research, then, is one of much conjecture and, as yet, little empirical verification, namely: "What are the effects of attempts to modify client's therapeutic expectations, motivation to change, and levels of manifest anxiety?" The review of the literature would suggest that this is an amiable enterprise, yet, at the same time, one which has received little in the way of empirical investigation. Considerable attention has been given to establishing client expectations, motivation and anxiety as accurate predictors of such factors as length of treatment,

probability of success and response to treatment; however, of the eight articles devoted to systematic preparation of clients for treatment, none address themselves to the issue of what impact, if any, this preparation has on the predictors of therapeutic success. The present research is devoted to analyzing systematic client preparation as it affects the predictors of outcome as well as the outcome itself. Consideration will be given to the impact of client preparation, via vicarious therapy pretraining (VTP) and role induction interviews (RII), on the pre-therapy client manifestations of positive therapeutic expectations, motivation to change and manifest anxiety. Beyond this, attention will be given to the effects of VTP/RII on subjective outcome criteria as reported by both clients and therapist, as well as to objective outcome criteria. In order to examine these issues, nine hypotheses have been formulated; each addresses itself to a specific aspect of the research and the composite, to the general question of the impact of VTP/RII on the clients and the outcome of group psychotherapy. Specifically, these hypotheses are as follows:

1) Those clients exposed to vicarious therapy pretraining (VTP) and a role induction interview (RII) will exhibit a significantly lower level of manifest anxiety than those not so exposed and pre- and post-test measures will show a significant within group reduction of manifest anxiety when exposed to VTP/RII.

2) Those clients exposed to VTP/RII will exhibit a significantly higher

level of positive therapeutic expectations than those not so exposed, and will show a significant within group increase when exposed to VTP/RII.

3) Those clients exposed to VTP/RII will exhibit a significantly higher motivation to change than those not so exposed, and will show a significant within group increase in motivation to change when exposed to VTP/RII.

4) Those clients exposed to VTP/RII will be rated significantly higher on a subjective scale of therapeutic improvement than will clients not so exposed.

5) Those clients exposed to VTP/RII will rate the experience as significantly more helpful than will those clients not exposed to VTP/RII.

6) Those clients receiving VTP/RII will score significantly higher on objective measures of therapeutic improvement, than will clients not receiving VTP/RII.

7) Client manifest anxiety, as measured by the Taylor (1953) Manifest Anxiety Scale, will be negatively correlated with objective and subjective outcome measures.

8) Client pre-therapy motivation as measured by the Miskimins (1967) Self-Goal-Other Discrepancy Scale will be positively correlated with objective and subjective outcome measures.

9) Client positive therapeutic expectations, as measured on the Fischer-Turner (1970) Attitudes Toward Seeking Professional Psychological Help Scale, will be positively correlated with objective and subjective outcome measures.

CHAPTER III

DESIGN AND METHODOLOGY

Subjects(N=21) for the study were randomly selected from the applications for treatment at the Ingham Medical Center Community Mental Health Center during the month of October, 1973. Each applicant was given a number from the table of random numbers, an identification which would eventually determine the treatment condition that the client would be assigned to. Those applicants who had previous experience in psychotherapy were excluded from the study, as were applicants with a primary diagnosis or presenting problem of alcohol or drug dependency. The first category was eliminated in an attempt to maximize the validity of the study and the latter category because the therapy techniques to be employed (Lawrence and Sundel, 1971) tend not to be particularly effective with addictive client groups. After excluding these groups (17 S's) and those who declined to participate in the research (2 S's) the initial sample of forty subjects was reduced to the final total of twenty one.

The sample consisted of fourteen women and seven men, a sex ratio which is representative of the clientele served at the clinic. The mean age of the sample was 28 years, the average yearly income $9,111 and mean number of years of education 13.1.

Eight of the subjects were married, six were divorced, four separated and three had never been married. Five of the subjects reported their primary problem as a marrital one, five as self concept or feelings of inadequacy, four as depression and three reported parent and child problems. Although no accurate data has been gathered on the distribution of client problems for the entire clinic, the distribution reported above appears representative of the range of problems dealt with in the outpatient unit and is congruent with Overall and Aronson's (1963) estimates of problem distributions in outpatient populations seen in community treatment agencies.

After selection, the subjects were randomly assigned to one of three treatment conditions. Group A received the pre- and post-test battery and the outcome battery; the video-tape VTP and a modified version of Orne's (1968) role induction interview (RII). Group B received the pre- and post-test battery and the outcome battery without receiving VTP/RII and group C received VTP/RII without the pre-test battery, although they did receive the post-test and outcome batteries.

Each group was assigned to the same therapist, who used the techniques of group behavior modification described by Lawrence and Sundel (1971) with all of the groups. Each session was audio-recorded and reviewed by the researcher to ascertain the uniformity with which the techniques were applied. This review disclosed no significant differences in the way each group was run or in the content of the sessions, although there were discernable differences in the amount of participant interaction and in the manner in which

participants interacted with each other and with the therapist. Although no formal analysis was done of the process of the groups, the review of the tapes suggested that the groups receiving VTP/RII interacted more freely, and began implementing the system sooner (mean =2.3 sessions) than did the group that did not receive VTP/RII (mean =3.4 sessions).

The review of the tapes also disclosed that although the design had called for maintaining the therapist's naiveté regarding which groups had received VTP/RII, by the third session both experimental groups had mentioned the utility of the procedure and as a consequence the possibility of conducting a blind study was eliminated.

By utilizing the same therapist and the same therapy techniques for all groups the design has effectively controlled for therapist differences and for the differential impact of theoretical and technical differences, an approach which seemed the most parsimonious solution to some of the research problems discussed in Chapter I.

Video-Tape Pretraining and Role Induction Interviewing

At an initial interview each subject was seen individually and instructed that they had the option of participating in group psychotherapy or of being seen in individual psychotherapy. If they initially chose to be seen in individual therapy as opposed to group, customary intake information was gathered, they were given an appointment with a staff therapist and the initial session was closed.

If they chose to participate in group therapy it was explained that they would be participating in a research project, that all material collected would be kept strictly confidential and that their identity would be disguised in the preparation and presentation of the research findings. Further, the baselining procedure to be used in the group was explained and they were instructed that the group would be meeting for six sessions, that its primary emphasis would be on modifying problematic behaviors and that it would be extremely important for them to attend all of the group sessions. If they were assigned to the control group they were advised of the time and date of the first group session, reminded of the importance of the baselining procedure and given a set of the pre-test instruments and instructed to fill them out completely and return them to the secretary before leaving the clinic. If they were to be assigned to the experimental groups they were told that an important part of the group was to participate in one additional individual session in which they would view a video-tape of a group in progress and would be told more about how the group worked and what they might expect. The subjects were then given an appointment for the VTP/RII session and depending on whether they were in experimental group B or C were given the pre-test instruments and instructed to fill them out and return them to the secretary as they left the clinic.

The VTP/RII sessions consisted of a half hour video-tape of a role played group session. It was led by a therapist who had a considerable amount of skill and experience using the technique of behavior modification in groups and the "clients" were volunteers

from a local crisis center who had expertise in role playing. The entire tape was adlibbed from a general direction script, written by the researcher (Appendix C), so as to give it the necessary focus and direction and at the same time contribute the quality of spontaneity. The script called for role playing the final phases of a teaching component (a common element of all six sessions), a brief question period, review of the baseline material from the previous week, and focusing on one "client's" report and evaluation of the changes elicited during the previous week. Other "members" were instructed to provide feedback and suggestions in accord with the handout "guidelines to giving and receiving feedback, criticisms and positive evaluations" an integral part of the programs structure. The "client" presenting the report was asked to make it generally positive and to respond as genuinely as possible to the feedback from the therapist and other group members; following this a behavioral assignment was negotiated for the next week and the video-tape faded out, suggesting that the process would be repeated for each of the remaining group members.

Viewing the tape was followed by a short question period, and then a modified version of Orne's (1968) role induction interview (RII) which suggested the appropriate client role in a group of this nature, and further suggested the efficacy of this approach to problem solving and that research (Lawrence & Sundel, 1971) had disclosed that when clients participated appropriately (as in the VTP) that they benefitted much more from the group and therapy. The

client was then asked if he had any further questions or comments and, if not, was advised of the time of the first group session, reminded of the importance of baselining the problem behavior and excused.

All treatment conditions (A,B,&C) were given the post-VTP battery just prior to the first session, in most cases this was two weeks from the date that they had taken the pre-VTP battery, although in some cases it was almost a month. The difficulties inherent in clinical research and selecting subjects are responsible for this time delay; however, all those who were initially assigned to groups appeared at least for the first two therapy sessions and consequently no subjects were lost from the study during this period. Furthermore, the time between pre- and post-testing, ranging from two to four weeks appears to have been sufficient, in terms of test repetition validity, without having been so long as to lose subjects due to frustration or lack of interest.

Instrumentation

For both the pre-VTP and post-VTP test batteries a series of three instruments were used to determine fluctuations in the client levels of anxiety, motivation and positive expectation. All instruments were chosen because they combined the qualities of relative brevity necessary in clinical research, where clients react negatively to what seems to them an inordinate amount of pointless testing (Gallagher, 1971), and have demonstrated research validity. The updated version of the short form Taylor Manifest Anxiety Scale (Taylor, 1953) was used as an indicator of client anxiety in both the pre- and post-test

conditions in all groups. Likewise, the Miskimins Self-Goal-Other Discrepancy Scale (Miskimins, 1967) and the Fischer-Turner Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970) were used for the measurement of motivation and positive therapeutic expectations respectively.

