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ABSTRACT

STIMULATED RECALL WITH VIDEOTAPE AND SIMULATION IN COUNSELING AND PSYCHOTHERAPY: A COMPARISON OF EFFECTS OF TWO METHODOLOGIES WITH UNDERGRADUATE STUDENT CLIENTS

By

Robert William Van Noord

This research represented an attempt to evaluate an integrated videotape/stimulated recall/affect simulation method of personal counseling and psychotherapy. In the evaluation of this method, a comparison was made between rated, self-reported, and peer-observed behaviors of undergraduate student clients who received the experimental therapy procedures and behaviors of clients who had received a second program consisting of traditional, dyadic therapy. The basic question underlying the study was whether an integrated affect simulation/Interpersonal Process Recall (IPR) procedure with videotape could effect more client growth in therapy over a six-week period of time than a traditional therapeutic approach.

The therapy model used in this study was derived largely from Kagan's (1967) IPR and and affect simulation methods. The sequential steps in the experimental therapy model included the following: (1) Regular counseling

sessions; (2) Affect Simulation Viewing-Client and Counselor discussion of client's reactions to filmed affective stimuli; (3) Video Recall of Affect Simulation (VRAS)--Client review of his videotaped reactions to affect simulation; (4) Client Recall-client review and exploration, with assistance from "inquirer," of thoughts, feelings and reactions during previously conducted and videotaped therapy session; (5) Mutual Recall--client and counselor together review videotape of just-completed session and explore feelings, thoughts and reactions. The traditional therapy model consisted of dyadic, relationship-oriented counseling and therapy, equated for time with the IPR model.

Students requesting personal counseling or therapy were randomly assigned to treatment groups and to counselors (employed by university counseling centers) within treatment groups and post-treatment comparisons were made between the two groups. Measures of client in-therapy verbal behaviors, client satisfaction with therapy, client self-concept change and peer reports of client behavior outside of therapy were employed with hypotheses predicting that clients who received IPR therapy would obtain higher in-therapy behavior ratings, satisfaction reports, and peer ratings, and lower self-concept discrepancy scores than clients who received traditional therapy.

Data were analyzed by a multivariate analysis of covariance procedure, with one covariable (rated empathic understanding of therapist) and five dependent variables

(a composite client growth scale, client self exploration, client satisfaction with therapy, client self concept discrepancy and peer reports). Two independent *t* tests were also performed as post hoc exploratory analyses of peer ratings results and covariable to dependent variable correlations and dependent variable intercorrelations were examined. Finally, subjective written comments of the client-participants in the study were obtained.

Results of the multivariate analysis on the five dependent variables taken together indicated no significant treatment effect. Results of univariate analyses carried out in the same procedure also indicated no significant treatment effects for the dependent variables taken separately. Post hoc analyses of frequencies of strong positive and negative peer responses indicated that, although peers of clients who received traditional therapy tended to respond with more strongly negative responses than peers of IPR group clients, the difference was nonsignificant.

Written comments of participating clients indicated that those who responded were pleased with their therapy experience, regardless of their group. Client statements appeared to indicate that individuals who received IPR therapy thought of videotape use as beneficial for self-exploration. Comments also seemed to demonstrate more awareness by IPR group members of client defensive dynamics and of an interactive client-counselor relationship than by traditionally counseled clients.

Conclusions from the results of the research were that the therapy model used for this study did not result in more client growth in therapy on the variables examined, but that affect simulation and IPR with videotape is seen by clients as beneficial and conducive to self exploration and exploration of the client-counselor relationship in personal therapy.

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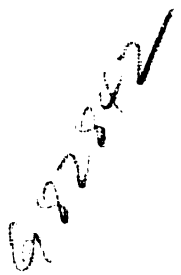

DEDICATION

To my parents, who provided the impetus for it all.

They would be pleased and proud.

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Acknowledgement is gratefully made to the many individuals who contributed directly and indirectly to the planning and completion of this project.

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understood myself first, and through that, the clients and others with whom I worked.

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CHAPTER I

INTRODUCTION

Purpose

The purpose of this study is to assess the effectiveness of a client therapy program which combines the use of Interpersonal Process Recall (IPR) and affect simulation films. The study is a modified replication of an earlier investigation (Schauble, 1970) and represents a further examination of a relatively new treatment program for clients. In this program IPR and affect simulation are incorporated into an ordered treatment program and the results of that treatment compared with the results of a more traditional college counseling program.

The Problem

Individuals in the field of counseling and psychotherapy have as one of their mandates the constant evaluation and upgrading of the effectiveness of their work, as well as the possession of a committment to provide helping services to those who come to them for assistance. In this study, an attempt is made to obtain a reliable assessment of the effectiveness of a recently developed method of helping people who have sought assistance with personality and/or adjustment problems from professional counselors. In this

way, an evaluation and possible upgrading of a way of providing mental health services to college age clients may be provided.

Traditionally practitioners have carried out counseling and therapy with college clients in an individual or group setting, and in this sense the present investigation does not depart significantly from the more typical method of therapeutic intervention. It does differ, however, in the specific technique of intervention. In this study a relatively new process and technology is used with the basic concept that therapeutic progress can occur more rapidly when specific behavior dimensions are isolated and promoted within the context of therapy.

Consideration of the notion of accelerating therapy is a step forward given the types of questions which have been asked about the field in the past. The issue of whether or not counseling or therapy is effective at all has undergone extensive debate as recently as the 1960's. Eysenck's (1952) report in which the claim was made that psychotherapy had no more effect than no treatment at all, provided the stimulus for many additional opinions and much further discussion (e.g., Sanford, 1953; Rosenzweig, 1954; DeSharmes, Levy and Wertheimer, 1954; Levitt, 1957). More recent investigations, however, have indicated that studies which reveal no effects as a result of therapeutic intervention may have had some shortcomings (Spielberger, Weitz

and Denny, 1962; Baymurr and Patterson, 1960; Draspa, 1959; Bergin, 1963; Kiesler, 1966). That is, while earlier investigators claimed that psychotherapy had no more effect than no treatment at all, later studies have revealed that there may be effects of therapy which are not observed because of the averaging of differences; the averaging of positive and negative effects produced a gross observation which led to the conclusion that there were no effects at all. Further evidence has indicated that when related to therapist functioning variables and specific interpersonal behavior dimensions, therapy may have positive effects which influence client change (Truax and Carkhuff, 1967; Carkhuff and Berenson, 1967). The significance of these later findings lies in the observation that therapy has been found to be for better or for worse (Traux and Carkhuff, 1967).

Given then, the possibility that therapy can be either beneficial or detrimental, it behooves the individuals in the profession to make every effort to insure that the effect will be beneficial and that the client can have a satisfying experience.

An effort is made in this study to evaluate a method designed to accelerate the positive impact of counseling and therapy. While there are many methods being tested and used to this end by various practitioners,

this investigation is focused on the use of a specific method of video technology (Interpersonal Process Recall) as an intervention in the counseling process. Interpersonal Process Recall (IPR), which uses videotape replay of the counseling session to stimulate recall (Kagan, Schauble, Resnikoff, Danish and Krathwohl, 1969), has been shown to have significant potential for accelerating growth in therapy with prison inmates (Kagan, Krathwohl, et al., 1967), with disabled adults (Schauble, 1968; Kagan, Krathwohl and Miller, 1963), and can be used in conjunction with hypnosis (Woody, Kagan, Krathwohl and Farquhar, 1956). IPR has also been demonstrated to be an effective method of training helpers to deal with various populations (Spivack, 1970; Archer, 1971; Dendy, 1971; Grzegorek, 1971; Heiserman, 1971; Scharf, 1971). Only one controlled study has been carried out, however, which assessed the effectiveness of IPR as a therapeutic mode with college student clients (Schauble, 1970). The aim of this project is to further examine the effectiveness and efficiency of the use of IPR and affect simulation as a therapeutic tool with college students.

IPR in general is the heart of this treatment program, but specific parts of the process are expanded and emphasized as elements contributory to therapy acceleration. The use of affect simulation films and of the "inquirer" role are two particularly important aspects of the experimental

counseling experience. The theory and a description of these portions of the treatment program will be described and expanded upon later in this and subsequent chapters.

In this study, no distinction is made between counseling and therapy. This position is based on the conclusion that ". . . there are no essential differences between counseling and therapy in the nature of the relationships, in the process, in the methods or techniques, in goals or outcomes (broadly conceived), or even in the kinds of clients involved" (Patterson, 1966, p. 3).

Definition of Terms

Special terms used in this study are defined as follows:

1. Interpersonal Process Recall (IPR): The term used to describe the process of recording on videotape an interpersonal interaction (e.g., the counseling relationship) and playing back the videotape, thus enabling either or both of the participants to stop the videotape to examine and verbalize the interpersonal dynamics of the original experience. A person in the role of "inquirer" (see below) is included in this process.

2. Recall Session: The phase of the IPR process where the videotape of a counseling interview is played back and an "inquirer" helps to stimulate examination by either or both of the participants of the underlying

dynamics of their interaction during the recorded counseling session.