Internal reliability of the Fischer-Turner (1970) instrument has been established at .86 and test-retest reliability at .89 and .82 for two and four week intervals respectively (Fischer & Turner, 1970). Likewise the internal consistency of the Miskimins' (1967) instrument has been established as significant at the .001 level and test-retest reliability as also significant at .001 for all factors (Miskimins, 1967). The broad usage of the Taylor (1953) instrument has yielded internal reliability figures ranging from .83 to .97 and test-retest reliability ranges from .91 to .99 (Distler et al., 1964) so it is not possible to give exact readings on reliability, however, the significance of all readings in the given ranges appear to be more than adequate to establish its utility for the present research.

Outcome measures were secured via the Collins-Curran Scale of Rational Attitudes (Appendix A) and a series of behaviorally oriented measures used by Lawrence and Sundel in their research on group behavior modification (Lawrence & Sundel, 1971) and by a Likert scaling of therapist progress evaluation. Outcome measures were administered to all treatment conditions following the close of the sixth and final session. Their selection was based on a combination of the factors discussed in Chapter I, their suitability as measures for the particular treatment modality used and their relative

brevity, for the reasons discussed above. By combining attitudinal, behavioral and subjective evaluations it was hoped that analysis might disclose potential differences in terms of impact; differences which, if present, would shed light on the usefulness as well as the specific implications of the techniques used.

Treatment Conditions

Each group utilized the same therapist and the same treatment method and modalities, the only differences being presence or absence of VTP/RII. The therapist was an experienced clinician with ten years of previous experience, who describes her primary treatment orientation as behavior modification and her preferred method of working as social group work; consequently, she was an ideal selection to lead the groups and to provide the best available model for the implementation of this particular therapy technique.

The model for behavior modification in groups (Lawrence & Sundel, 1971) used in the research, called for six therapy sessions each covering a selected area of problematic behavior, a cognitive component relevant to the amelioration or solution of the problem and the development of a behavioral assignment to be implemented and evaluated in the following week. Chronologically the sessions covered: 1) Problem specification, a topic relating primarily to the importance of clearly understanding the nature, boundaries and behavioral indices of the perceived problem. Participants were encouraged to select <u>one</u> problematic behavior on which to work and were cautioned that "grandiose" problems, such as "finding a meaning in life" tend to be life-long concerns

and to expect an answer to a problem such as this, in six weeks, is not realistic. 2) Reinforcement; the nature and impact of reinforcement, in both its positive and negative forms was explored. Consideration was given to the amount of "unthinking" reinforcement one uses and it was suggested that interpersonal problems frequently stem from the fact that one is reinforcing or being reinforced for a particular behavior without realizing it. It was suggested that close attention to reinforcement often leads to such a discovery and consequently to the solution of the problem. 3) Extinction; the relationship of extinction to the nature and change of human behavior was explained and the utility of extinction was related to the content of the previous week's session. Discussion was directed to how one might use the concept of extinction, in conjunction with reinforcement, to modify one's own or another's problematic behavior. It was pointed out that this is not artifical manipulation of one's self or of another, but rather, negotiation to achieve change that would result in more satisfactory behavior. 4) Trying out new behaviors; it was suggested that, given the extinction of a problematic behavior, another behavior will inevitably take its place, and since human beings tend to behave in relatively set patterns, trying out new behaviors will be necessary to avoid adopting a behavior that may prove to be as troublesome as the old problematic behavior. This was followed by a discussion of the "mythical" fears that tend to act as reinforcers to perpetuate problem behavior and the observation was made that when one actively confronts these "mythical fears" that one tends to be much more in control of one's life and as a consequence to feel freer to

change other behaviors. 5) Antecedent-Behavior-Consequence; the observation was made that all human behavior takes place in an A-B-C progressional system and that by isolating the relationship of antecedants to behavior and observing the consequences, one can effectively determine if modifying a particular behavior is desirable and if so, how the modification may be brought to fruition. Discussion was directed to how this might be useful in interpersonal, parent/child, work and school relationships. 6) Making requests--giving and receiving positive feedback; the final session was devoted to an exploration of participants' reactions to giving and receiving positive feedback and to the analysis of the ways in which they typically made requests. Almost uniformly clients found that it was difficult for them to accept positive feedback and that when they gave negative feedback it was usually done in anger. Conversely, negative feedback was frequently received angrily and positive feedback given grudgingly or in a manipulative manner. Discussion centered on alternative methods of expression, in light of previous sessions and possible change strategies, should change be deemed appropriate. The remainder of the final session was devoted to the evaluation of progress toward modifying the specific behavior identified in the first session and to administering the outcome test battery.

Each session typically called for a thirty minute cognitive presentation on the appropriate area, followed by a short question period and then the "working" period which lasted approximately two hours. Each client volunteered to report on the behavioral assignment from the previous week and to "work" on applying what had

been learned this week to enhance what progress had already been made. Following this, each client negotiated a behavioral assignment for the next week, a process involving both the therapist and the other group members. This process was repeated until all participants had an opportunity to "work" and to formulate a new or expanded behavioral assignment.

This particular treatment format was selected because; 1) its utility and efficacy has been demonstrated (Lawrence & Sundel, 1971); 2) experienced and expert therapists were readily available; 3) it appeared that modifications of clients' levels of anxiety, motivation, and positive expectation would be particularly impactful in this format; 4) the format is congruent with the researcher's treatment bias and consequently questions of ethics, therapist and/or experimenter bias and replicability were not an issue.

Although clinical research is at best a difficult undertaking, as discussed in Chapter II, it was given priority in the present research because of its greater potential for impact on clinical practice and because of the paucity of literature that is directly relevant to the practitioner. The present research incorporates a design which, while falling short of the ideals presented by Strupp & Bergin (1969), represents the best available compromise between the realities of clinical research and the goals of "straight" empirical research. Highly sophisticated statistical analysis is not employed because the "state of the art" does not allow sufficient specification of operational definition of variables (Bordin, 1965). The theoretical

basis for multivariate or factorial analysis of clinical practice being as yet undiscovered, or at least unpublished, it was felt that the best possible compromise could be reached by tightly controlling variables such as therapist personality, technique, theoretical orientation and relying on a relatively simple design (Arbuckle, 1967) so as to make analysis as straightforward, and consequently, as uncontaminated, as possible.

CHAPTER IV

RESULTS

The results are organized into four sections. The first reports the results of the analysis of variance which examines the impact of VTP/RII on the client's anxiety, motivation and positive therapeutic expectations. The second section is devoted to the analysis of variance which examines subjective evaluation of therapeutic impact as it is affected by the presence or absence of VTP/RII; results are reported both for client evaluation and therapist evaluation. The third section reports the results of the analysis of variance which examines the affect of VTP/RII on objective measures of therapeutic outcome and the final section is devoted to correlational data relating to anxiety, motivation and expectation levels and objective measures of outcome.

Analysis of Variance for Effects of Vicarious Therapy Pre-Training/ Role Induction Interviews

Tables 1 through 9 summarize the results of the analysis of variance utilized to examine the impact of VTP/RII on the levels of client manifest anxiety, motivation to change and positive therapeutic expectations, respectively. Table 1 summarizes the results of the analysis of variance evaluating the impact of VTP/RII on the manifest anxiety exhibited by clients before and after exposure to VTP/RII

and indicates that there are significant differences between groups following this exposure. Table 2 summarizes the analysis of variance relating to the within group impact of VTP/RII and indicates that, although, the results were not significant, they were in the predicted direction.

Table 1

Analysis of Variance of Manifest Anxiety as Affected by VTP/RII

Referent in Time Pre- or Post-Test Analysis	Comparison Groups	Groups Receiving VTP/RII	Groups Receiving Pre-Test	df	F
Pre-Test	A and B	A yes B no	A yes B yes	1,12	0.0127
Post-Test	A and B	A yes B no	A yes B yes	1,12	8.5392*
Post-Test	A and C	A yes C yes	A yes C no	1,12	0.0028
Post-Test	B and C	B no C yes	B yes C no	1,12	7.1710*

*<.05

Table 2

Analysis of Variance of Manifest Anxiety as Affected by VTP/RII on Pre- & Post-Test Measures

Group	Comparison	df	F
A	Pre- & Post-Test	1,12	3.2048
B	Pre- & Post-Test	1,12	0.9433

* < .05

As predicted from hypothesis 1 the results indicate that the presence of VTP/RII produces a significant differentiation between these groups and those not receiving VTP/RII. Further analysis, presented in Table 2, indicates that this anxiety reduction is also present within groups subjected to pre- and post-testing, although in this case the results were not significant.

Table 3 represents the results of analysis of variance for fluctuations of client positive expectations of therapeutic outcome and Table 4 the within group fluctuations of groups exposed differentially to VTP/RII or not so exposed.

Again the results indicate a significant impact on client positive expectations, which tends to substantiate hypothesis 2 which suggested that VTP/RII would significantly increase client positive expectations of therapeutic outcome.

Table 3

Analysis of Variance of Positive Therapeutic Expectations as Affected by VTP/RII

Referent in Time Pre- or Post-Test Analysis	Comparison Groups	Groups Receiving VTP/RII	Groups Receiving Pre-Test	df	F
Pre-Test	A and B	A yes B no	A yes B yes	1,12	0.0623
Post-Test	A and B	A yes B no	A yes B yes	1,12	10.1866**
Post-Test	A and C	A yes C yes	A yes C no	1,12	2.3023
Post-Test	B and C	B no C yes	B yes C no	1,12	8.1724*

* < .05
** < .01

Table 4

Analysis of Variance of Positive Therapeutic Expectations as Affected by VTP/RII on Pre-Post-Test Measures

Group	Comparison	df	F
A	Pre- & Post-Test	1,12	9.4986**
B	Pre- & Post-Test	1,12	1.7015

** < .01

Likewise the results represented in Tables 5 through 8 provide substantive validation for hypothesis 3 which suggested that exposure to VTP/RII would have the tendency to significantly increase clients' motivation to change.

Table 5

Analysis of Variance for Motivation to Change (Part I) as Affected by VTP/RII

Referent in Time Pre- or Post-Test Analysis	Comparison Groups	Groups Receiving VTP/RII	Groups Receiving Pre-Test	df	F
Pre-Test	A and B	A yes B no	A yes B yes	1,12	1.1931
Post-Test	A and B	A yes B no	A yes B yes	1,12	10.6353**
Post-Test	A and C	A yes C yes	A yes C no	1,12	0.4569
Post-Test	B and C	B no C yes	B yes C no	1,12	8.5188*

* < .025
** < .01

Table 6

Analysis of Variance of Motivation to Change as Affected by VTP/RII of Pre- and Post-Test Measures

Group	Comparison	df	F
A	Pre- & Post-Test	1,12	6.6507**
B	Pre- & Post-Test	1,12	2.7647

* < .05
** < .025

Table 7

Analysis of Variance of Motivation to Change (Part II) as Affected by VTP/RII

Referent in Time Pre- or Post-Test Analysis	Comparison Groups	Groups Receiving VTP/RII	Groups Receiving Pre-Test	df	F
Pre-Test	A and B	A yes B no	A yes B yes	1,12	0.0236
Post-Test	A and B	A yes B no	A yes B yes	1,12	7.2202**
Post-Test	A and C	A yes C yes	A yes C no	1,12	0.0032
Post-Test	B and C	B no C yes	B yes C no	1,12	8.3863**

* <.05
** <.025

Table 8

Analysis of Variance of Motivation to Change as Affected by VTP/RII

Group	Comparison	df	F
A	Pre- & Post-Test	1,12	7.8070**
B	Pre- & Post-Test	1,12	1.3690

* <.05
** <.025

Analysis of Variance for Subjective Therapist Ratings of Improvement as Affected by Vicarious Therapy Pre-Training/ Role Induction Interviews

Table 9 summarizes the results of analysis of variance for subjective therapist ratings of improvement. The results confirm, for most factors, that clients exposed to VTP/RII were rated significantly higher, on a subjective scale of client functioning at the termination of the group, than were clients not exposed to VTP/RII. These findings are largely, though not wholly, consistent with the prediction of hypothesis 4.

Table 9

Analysis of Variance of Subjective Therapist Rating of Improvement As Affected by VTP/RII

Area of Functioning	Comparison Groups	Groups Receiving VTP/RII	df	F
Social Functioning	A and B	A yes B no	1,5	6.0586*
Social Functioning	B and C	B no C yes	1,5	4.1202
Social Functioning	A and C	A yes C yes	1,8	0.9414
Family Functioning	A and B	A yes B no	1,5	9.8247**
Family Functioning	B and C	B no C yes	1,5	7.0791**
Family Functioning	A and C	A yes C yes	1,8	0.1594
Primary Relationships	A and B	A yes B no	1,5	3.7240
Primary Relationships	B and C	B no C yes	1,5	4.4731*
Primary Relationships	A and C	A yes C yes	1,8	0.4677
Primary Goal Attainment	A and B	A yes B no	1,5	7.8358**
Primary Goal Attainment	B and C	B no C yes	1,5	8.4375**
Primary Goal Attainment	A and C	A yes C yes	1,8	1.2936
Vocational Functioning	A and B	A yes B no	1,5	6.0586*

Table 9 Continued

Area of Functioning	Comparison Groups	Groups Receiving VTP/RII	df	F
Vocational Functioning	B and C	B no C yes	1,5	7.8536**
Vocational Functioning	A and C	A yes C yes	1,8	0.5366

* < .10
** < .05

Tables 10 and 11 summarize the results of analysis of variance for subjective client evaluation of goal achievement and of improved functioning in interpersonal relationships. The results confirm that there are significant differences between the VTP/RII and non-VTP/RII groups, in most categories, with respect both to their perceived attainment of therapy goals and their improved functioning in interpersonal situations. Again, the results are consistent with the trends predicted by hypothesis 5.

Analysis of Variance for Objective Outcome Measures as Affected by VTP/RII

Table 12 summarizes the results of analysis of variance for the objective outcome measures as affected by VTP/RII. As predicted by hypothesis 6, those groups receiving VTP/RII scored significantly higher on the Collins-Curran Scale. The outcome measures on the Lawrence scales (parts 1-3) were not significant, but did demonstrate a trend in the predicted direction. The failure to meet the criteria of significance with the Lawrence scales will be explored in more depth in Chapter 5.

Table 10

Analysis of Variance of Subjective Client Evaluation of Improvement as Affected by VTP/RII

Area of Evaluation	Comparison Groups	Groups Receiving VTP/RII	df	F
Primary Goal Attainment	A and B	A yes B no	1,5	8.9146**
Primary Goal Attainment	B and C	B no C yes	1,5	6.0900*
Primary Goal Attainment	A and C	A yes C yes	1,8	0.0440
Secondary Goal Attainment	A and B	A yes B no	1,5	7.3499**
Secondary Goal Attainment	B and C	B no C yes	1,5	5.9393*
Secondary Goal Attainment	A and C	A yes C yes	1,8	1.0682
Tertiary Goal Attainment	A and B	A yes B no	1,5	3.4033
Tertiary Goal Attainment	B and C	B no C yes	1,5	12.0000**
Tertiary Goal Attainment	A and C	A yes C yes	1,8	0.1794

* < .10
** < .05

Table 11

Analysis of Variance of Number of Areas of Interpersonal Relationship Improvement as Subjectively Evaluated by Clients and Affected by VTP/RII

Comparison Groups	Groups Receiving VTP/RII	df	F
A and B	A yes B no	1,5	8.6072**
B and C	B no C yes	1,5	7.5263**
A and C	A yes C yes	1,8	0.5677

* < .10
** < .05

Table 12

Analysis of Variance of Objective Outcome Measures as Affected by VTP/RII

Instrument	Comparison Groups	Groups Receiving VTP/RII	df	F
Collins-Curran Scale	A and B	A yes B no	1,5	5.7228*
Collins-Curran Scale	B and C	B no C yes	1,5	7.8800**

Table 12 Continued

Instrument	Comparison Groups	Groups Receiving VTP/RII	df	F
Collins-Curran Scale	A and C	A yes C yes	1,8	0.0671
Lawrence Scales Part 1	A and B	A yes B no	1,5	0.9772
Lawrence Scales Part 1	B and C	B no C yes	1,5	1.0909
Lawrence Scales Part 1	A and C	A yes C yes	1,8	0.3571
Lawrence Scales Part 2	A and B	A yes B no	1,5	0.4794
Lawrence Scales Part 2	B and C	B no C yes	1,5	0.2264
Lawrence Scales Part 2	A and C	A yes C yes	1,8	0.0033
Lawrence Scales Part 3	A and B	A yes B no	1,5	1.6326
Lawrence Scales Part 3	B and C	B no C yes	1,5	0.4444
Lawrence Scales Part 3	A and C	A yes C yes	1,8	0.2413

* < .10
** < .05

Correlational Data Evaluating The Relationship of Post-Test Measures to Outcome Measures

Tables 13 and 14 summarize the results of correlations for post-test data and outcome data. The results confirm that manifest anxiety is negatively related to outcome and that positive therapeutic expectations and motivation to change are positively related to therapeutic outcome, as predicted by hypotheses 7 through 9.