3. Inquirer: The designation given to the third person whose function is to facilitate the client or counselor's self-analysis of thoughts, feelings, images, and general pattern of interaction with the other. Since this person's clinical function is limited to actively probing the immediate past (contained on the videotape), the name "interrogator" was initially selected, then changed to "inquirer" to more accurately describe his role.[1]

4. Affect Simulation: A technique using films which simulate various kinds and intensities of emotional stress. The films are structured so that a filmed actor looks at the client and confronts him with various interpersonal stress situations. Client reactions to such situations can thus be studied with the counselor in order to develop understanding and new and more satisfying ways of responding to the kinds of stress simulated by the films.

5. Video Recall of Affect Simulation (VRAS): Clients are videotaped while viewing the Affect Simulation Films, and the client's videotaped behavior while watching the films becomes the focus of a personal counseling session.

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[1] In previous literature, the terms "interrogator," "recaller" and "inquirer" have been used to designate the same person. In this study, the terms, "inquirer" and "recaller" are used synonomously.

6. Traditional Counseling: Counseling of the type generally carried out at the MSU Counseling Center and characterized in this study by the following: (1) It is dyadic in that the client and the counselor are the only two individuals in the setting and the relationship; (2) It is relationship oriented. That is, it is considerate of the ongoing relationships of the client, including that with his therapist; (3) It is developmentally oriented in that developmental antecedents of the client's present psychic situation are often considered; and (4) It is immediate in the sense that immediate events in the client's life are typically the focus of concern and consideration.

Need for the Study

The increasing use made by students of college counseling centers across the country may be indicative of more than a lessening of the stigma attached to seeking help for a personal or interpersonal concern. Another reason professional counselors are finding increasing demands for their services may be because many people in distress are unable to find facilitative agents in their everyday lives. Carkhuff and Berenson (1967) note that individuals in the general population, when asked to act as helpers for another, function considerably below the minimum level of facilitative helpfulness. This implies

that the general populace is quite oblivious to the feelings and experiences of the people with whom they relate--they are essentially immune to constructive human encounters. Psychological literature abounds with evidence that people are in need of help, but also mirrors the fact that the field of counseling and therapy is lacking many answers to the problems presented to its professionals. Still, people continue to come for professional help, seeking answers to problems of everyday living and desiring to cope effectively with the ever increasing stress of society. These people reflect, to some extent, the state of our society described by Carkhuff and Berenson (1967):

> An unhealthy society is one in which only 20 per cent of its people are free of signs of emotional distress. An unhealthy society is one in which one third of its members demonstrate distressing psychiatric symptomatology. An unhealthy society is one in which half of the hospital beds are occupied by mental patients, and in which one third of these are second admissions. American society, in which all of these conditions exist, is not healthy (p. 3).

Unfortunately, however, many professionals are unable to provide for the needs of clients in counseling and therapy. Carkhuff and Berenson (1967) continue:

> If counselors and psychotherapists functioned in real life the way they do in the therapeutic hour, they would be patients. The professional helpers to whom we turn because human sustenance is not available in the general environment are themselves functioning at ineffectual levels of those dimensions related to constructive change or gain (p. 11).

Yet, it has been acknowledged that counseling and therapy can have a positive effect (Truax and Carkhuff, 1966; Carkhuff and Berenson, 1967) and with this acknowledgement comes the mandate that the counseling profession constantly evaluate and upgrade its theory and methodology in order to ensure that the client is able to have a valuable experience.

The need for upgrading of both theory and methodology is obvious. The tasks facing counselors are to determine how this may be done and to carry it through. Examination of counselor and client variables in an attempt to determine those which foster client growth has been one productive activity aimed at upgrading the therapy process. Another has been the development and testing of therapeutic methodologies which may be used to assist those in distress. It is with this latter activity that this study is concerned.

In this study an attempt is made to assess the usefulness of a methodology which is thought to benefit clients in therapy. Through the use of a specific technology, clients may be helped to expand and clarify their experiences; by viewing themselves as both object and subject in this treatment program, clients may be able to expand their consciousness and gain contact with more effective ways of living and relating. In this way individuals may be able to rise above the dilemma and attain the goal to which May (1967) refers.

> . . . I have described the human dilemma as the capacity of man to view himself as object and as subject. My point is that both are necessary--necessary for psychological science, for effective therapy, and for meaningful living. I am also proposing that in the dialectical process between these two poles lies the development, and the deepening and widening, of human consciousness (p. 20).