Table 13

Correlational Data Evaluating the Relationship of Post-Test Data to Outcome Data

Post-test Instrument	Outcome Instrument	Post-test/Outcome Correlation
Taylor	Collins-Curran	-0.4536
Taylor	Lawrence Part 1	-0.4464
Taylor	Lawrence Part 2	-0.4856
Taylor	Lawrence Part 3	-0.1786
Fischer-Turner	Collins-Curran	0.7207**
Fischer-Turner	Lawrence Part 1	0.6619**
Fischer-Turner	Lawrence Part 2	0.6120*
Fischer-Turner	Lawrence Part 3	0.0261
Miskimins Part 1	Collins-Curran	0.5311*
Miskimins Part 1	Lawrence Part 1	0.3992

Table 13 Continued

Post-test Instrument	Outcome Instrument	Post-test/Outcome Correlation
Miskimins Part 1	Lawrence Part 2	0.5767*
Miskimins Part 1	Lawrence Part 3	0.3511
Miskimins Part 2	Collins-Curran	0.3758
Miskimins Part 2	Lawrence Part 1	0.4045
Miskimins Part 2	Lawrence Part 2	0.5182*
Miskimins Part 2	Lawrence Part 3	0.1825

* <.05
** <.01

Table 14

Correlational Data Evaluating the Relationship of Post-Test Data to Subjective Outcome Data

Post-test Instrument	Scale on Outcome Measure	Post-test/ Outcome Correlation
Taylor	Social Functioning	-0.7386**
Taylor	Family Functioning	-0.6765**
Taylor	Primary Relationship	-0.6640**
Taylor	Primary Goal Attainment	-0.7586**
Taylor	Vocational Functioning	-0.4239
Fischer-Turner	Social Functioning	0.4621

Table 14 Continued

Post-test Instrument	Scale on Outcome Measure	Post-test/ Outcome Correlation
Fischer-Turner	Family Functioning	0.3272
Fischer-Turner	Primary Relationship	0.4392
Fischer-Turner	Primary Goal Attainment	0.6902**
Fischer-Turner	Vocational Functioning	0.3016
Miskimins Part 1	Social Functioning	0.8950**
Miskimins Part 1	Family Functioning	0.7621**
Miskimins Part 1	Primary Relationship	0.8620**
Miskimins Part 1	Primary Goal Attainment	0.6202*
Miskimins Part 1	Vocational Functioning	0.1632
Miskimins Part 2	Social Functioning	0.7496**
Miskimins Part 2	Family Functioning	0.4899*
Miskimins Part 2	Primary Relationship	0.6283*
Miskimins Part 2	Primary Goal Attainment	0.6566**
Miskimins Part 2	Vocational Functioning	0.1632

* < .05
** < .01

CHAPTER 5

DISCUSSION

The results for the most part support the hypotheses presented in Chapter 3. Analysis indicates that VTP/RII is an affective agent for reducing manifest anxiety and increasing motivation to change and positive therapeutic expectations. The results also indicate that VTP/RII significantly increases the positive impact of psychotherapy as measured both by objective and subjective instruments. Furthermore, the results disclosed the predicted positive correlation between positive indicators of motivation and expectation and positively evaluated therapeutic outcome. Beyond this, the same holds true for manifest anxiety although in the opposite direction; manifest anxiety being negatively correlated with outcome.

The Impact of VTP/RII on Manifest Anxiety Motivation to Change and Positive Expectations

The results strongly support hypothesis 1, clearly indicating that groups exposed to VTP/RII exhibit significantly lower levels of manifest anxiety than do groups not exposed to VTP/RII. As reviewed in Chapter 2, the research literature (Bergin & Jasper, 1969; Distler, 1964; Gallagher, 1954; Gottschalk, 1967; Katz, 1958; Kirtner & Cartwright, 1958; Hamburg et al., 1967; Luborsky, 1963) is abundant with studies

demonstrating the impact of pre-therapy and during therapy manifest anxiety on eventual therapeutic outcome; in addition, a number of studies demonstrate the predictive validity of pre-therapy manifest anxiety. However, to this date, the literature has not given much attention to the viability of modifying the client exhibited levels of anxiety or to determining what impact such modification might have on the eventual outcome of psychotherapy. The present research demonstrates that manifest anxiety is amenable to modification, and beyond this, that such modification can be achieved with relatively little difficulty by utilizing VTP/RII methods. The implications of this research are quite clear, it suggests that utilization of VTP/RII in the contemporary clinic can provide a feasible and effective response to such common frustrations as pre-mature client terminations, policy directives to serve the greatest number of people in the least amount of time, and ethical directives to provide the highest quality of service available. The research suggests that implementation of VTP/RII programs, modified to fit the theoretical and technical orientations of a variety of therapists, can increase the efficacy of therapy, facilitate its process, and significantly increase the probability of positive therapeutic outcome by making the process easier for the client to conceptualize, while at the same time decreasing the probability that he will become a victim of premature termination.

Similarly the present research supports hypothesis 2, indicating a significant increase in the level of positive therapeutic

expectations. Salesmen and others engaged in daily interpersonal exchanges have long known that a person tends to respond affirmatively only if he holds not only positive attitudes toward them, but also expects their product to perform as well as they suggest it will. Management research (Cole, 1973) indicates that brand loyalty and repeat buying is more significantly affected by the congruency of the consumers' expectations and perceived product performance than it is by actual quantifiable performance of the product. Likewise, the psychotherapy research literature (Brady et al., 1970; Conrad, 1960; Goldstein & Shipman, 1961; Lipkin, 1954) recognizes the impact of positive therapeutic expectations and Frank (1969) suggests that it is perhaps, the most reliable predictor of therapeutic success currently available. The present research addresses itself to the paucity of information available on techniques for modifying the expectations of psychotherapy held by the client. The significance of the results and the relative ease with which VTP/RII is administered suggest that it is a technique, which if applied to clinical practice generally, could have the effect of not only increasing the efficiency of clinical practice but also increasing client satisfaction with the system. Such increases would be reflected in more efficient delivery of services, shorter waiting periods between initial contact with the clinic and provision of services, and shorter periods of treatment for most clients, consequently, allowing understaffed clinics to serve more people, more efficiently and with a higher degree of client satisfaction.

The results also indicate a significant increase in client motivation to change as a result of exposure to VTP/RII. Again the research literature (Cartwright & Lerner, 1963; Conrad, 1962; Schoeder, 1960; Siegal & Fink, 1962; Strupp et al., 1963) has suggested that motivation to change is an intrinsic ingredient in successful psychotherapy and although it has not addressed itself directly to the issue of increasing motivation, there is an implicit suggestion that doing so would improve the prognosis for any given client. In as much as the results have clearly shown that exposure to VTP/RII increases motivation to change, it is suggested that its utilization may result in further streamlining of the therapeutic process and at the same time increase the probability of successful achievement of therapeutic goals.

The discussion, thus far, has illustrated the positive therapeutic impact of VTP/RII and has suggested that its implementation in the therapeutic community would result in increased efficiency, impact, client satisfactions and probability of successful outcome. Further, it has been seen that VTP/RII, as predicted, significantly reduces client pre-therapy manifest anxiety, while increasing both positive therapeutic expectations and client motivation to change. What remains to be discussed is the empirical impact of VTP/RII on subjective and objective measures of therapeutic improvement.

The Affects of VTP/RII on Subjective Evaluations of Therapeutic Improvement

As predicted by hypothesis 3, those subjects receiving VTP/RII were rated significantly higher, on subjective therapist

evaluation scales, than were those subjects not exposed to VTP/RII. These findings are consistent with the research discussed in the previous section, which suggested that client pre-therapy motivation to change, positive therapeutic expectations and manifest anxiety, all comprise effective predictors of therapeutic success. Coupled with the fact that the results demonstrate the relative ease with which these variables can be modified, it becomes possible to conclude that VTP/RII is an effective and parsimonious method for increasing the liklihood of positive therapeutic outcome, at least as subjectively evaluated by the therapist.

The same situation holds true for client subjective reports of therapeutic success, the results indicating that clients who were exposed to VTP/RII reported significantly greater success in achieving the primary, secondary and tertiary behavioral goals which they had set for themselves at the onset of therapy. Contrary to predictions by Paul (1966), client and therapist evaluations in this case are not in conflict, probably, at least in part, due to the fact that clients and therapists were rating the same things and that each has an adequate understanding of the criteria of improvement. The primary source of conflict between therapist and client evaluations, as discussed by Paul (1966) was found to be the lack of clarity regarding what was being rated. Obviously, if the client and the therapist are not rating the same thing, or if they entered therapy with differing expectations or goals, their ratings of success will inevitable be disparate. On the other hand, as the results of the

present research suggest, such disparities are not the inevitable product of client/therapist ratings, but apparently are due more to miscommunication and misunderstandings relating to the criteria of improvement utilized in the ratings.

Additional subjective results indicate that when clients evaluated the number of interpersonal relationship areas in which they felt they had improved, those clients receiving VTP/RII domonstrated a significantly greater number and magnitude of areas of improvement. The consistency of the results is somewhat surprising given the cautions of Chapter 1 relating to the use of subjective evaluation instruments, but does speak quite highly of the techniques (both therapy and evaluation) used in the present research. Perhaps it is the relative concreteness of the behavior modification format, as opposed to other modalities of therapy that is, at least in part, responsible for this consistency, or perhaps it is the instrumentation that was used. Whichever, it is heartening to note the consistency of the results and possible to suggest that it is not the unreliability of subjective measurement that is responsible for the problems observed in Chapter 1, but rather that is may be the lack of specificity, both with regard to therapeutic techniques and evaluative instruments.