General Hypotheses

General hypotheses proposed for this investigation are stated here. Specific research hypotheses will be outlined in Chapter III.

1. Clients who receive counseling with IPR and affect simulation will evidence more growth on rated process dimensions of Owning of Feelings, Differentation of Stimuli, Committment to Change and Degree of Self Exploration than will clients who receive traditional counseling.

2. Clients who are counseled with IPR and affect simulation will be more satisfied with their therapy sessions than will clients who are counseled with traditional methods.

3. Clients who receive counseling with IPR and affect simulation will reveal less discrepancies between their self concept, their goal self concept and the way they think others see them than will clients who receive traditional counseling.

4. Peers of clients will report more positive behavior changes for clients who receive counseling with IPR and affect simulation than for clients who receive traditional counseling.

Basic Assumptions

This investigation of therapy acceleration through a specific treatment program is carried out under a set of assumptions which are briefly outlined here:

1. Clients who seek assistance and are counseled at the Michigan State University Counseling Center do not differ from clients who seek help and are counseled at other university counseling centers in their ability to increase their interpersonal functioning.
2. Clients are capable of achieving insights into their own behavior and of consequently changing their intra- and interpersonal behaviors.
3. Client within-interview behavior can be adequately judged from listening to only audiotaped samples of a total interview. Further, measures which use ratings of clients' within-interview verbal behavior are valid and capable of determining changes in that behavior.
4. Client's subjective reports are valid measures of client satisfaction.
5. While some therapeutic change may occur exclusively intraindividually, some changes in client behavior as a result of therapy are capable of being observed by the individuals with whom clients interact outside of the therapy setting.

Theory

The theory underlying the treatment program developed for this study grew primarily from observations, inferences, and investigations of what constitutes and promotes positive client movement in counseling. General theoretical foundations described by Kell and his associates (1966, 1970) are used and the therapeutic model is based on Kagan's (1967) work with IPR and affect simulation. In addition some of Carkhuff's (1967 a,b) techniques of tape rating (with revisions), have been included in the criterion instruments. In this section, these theoretical formulations are reviewed and a description of the theoretical model of treatment is given.

The general theoretical base for the procedures used in this study stems from a relationship theory of counseling. It is closer to the views of neo-analysts (eg. Sullivan) than of classical Freudianism, and more akin to the views of Bruner (learning by discovery) than to more "behavioristic" approaches such as those of B. F. Skinner (operant conditioning) (Dendy, 1971). The approach being taken here, therefore, considers the client as a positive force in the resolution of his own concerns, and capable of achieving insights which will lead to more appropriate behaviors and to more positive mental health. The task of the counselor is to facilitate this process.

The counseling situation, and the relationship within it, is further seen as a microcosm, and thus representative of the client's life in general, including the relationships in which he engages. In his interactions with significant (and sometimes nonsignificant) others in his life, the client has learned ways of coping and behaving. He carries these modus operandi with him into therapy and uses them with his counselor, who becomes a significant figure in the life of the client. Given that these interpersonal behaviors are to some extent maladaptive and productive of the dissatisfaction in life which brought the client to counseling, one of the tasks of the counselor is to assist the client in examining these interactive behaviors.

In spite of counselor efforts to assist the client, however, the client may continue in attempts to elicit responses from his counselor in order to effect certain goals. These eliciting behaviors which seem to be maladaptive in the client's present life are interpersonal methods that the client has developed as ways of coping with anxiety. As Kell and Mueller (1966) say:

> The purpose for which the behaviors were learned and the reasons that the client still clings tenaciously to them is to ward off anxiety. Anxiety, therefore, is the emotionally motivating force that runs through all of the eliciting behaviors. Although anxiety can be an experience related to many different conflicts, basically it arises out of the meaning that establishing and breaking human relationships has for a person. The

> motivation for the genesis and utility of the eliciting behaviors stems from a person's needs to manipulate and maintain interpersonal contacts and to avoid pain (p. 47).

It is necessary that these eliciting behaviors be examined by the counselor and the client in terms of what purposes they serve for the client and how they are operational in the client-counselor relationship. In addition, an examination of these behaviors is necessary in order for the counselor to grasp the particular concern of the client, since the eliciting behaviors are the behavioral manifestations of the client's interpersonal conflicts (Kell and Mueller, 1966).

Through the use of stimulated recall and affect simulation with clients in therapy, it was hypothesized that clients could be more effectively helped to examine their own behaviors and underlying conflicts than through the use of traditional counseling techniques, especially in the initial stages of counseling. Consequently, Interpersonal Process Recall methods and affect simulation films were used in an attempt to accelerate the process of client self-examination and discovery.