The Affects of VTP/RII on Objective Measures of Therapeutic Outcome

The results of the analysis of variance for objective outcome measures indicate that VTP/RII impact is strongest on the Collins-Curran scale and that although the results are in the

predicted direction on the three Lawrence scales, they fall short of significance. In part the failure of the Lawrence scales to produce significant discriminations may be due to the relative brevity of the scales and the fact that the extreme high score of four and the extreme low score of zero, leaves very little room for meaningful discriminations. The lack of discriminatory ability on these scales is consistent with much of the experience of Lawrence (1974), who reports that in studies using much larger samples and employing the same therapy techniques, but without VTP/RII, the scales used in the present research also failed to discriminate between high and low outcome groups. Lawrence has dealt with this problem by designing different scales, which discriminate much more clearly. However, since it is impossible to re-examine the subjects of the present research, it is possible only to observe that VTP/RII had significant effect on the reduction of anxiety and increase of positive therapeutic expectation and motivation to change and infer from the studies cited in Chapters 1 & 2 and from the objective data gathered on the Collins-Curran scale that VTP/RII has a positive impact on outcome, although further research is obviously required to make empirically strong claims for the magnitude of its power. The specificity of the design and as a consequence, the ease with which it may be replicated, however, makes such replication and expansion relatively simple. As is the case with all original research in an area that is as yet underdeveloped, further study and replication was taken as a given, and in fact, the present research was designed with replication in mind.

Correlational Data Evaluating the Relationship of Post-Test Measures to Outcome

Fortunately, although the analysis of variance for objective outcome measures did not yield the desired level of significance, this is somewhat compensated for by the correlational data reviewed in Tables 13 and 14 of Chapter 4. The results clearly indicate that, as predicted from hypothesis 7 manifest anxiety is negatively correlated, both to subjective and objective outcome criteria. Again, particularly high correlations are found on the Collins-Curran scale and on the therapist evaluation scale, although the Lawrence scales, with the exception of Lawrence part 3, display correlations at a level similar to that found with the other instruments.

Likewise, and as predicted from hypotheses 8 and 9, the data disclose significant positive correlations for motivation to change and positive therapeutic expectations on both objective and subjective outcome criteria. Interestingly, correlations for vocational functioning are significantly lower than for the other areas of functioning suggesting, for the population studied at least, that functioning in the work or school areas is less responsive to the effects of psychotherapy or perhaps that this area is less reflective of changes in interpersonal functioning.

For all other areas and measures, however, the correlations are high enough to allow the observation that modification of manifest anxiety, positive therapeutic expectations and motivation to change

constitute a viable method for improving the efficacy of behavior modification in groups.

General Discussion of Results

While falling short of the desired levels of significance in some areas, the present research does provide substantive evidence of the positive impact engendered by the utilization of VTP/RII. The results have conclusively shown that VTP/RII is a viable method for modifying the levels of three important variables that have been uniformly identified in the psychotherapy literature as reliable predictors of therapeutic outcome. Likewise it has been shown that the administration of VTP/RII can be effective in improving the subjective evaluations of both therapists and clients. In as much as Katz (1958) has suggested that the premature therapy dropout rate of 30-65%, reported nationwide, is primarily reflective of the fact that clients frequently don't understand the process of therapy, or what is expected of them, it is clear that VTP/RII may be effectively employed to reduce this premature termination rate. Moreover, as VTP/RII has been shown to be an effective catalytic agent in the process of therapy, it is suggested that implementation of this, or similar programs, in the existing community mental health programs can effectively streamline their operation by shortening the length of the "initiatory period" during which the client and therapist are struggling to define the therapy relationship and by clearly and concisely communicating to clients what they may realistically expect from therapy and what may realistically be expected of them.

The trends in mental health are clearly toward shorter term, brief and crisis oriented therapy. This being the case, it is incumbant upon the professional (Mann, 1973) to successfully bridge the ethical gap between providing the highest quality of services and providing them in the briefest possible period of time. In keeping with this objective, the VTP/RII program has been developed to minimize the time required to begin the "work" of therapy, while at the same time not jeopardizing the therapeutic factors involved in the development of the therapy relationship. The results of the present research clearly indicate that, while some methodological and/or measurement modifications are in order, VTP/RII represents a parsimonious approach to, and an efficacious solution of, the problem of decreasing client manifest anxiety, maximizing positive expectations and motivation within the confines of the clinical setting, while at the same time increasing goal attainment and client satisfaction.

Implications for Further Research

It has been observed, throughout much of the discussion of results, that as with most pieces of original research, the present research has certain instrumentation problems that need to be ironed out before strong empirical statements may be made as to its viability as a method of strengthening objective outcome criteria. While the criticisms of therapist differences, unspecified therapy techniques and uncertain designs leveled against earlier studies in Chapter 2 have been dealt with in the design of the present research,

some problems remain. Most obvious, is the problem of developing instrumentation to measure accurately the impact of VTP/RII on objective outcome criteria. The primary problem here, rests with the Lawrence scales parts 1-3. Although the scales are congruent with the therapeutic methodology of the program, the results of this, and other research (Lawrence, 1974) indicate that they are lacking in discriminatory ability and that suitable modifications, are necessary before they can begin to supply the substantive data for verification of the impact of such therapy programs.

Beyond this, it is important to examine the viability of larger scale studies, incorporating larger samples and perhaps a variety of matched therapists and clinical settings. The argument was advanced in Chapter 3, that laboratory research frequently has questionable validity when applied to clinical settings and it was observed that while clinical research is more readily translated to clinical practice, it also has significant drawbacks, in terms of obtaining large numbers of subjects and the problem of experimental design within the confines of clinical procedure. Further, it was noted in Chapter 3, that while a larger sample size might have been desirable, the pragmatics of clinical research, without financial support, made utilization of a larger sample size a fiscal, as well as physical, impossibility. It is suggested that if and when Federal research grants once again become available that a large scale replication of the present research would be most desirable.

Beyond research considerations, however, the present research has implications in a number of areas. As already reviewed it has

great promise for modernizing and streamlining the practice of psychotherapy, a most desirable objective in this age of accountability. Possibilities also exist for the implementation of VTP/RII programs, such as the one examined here, in the fields of education, labor-management relations and in fact any endeavor that incorporates the concepts of change and group interaction. As a means of facilitating the process of group interaction, and minimizing the "measuring up" period which charaterizes all newly formed groups, VTP/RII offers the potential of maximizing the impact of many divergent, group oriented endeavors.

Conclusion

In summary, then, VTP/RII has been shown to be an affective agent for decreasing client manifest anxiety, while increasing positive therapeutic expectations and motivation to change. The present research reports significantly higher client and therapist ratings of successful outcome, as well as significantly higher objective criteria ratings of outcome. Further it has been shown that, consistent with previous research, manifest anxiety, positive therapeutic expectations and motivation to change are reliable and congruent discriminators when applied both to prediction of therapeutic success and to differentiating levels of outcome.

It has been suggested that, with minor changes in instrumentation, VTP/RII programs may elicit even more significant results, and that, given the availability of research funds, larger scale replication is called for.

Finally, the scope of VTP/RII was discussed and it was suggested that the range of such programs is not limited to the clinical setting but that with minor adaptations, the VTP/RII program may be used as a facilitator to the process of a wide variety of group interactional situations, with positive results.

Much remains to be done, and the research presented here is only a small, but positive step, in the direction of improving the systems of service delivery that are, everyday, constituting a greater part of our lives.

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APPENDICES

APPENDIX A

UNPUBLISHED INSTRUMENTATION

APPENDIX A

UNPUBLISHED INSTRUMENTATION

THERAPIST EVALUATION OF CLIENT IMPROVEMENT

Social Functioning

0	16	32	48	64	80

Family Functioning

0	16	32	48	64	80

Primary Relationships

0	16	32	48	64	80

Attainment of Primary Goal

0	16	32	48	64	80

Vocational Functioning

0	16	32	48	64	80

Key for scoring: Please rate each client somewhere along the above numerical scales, indicating the approximate numerical rating or his improvement in each category.

0-16 Very Much Worse
17-32 Worse
33-48 No Change
49-64 Improved
65-80 Very Much Improved

COLLINS-CURRAN SCALE OF RATIONAL ATTITUDES

I. Please try to put yourself in this situation and on the checklisk that follows check those reactions that you feel would be closest to your own. For example, if you feel that you would be very likely to get out out of the situation, check "Very Likely" under choice 1. If you feel you would be very unlikely to do so, check, "Very Unlikely" under response 5. Please note: This checklist is to be used only to help us evaluate the procedures of this program, therefore, it is not necessary for you to sign your name. Since we are, however, planning to evaluate attitude change during the program it will be helpful if you would put your social security number or your date of birth (day, month, year) at the top right-hand corner.

II. You have just been told by someone close to you (husband, wife, lover, etc.) that they feel that you've outgrown one another and that the relationship is dead. It's not anything in particular that you've done, it's just that they're feeling trapped in the relationship and want to experience other things and other people. They don't feel that there is anything to discuss and just hope that you'll understand.

---

1. Very Likely 3. Don't Know 5. Very Unlikely

2. Likely 4. Unlikely

1 2 3 4 5	1.	Try to see the humorous side of the situation.
1 2 3 4 5	2.	Take some positive, concerted action on the basis of your present understanding of the situation.
1 2 3 4 5	3.	Not worry about it, everything will work out fine.
1 2 3 4 5	4.	Talk it over with the persons in the situation to see if you can work it out.
1 2 3 4 5	5.	Try to put yourself in the other's shoes.
1 2 3 4 5	6.	Become involved in other activities in order to help keep your mind off the problem.
1 2 3 4 5	7.	Draw upon your past experiences from a similar situation.
1 2 3 4 5	8.	Seek some professional help or advice.

1 2 3 4 5 9. Get out of the situation.

1 2 3 4 5 10. Get your feelings out by talking to someone.

1 2 3 4 5 11. Make several alternative plans for handling the situation; after all, you never know what might work.

1 2 3 4 5 12. Try to get some perspective by talking it over with a friend.

1 2 3 4 5 13. Re-examine you own thoughts and feelings-- the problem may be with you.

1 2 3 4 5 14. Express your feelings to some "out front" person, to get their reaction.

1 2 3 4 5 15. Try some experimenting.

1 2 3 4 5 16. Try to reduce your tension by smoking, drinking, etc.

1 2 3 4 5 17. Act spontaneously-- do the first thing you think of.

1 2 3 4 5 18. Be prepared to expect the worst.

1 2 3 4 5 19. Read some books dealing with what may be the worst possibility.

1 2 3 4 5 20. Confront the person with your feelings.

EVALUATION BY GROUP MEMBER

(1) Problem Objective

Very Much Worse	Worse	Slightly Worse	No Change	Slightly Better	Better	Very Much Better

(2) Problem Objective

Very Much Worse	Worse	Slightly Worse	No Change	Slightly Better	Better	Very Much Better

(3) Problem Objective

Very Much Worse	Worse	Slightly Worse	No Change	Slightly Better	Better	Very Much Better

LAWRENCE SCALES PART I

Mrs Jones and Jimmy

Part I:

Mrs. Jones is married and is a mother of one child. She is a friend of yours and she has asked you to help her with a problem she has with her two year old son, Jimmy. She complains that Jimmy's behavior is becoming intolerable, and she is beginning to question her own ability as a mother.

Instructions: Listed below are several questions that you might want answers to in order to help Mrs. Jones decide what would be the best thing to do about the problems. Please rank these questions according to how important you think the answers might be in deciding what to do about the situation. That is, what do you think the most important question is, the second most important question, and so on. Please place a "1" beside the most important, a "2" beside the second most important, and so on.

Questions:

_____ How much time does the mother spend away from Jimmy?

_____ Exactly what does Jimmy do to cause his mother to call his behavior intolerable?

_____ What attitudes do the father and mother have about child rearing?

_____ What kind of problems are there between the mother and her husband?

_____ When, where, and how often does Jimmy behave badly?

_____ How was the mother raised as a child?

If you think there are any other questions that would be important to ask please write them below.

LAWRENCE SCALES PART II

Mrs. Jones and Jimmy

Part II:

Mrs. Jones is a housewife. She seldom gets out of the house these days because her son, Jimmy requires a lost of attention and Mrs. Jones is unwilling to leave him with a babysitter. Before Jimmy's grandmother died six months ago, she used to leave Jimmy with his grandmother occasionally. Mr. Jones works during the day, but he is usually at home in the evening. Mr. Jones considers disciplining Jimmy something that Mrs. Jones is responsible for. Mr. Jones frequently complains, and yells at Mrs. Jones about Jimmy's behavior and the noise he makes around the house. An example of what Mr. Jones might say in an angry tone of voice is, "Why can't you keep that kid quiet?"

An example of Jimmy's behavior is that he will come into the kitchen, point to the refrigerator and ask for ice cream or pop. Mrs. Jones says, "No," and Jimmy lies down on the floor and kicks and screams. Then Mrs. Jones either gives Jimmy the ice cream or pop, comforts and distracts him, or spanks him. Jimmy does this three to four times every day.

Instructions: Please answer the following question by checking the one statement that you think best answers the question. Check only one of the statements for each question.

Question 1 Jimmy's kicking and screaming behavior is probably caused by:

_____A. The inconsistency with which the mother behaves toward him.

_____B. The loss of his grandmother.

_____C. The lack of attention he gets from his father.

_____D. The attention he gets from his mother right after he kicks and screams.

Question 2 The mother behaves toward Jimmy's kicking and screaming in the way she does because:

_____A. She is confused about the feelings she has toward Jimmy.

_____B. Jimmy stops screaming and kicking.

_____C. Her personal insecurity makes her behave inconsistently.

_____D. She is sometimes angry, and sometimes sympathetic toward Jimmy.

Question 3 The best thing for Mrs. Jones to do in order for Jimmy not to kick and scream whenever she refuses his demands is to:

_____A. Spank Jimmy each time he does this and explain to him that children should not behave this way.

_____B. To pay absolutely no attention to Jimmy when he is kicking and screaming.

_____C. To set up a schedule where Jimmy can have treats only at certain times of the day, and explain this to him every time he asks for treats.

_____D. Never to give Jimmy the ice cream or pop after saying, "No" and to hold him whenever he kicks and screams to show him he is loved.

Another example of Jimmy's behavior is that he will scream and yell after being put to bed at night. If left alone he will kick the wall, throw his toys and cry. On these occasions, Mrs. Jones usually stays with Jimmy until he falls to sleep. This has been occurring almost every night for three months now.

Instructions: Please check the one statement that best answers the following questions:

Question 4 Jimmy probably has these tantrums almost every night because:

_____A. He likes the attention he gets when his mother stays with him.

_____B. He doesn't get enough attention from his father.

_____C. He is afraid of being alone, which is normal for two year olds.

_____D. He is insecure about how much his father and mother love him.

Question 5 The most likely explanation for Mrs. Jones' behavior of staying with Jimmy until he falls asleep is:

_____A. She is worried that he will not be healthy if he doesn't get enough sleep.

_____B. Mr. Jones gets angry at her when Jimmy is yelling and screaming.

_____C. She is worried about the psychological damage that may occur if he cries himself to sleep.

_____D. She really enjoys this quiet time with Jimmy.

Question 6 The best thing for Mrs. Jones to do in order for Jimmy to learn to go to sleep without throwing tantrums is to:

_____A. Convince Mr. Jones that he should discipline Jimmy at night.

_____B. Sit with Jimmy while he is falling to sleep until he grows out of this "stage".

_____C. Go into Jimmy's bedroom each time he throws a tantrum, tell him she loves him but wants him to be quiet and go to sleep now, and then leave the room immediately.

_____D. Pay no attention to Jimmy's screaming and yelling after he is tucked into bed.

LAWRENCE SCALES PART III

Mr. and Mrs. Smith

Mr. and Mrs. Smith have been married for five years and have no children. They both say that their marriage is "on the rocks," and they complain that they are constantly arguing with each other. They both say that they care for each other, and would like to "make their marriage work."

Instructions: Listed below are several questions that might be asked about the Smith's problem in order to find out what would be the best thing to do about their situation. Please rank these questions according to how important you think the answers might be in deciding what to do about the situation. That is, what do you think the most important question is, the second most important question, and so on. Please place a "1" beside the most important question, a "2" beside the second most important question, and so on.

Questions:

_____ How compatible are their attitudes toward marriage?

_____ What do they argue about, and what are some examples of their arguments?

_____ What kind of family life did each of them have as children?

_____ When, where, and how often do they argue?

_____ Do they have a satisfying sexual relationship?

_____ What happens just before and right after their arguing?

_____ Why haven't they had any children?

If you think there are any other questions that would be important to ask, please write them below.

APPENDIX B

CORRELATIONAL DATA

APPENDIX B

CORRELATIONAL DATA

Table B-1

Correlational Data for Intergroup
Pre-Test Measures

Instrument	Comparison Groups	Correlation
Taylor	A and B	0.5933*
Fischer-Turner	A and B	0.8498**
Miskimins Part 1	A and B	0.6255*
Miskimins Part 2	A and B	0.7933**

* <.05
** <.01

Table B-2

Correlational Data for Intergroup
Post-Test Measures

Instrument	Comparison Groups	Groups Receiving VTP/RII	Correlations
Taylor	A and B	A-yes; B-no	-0.4676
Fischer-Turner	A and B	A-yes; B-no	0.0556
Miskimins Part 1	A and B	A-yes; B-no	-0.2075
Miskimins Part 2	A and B	A-yes; B-no	-0.1019
Taylor	A and C	A-yes; C-yes	0.7270**
Fischer-Turner	A and C	A-yes; C-yes	0.6274*
Miskimins Part 1	A and C	A-yes; C-yes	0.8022**
Miskimins Part 2	A and C	A-yes; C-yes	0.7803**
Taylor	B and C	B-no; C-yes	-0.6112*
Fischer-Turner	B and C	B-no; C-yes	-0.4391
Miskimins Part 1	B and C	B-no; C-yes	-0.2765
Miskimins Part 2	B and C	B-no; C-yes	-0.1056

* $< .05$
** $< .01$

Table B-3

Correlational Data for Pre- and Post-Test Measures Within Groups

Instrument	Group	Correlation
Taylor	A (VTP/RII)	0.1689
Fischer-Turner	A (VTP/RII)	0.2623
Miskimins Part 1	A (VTP/RII)	0.2030
Miskimins Part 2	A (VTP/RII)	0.0452
Taylor	B	0.4078
Fischer-Turner	B	0.6297*
Miskimins Part 1	B	0.7019**
Miskimins Part 2	B	0.3081

* $<.05$
** $<.01$

Table B-4

Correlational Data for Instruments
Within Groups

Comparison Measures	Group	Correlation
Taylor I/Fischer-Turner I	A	0.7874**
Taylor I/Miskimins Pt. 1	A	0.5254*
Taylor I/Miskimins I Pt. 2	A	0.4012
Fischer-Turner I/Miskimins I Pt. 1	A	0.7448**
Fischer-Turner I/Miskimins I Pt. 2	A	0.8400**
Taylor I/Fischer-Turner I	B	0.3003
Taylor I/Miskimins I Pt. 1	B	0.6029*
Taylor I/Miskimins I Pt. 2	B	0.5128*
Fischer-Turner I/Miskimins I Pt. 1	B	0.6257*
Fischer-Turner I/Miskimins I Pt. 2	B	0.3940
Taylor II/Fischer-Turner II	A	0.3490
Taylor II/Miskimins II Pt. 1	A	0.6829**
Taylor II/Miskimins II Pt. 2	A	0.4409
Fischer-Turner II/Miskimins II Pt. 1	A	0.5241*
Fischer-Turner II/Miskimins II Pt. 2	A	0.5119*
Taylor II/Fischer-Turner II	B	0.7194**
Taylor II/Miskimins II Pt. 1	B	0.7133**
Taylor II/Miskimins II Pt. 2	B	0.5178*
Fischer-Turner II/Miskimins II Pt. 1	B	0.6300*
Fischer-Turner II/Miskimins II Pt. 2	B	0.5049*

Table B-4 Continued

Comparison Measures	Group	Correlation
Taylor II/Fischer-Turner II	C	0.4815
Taylor II/Miskimins II Pt. 1	C	0.5290*
Taylor II/Miskimins II Pt. 2	C	0.6482*
Fischer-Turner II/Miskimins II Pt. 1	C	0.5071*
Fischer-Turner II/Miskimins II Pt. 2	C	0.4091

* < .05
** < .01

Table B-5

Correlational Data for Outcome Instruments Within Groups

Comparison Instruments	Group	Correlation
Collins-Curran/Lawrence 1	A	0.3467
Collins-Curran/Lawrence 2	A	0.5234*
Collins-Curran/Lawrence 3	A	0.7126**
Lawrence 1/Lawrence 2	A	0.3273
Lawrence 1/Lawrence 3	A	0.8728**
Lawrence 2/Lawrence 3	A	0.6428*
Collins-Curran/Lawrence 1	B	1.0000**
Collins-Curran/Lawrence 2	B	1.0000**
Collins-Curran/Lawrence 3	B	1.0000**
Collins-Curran/Lawrence 1	C	0.3279
Collins-Curran/Lawrence 2	C	0.5441*
Collins-Curran/Lawrence 3	C	0.3279
Lawrence 1/Lawrence 2	C	0.9075**
Lawrence 1/Lawrence 3	C	1.0000**
Lawrence 2/Lawrence 3	C	0.9705**

* $< .05$
** $< .01$

APPENDIX C

MEAN SCORES: REPORTED BY GROUP

APPENDIX C

MEAN SCORES: REPORTED BY GROUP

Table C-1

Pre- & Post-Test Scores

Pre-Test	Post-Test	Group	Mean
Fischer-Turner		A	52.40
Fischer-Turner		B	53.10
	Fischer-Turner	A	59.70
	Fischer-Turner	B	48.40
	Fischer-Turner	C	55.00
Taylor		A	31.10
Taylor		B	30.10
	Taylor	A	23.40
	Taylor	B	34.10
	Taylor	C	22.60
Miskimins Pt. 1		A	41.70
Miskimins Pt. 1		B	46.60
	Miskimins Pt. 1	A	54.70
	Miskimins Pt. 1	B	35.60
	Miskimins Pt. 1	C	49.60

Table C-1 Continued

Pre-Test	Post-Test	Group	Mean
Miskimins Pt. 2		A	41.10
Miskimins Pt. 2		B	42.10
	Miskimins Pt. 2	A	48.00
	Miskimins Pt. 2	B	33.30
	Miskimins Pt. 2	C	47.20

Table C-2

Outcome Scores

Outcome Measures	Group	Mean
Lawrence Pt. 1	A	2.40
Lawrence Pt. 1	B	2.00
Lawrence Pt. 1	C	2.75
Lawrence Pt. 2	A	2.20
Lawrence Pt. 2	B	1.50
Lawrence Pt. 2	C	2.25
Lawrence Pt. 3	A	2.40
Lawrence Pt. 3	B	3.00
Lawrence Pt. 3	C	1.75
Collins-Curran	A	45.40
Collins-Curran	B	61.50
Collins-Curran	C	46.75

Table C-2 Continued

Outcome Measure	Group	Mean
Therapist evaluation of Social Functioning	A	68.00
Therapist evaluation of Social Functioning	B	49.00
Therapist evaluation of Social Functioning	C	67.25
Therapist evaluation of Family Functioning	A	72.80
Therapist evaluation of Family Functioning	B	32.00
Therapist evaluation of Family Functioning	C	71.50
Therapist evaluation of Primary Relationships	A	65.40
Therapist evaluation of Primary Relationships	B	42.50
Therapist evaluation of Primary Relationships	C	56.25
Therapist evaluation of Primary Goal Attainment	A	66.66
Therapist evaluation of Primary Goal Attainment	B	29.50
Therapist evaluation of Primary Goal Attainment	C	61.95
Therapist evaluation of Vocational Functioning	A	74.80
Therapist evaluation of Vocational Functioning	B	23.00
Therapist evaluation of Vocational Functioning	C	69.25
Client evaluation of Primary Goal Attainment	A	67.00
Client evaluation of Primary Goal Attainment	B	45.75
Client evaluation of Primary Goal Attainment	C	64.75
Client evaluation of Secondary Goal Attainment	A	62.75
Client evaluation of Secondary Goal Attainment	B	47.25
Client evaluation of Secondary Goal Attainment	C	58.50

Table C-2 Continued

Outcome Measures	Group	Mean
Client evaluation of Tertiary Goal Attainment	A	57.25
Client evaluation of Tertiary Goal Attainment	B	48.50
Client evaluation of Tertiary Goal Attainment	C	67.50
Client evaluation of Interpersonal Relationships	A	8.25
Client evaluation of Interpersonal Relationships	B	5.00
Client evaluation of Interpersonal Relationships	C	10.00

APPENDIX D

VTP/RII PROCEDURES

APPENDIX D

VTP/RII PROCEDURES

VTP ROLES

Harold (Ed Brown) Father having trouble with a 16 year old girl. Specifically he finds himself yelling at the girl, and the girl (Jill) just runs up to her room and locks the door. These confrontations usually take place over whether the daughter will do household chores. Treatment goal--daughter will do household chores and perform reasonable requests made by Harold without his recourse to shouting.

Sheila (Betty Larsen) Presenting problems. Usually complies to unreasonable request of her employers without resistance. This leads to overwork, fatigue, insomnia and somatic complaints. Tentative treatment goal--to refuse to comply to unreasonable requests of employers through performance of appropriate assertive behavior.

Ted (Jim Nevels) Presenting Problems. Son frequently violates parental rules. Client responds by interrogating the son as to his motives and makes demeaning comments. Tentative treatment goal--son will obey parental rules without recourse by client to interrogation and demeaning remarks.

Barbara (Michele Nevels) Presenting Problems. Employers are

unduly critical of her work and often make requests of her in a sarcastic manner. Client responds by complying with the requests, but in a non-productive fashion leading to further complaints by her employers. Tentative treatment goal--to reduce the frequency of criticism and sarcasm by her employers concerning her work.

Janice (Jeanine Mitchell) Presenting problems. Son frequently hits and threatens younger siblings, and when asked to perform chores, he delays in compliance and makes annoying comments to the client. Tentative treatment goals--the frequency of hitting and threatening siblings will be significantly reduced, and son will perform chores at the time he is asked, without making abusive comments.

VTP SCRIPT OUTLINE

Tape opens with Jim (therapist) summarizing the teaching component on making requests. Summarizes three main points, 1. specify the behavior you are requesting, what, when, where, and how; 2. state the reason for the request; 3. sometimes, offer an exchange. Jim asks if there are any questions, or if anyone can give an example of how it might be useful. The group responds by giving some appropriate examples of how they might utilize these suggestions in the future.

Jim--"it seems that we understand making requests quite well. Would everyone hand in their assignments from last week . . ."

The group members respond and Jim chooses Harold to report first on how he and his daughter are progressing in their relationship. Harold reports that his daughter didn't do the dishes as she was

supposed to, four times last week and that he wound up yelling at her. On three other occasions, however, she did do the dishes and he didn't find it necessary to get angry with her. Jim questions Harold about a specific example of one of the times that she didn't do the dishes and one of the times that she did.

Harold reports on the various situations, but at this point he has not made any connection between how he responds and what happens immediately afterward or the next time that Jill is supposed to do the dishes. He doesn't feel that he should have to "pat her on the head" everytime she does something right.

Further questioning brings out the fact that each time she did the dishes and Harold did not reinforce her, that the next evening she conveniently forgot to do the dishes and Harold wound up yelling at her. At this point Harold realizes that if he were to reinforce her for doing the dishes, that she might comply with his wishes more willingly and more frequently.

He also wonders if he might be able to use the new information on making requests to further improve his relationship with his daughter. Jim asks him to try to formulate a request to his daughter and he responds with: "Jill, I would like you to do the dishes now, I want to get some things from the hardware store and you may use the car when I get back, if the dishes are done." This strikes one of the group members as a bribe and she asks Jim and Harold if there might be a better way of approaching this situation. Jim explains that, in this situation, Harold is offering a negotiation and not a bribe, but

it may well be that there would be a more appropriate response and asks her if she might have a suggestion for Harold. . .

After some more interchange the therapist and the group provide feedback on Harold's request and begin to help him to formulate the behavioral assignment for the next week. He will continue to keep a record of the conflictful situations that arise between himself and Jill and will place special emphasis on what happens just before and after each situation. He will also try to provide more positive reinforcement for Jill's helping around the house and to make certain that he makes requests rather than making demands.

Jim then moves to the next client, who will repeat essentially the same process with his problem, but more likely time will have elapsed and the VTP will be ended.

OUTLINE FOR ROLE INDUCTION INTERVIEW

Outline for the role induction interview that follows the presentation of the pre-training video-tape.

I. Answer any client questions about the tape.

II. A general exposition of behavior-modification groups.

- a. Stressing the role of behavior in causing feelings and reactions.
- b. Citing support for the thesis that helping a person to change his behavior will help the person change many facets of his life.
- c. Re-stressing the importance of regular attendance and carrying out behavioral assignments and reporting as self-reinforcement as well as contributing to the group.
- d. Preparation for resistance to change and suggestion that a person makes an active choice to resist change and that he doesn't have to resist.
- e. Psychotherapy as a learning process and this particular group technique as one of the most effective.
- f. The importance of vicarious learning and contributing to the solution of others' problems, especially as it relates to helping the individual get a handle on changing his own behavior.

III. The induction of a realistic expectation for improvement within six sessions.

APPENDIX E

GROUP PROCEDURES AND GROUP PROCESS

APPENDIX E

GROUP PROCEDURES AND GROUP PROCESS

Group Procedures

I. General Procedure:

The general procedure entails, in step-wise fashion, the selection of a problem, problem specification, assessment of controlling conditions, the assessment of resources and conditions for modification, planning and implementation of modification, and maintenance. In addition, a follow-up procedure is being planned which will not involve the group leaders. For the most part, it will be expected that clients will be at various stages in the procedure. This is appropriate in that clients pose varying degrees of difficulty in moving through the steps. It is important that modification not be implemented prematurely, that is, without a completed assessment of the target behavior. It is conceivable that, for some clients, it may not be possible to implement modification at all or until the very end of the group sessions. In such cases we will want to investigate the relevant factors with respect to the group model, rather than ignoring such situations by implementing ad hoc modification. Hopefully, such occasions where modification is late or does not occur will be rare.

In addition to the general sequential procedural steps there are several sub-steps that may also occur sequentially. I am referring to specification, assessment, and modification probes. Specification probes are activities designed to explore possible reference of the stated problem as opposed to activities designed to collect information on certain referants as when specification has been completed. Assessment and modification probes are the same sort of activities; namely, those employed prior to completed assessment or planned modification for purposes of scanning possibilities or testing hypotheses. The notion of probes is an interesting one in behavior modification and we hope to obtain feedback from the group leaders on their use of probes.

II. Mini-Lectures and Demonstrations:

The group model calls for training clients in certain aspects of behavior management. This is to be accomplished through the use of mini-lectures, demonstrations, illustrations, and feedback throughout the group sessions. Illustrations refer to procedures involving the utilization of client situations as examples of behavior principles and feedback refers to the process of interpretation and clarification of these principles as illustrated by client situations. Illustrations and feedback involve both client and therapist participation.

The mini-lectures and demonstration activities are planned and implemented by the group leaders. Listed below are those mini-lectures and demonstrations that are to be implemented during

the 6 sessions. Also indicated are the appropriate sessions for each.

1. Behavior and behavior specification: first session.
2. Antecedents and consequences: second session.
3. Positive reinforcement, punishment and avoidance behavior: third session.
4. Ways to increase desired behavior while decreasing undesired behavior (extinction and differantial reinforcement): fourth session.

The objective is to utilize lecturing and demonstrations so that clients can learn these basic ways to observe and manage behavior. The mini-lectures and demonstrations should be short, simple and to the point. I recommend that you use behavior modification jargon sparingly, denoting these principles rather than providing terms for them.

There are several ways of planning a mini-lecture and demonstration. These are indicated as follows: Lecture then demonstration; demonstration then lecture; demonstration, lecture and demonstration: etc. The task of planning mini-lectures and demonstrations is the responsibility of the group leaders with consultation being available as desired. The point is to get these notions across as effectively and as efficiently as possible. The use of illustrations and feedback is to follow up on these mini-lectures and demonstrations as applicable to client situations.

III. Constituent Techniques:

Constituent to the procedure are various techniques to be employed or initiated by the group leaders, for the purpose of obtaining information about behavior or for modifying behavior. Some

of these techniques are given below:

1. Behavior re-enactment: A technique to obtain response display of a target behavior for assessment or modification (via feedback). This technique involves verbal interchanges exemplifying a previous behavioral situation or one similar to a previous situation and may employ either client-client or client-therapist dyads.
2. Behavioral skits: A Technique to demonstrate behavioral events for illustrating behavioral principles, appropriate vs inappropriate behaviors, or appropriate behaviors (such as in modeling).
3. Behavior rehearsal: A technique involving instructions to the client to exhibit in the presence of the group a desired behavior. The purpose of rehearsing a behavior may be to bring that behavior under discriminative control, to shape the form of the behavior, to strengthen an infrequent behavior or all of these.
4. Corrective feedback and instructions: A technique combining a discrimination training procedure, using verbal contrast or designations of one or more behaviors, and behavior prescriptions. Corrective feedback may occur alone, (the group may be used in providing corrective feedback alone) and instructions may be aimed at in-session responding or extra-session responding or both.
5. Instigation: Prescribing certain behaviors the client is to exhibit in his natural environment.

Group Process

Each of the six group sessions began in the same way, that is, the group leader presented a mini-lecture on the specific area of behavior modification to be considered. The content of these mini-lectures was ordered in such a way as to build on the content of the previous session. In addition the group leader designed each mini-lecture so that it was as closely related to the problems presented by the group members as possible. A weekly treatment plan was formulated for each group member, building upon the progress that had been observed in the previous session and incorporating the content of the present mini-lecture. The mini-lectures covered a step-by-step progression, beginning with problem specification, which was followed by sessions on reinforcement, extinction, trying out new behavior, the antecedant-behavior-consequence theory of behavior modification and concluded by the session on making requests.

Following the mini-lecture, which usually lasted about thirty minutes, participants were encouraged to ask questions or to seek clarification. Special emphasis was placed on clarifying the relationship of the mini-lectures content to the target behavior each of the members was attempting to modify.

After sufficient clarification had been achieved, the therapist shifted the group focus to the weekly 'work' sessions, in which each client volunteered to work on clarifying the events of the previous week and how he might more profitably employ the concepts of behavior modification. During these work sessions the therapist and group members attempted to help the client to further understand the nature

of the problematic behavior as well as factors that might be contributing to its maintainance or blocking its modification. This process within the group was stressed as a microcosmic representation of social interactions and group members were encouraged to use what they had learned in attempting to help the other members specify their problem behavior and more fully understand the environment in which it is observed. Each member, in turn, had an opportunity to work each week and the importance of taking full advantage of this opportunity was stressed. Again, the review of the tape recordings disclosed that groups who had been exposed to VTP/RII were far less hesitant to volunteer to "work", a fact seemingly accounted for by their high levels of motivation to change and expectation, as well as their lower anxiety level. In all groups, however, after the third session it was not necessary for the therapist to coerce members into taking their turn at working as they began to see the effectiveness of the process and to become accustomed to giving and accepting feedback on what were frequently perceived as very personal problems.

In addition to facilitating learning, the "work sessions" also appeared to greatly enhance the development of cohesiveness in the group. By structuring the interactional process, while at the same time sanctioning more direct and meaningful communication, the "work sessions" served as an excellent opportunity for behavioral rehersal or trying out new behaviors and for facilitating the feeling of 'groupness' or cohesion at the same time.

Subjectively, this technique of group behavior modification seems to be relatively free of the "techniques-ness" that seems to characterize many behavioral groups and in fact seems freer of this malady than many techniques loosely grouped into the sensitivity, growth or Gestalt categories. Group members interacted freely and for the most part observed that the structure of the group, far from detracting from the closeness of the group contributed to its development by making risks easier to take. Members also observed that by interacting with other clients along with the therapist they did not feel the sort of therapist/client division that they had expected and yet, at the same time, they didn't feel that the group process was left entirely up to them, with the therapist riding along as a sort of "fifth wheel". In summation then, client's responses to the group procedure were generally positive, they liked the structure and cognitive content of the group but also responded favorably to the flexibility which allowed, and in fact facilitated the development of closeness and cohesion. Participants also responded positively to the VTP/RII procedure, which they felt, contributed greatly to reducing their fears and correcting the myths they may have held about groups. In general it was a positive experience for the clients, a fact which is reflected in the results of Chapter 4.