But why do clients persist in carrying out these maladaptive behaviors both with the counselor and with significant others in everyday life? A review of some obstacles to client growth may be pertinent at this point.

Obstacles to Client Growth

A number of obstacles can be present in the therapy situation which make the task of the counselor and client more difficult. Some of these obstacles are the client's defensive dynamics, client subjectivity, the compression of prior client experiences and fears of psychological closeness to the counselor.

Client anxiety often results in client defensiveness. The client attempts to defend against the counselor, making it extremely difficult for the client to react spontaneously to the therapist and for the therapist to completely understand the experiences of client in the same way the client experienced them. A "strong wall" is erected (Brammer and Shostrom, 1960) which may inhibit therapeutic progress.

This situation is compounded because participation in an emotional experience makes it extremely difficult for a person to make precise, objective, unbiased observations (Kubie, 1958). Because of the very nature of his involvement in the experience and his closeness to it, the client is unable to label what he feels easily, much less identify it precisely. He cannot identify the precipitating conditions of his condition easily and finds it difficult to communicate these to the counselor. Kubie elaborates on this in referring to the counselor trainee supervision process; his comments seem to have relevance to counselor and client alike.

> . . . So much of our raw data consists of brief impressions of evanescent, fleeting moments of behavior. They are here and gone in a flash, never to recur, never to be reenacted or relived in exactly the same way. . . . It is this fleeting moment which must be studied. For this purpose it would have to be perceived and recorded and recalled with precision. Yet, we know that during the whole experience the observer himself is emotionally involved. . . . When we are involved emotionally, we are hardly free to make precise, objective observations, to record them accurately, or to recall them without bias. . . . Parents and teachers and psychiatrists have all been dependent for their basic data upon these imperfect and fallible memories of visual and auditory perceptions which are themselves subject to distortion (p. 84).

As possible solutions to the dilemma described by Kubie, two new developments reported by Goldberg (1967) have promise: "(1) The advent of videotape which provides an immediate, accurate, and undistorted recreation of a previously experienced interaction, and (2) the adaptation of stimulated recall methodology, designed to activate a person's ability to introspect about his inner experiences, to the process of . . . therapy. . . ." (p. 2). Both of these developments are used in this study in an attempt to promote client growth.

Kell and Mueller (1966) point out another obstacle to client growth in counseling. Very early in his therapeutic encounters with a counselor, a client presents a picture which is a synthesis of his whole life history expressed in terms of the significant content of his life. The many experiences of the client have been compressed into a few ways in which the client thinks about himself. That is, the client tends

to represent himself in terms of only a few feelings or characteristics about himself. He has, in fact, lost awareness of important distinctions between prior events and perceives them in a global, undifferentiated manner. The client's perception of these events as being similar in character may further lead him to believe that these many different events all influence him in the same manner and that his way of responding to them is the same in every similar circumstance. He loses sight of distinctions between differing events and between his reactions to these events.

Attached to each of these compressed client experiences is a particular affect which has also been compressed. The affect, as well as the experiences, are difficult for the client to regain awareness of. Searching for and grasping these cognitive and affective experiences and expanding them accounts for considerable time in therapy, particularly in the initial stages. Without contact with these experiences, the client's attempts to convey prior emotional experiences to the counselor may take on entirely different meanings--distorted further by lapses of time, client defensive behaviors, and numerous other factors related to client, counselor, or relationship variables. This treatment program was intended not only to assist the client and counselor in regaining contact with experiences, but also to cut through these possible distortions.

Fear of psychological closeness may also contribute a hindrance to client growth in therapy. An approach-avoidance dynamic has been reported in previous investigations, both during the initial stages of therapy (Kell and Mueller, 1966) and throughout the therapeutic process. Past research with the IPR method showed frequent occurrences of the dynamic--the client seemed to both approach and retreat from psychological closeness with his counselor (Kagan, Krathwohl, et al., 1967). The observation was made that while the client and counselor were talking about events external to the counseling relationship they were also having conflicting feelings about the relationship itself. In varying intensities across different client-counselor interactions, four basic affective client experiences seemed nearly universal: hostility, affection, fear of hostility, and fear of affection. Given these fears of closeness, continued expression and exploration of emotion by the client and the counselor in the therapeutic relationship seems quite unlikely without some other assistive technique; previous investigations indicate that simulation films and IPR may be potentially helpful to individuals in dealing with and overcoming these fears.

Basic Client Needs

A similarity between client in-therapy needs and the obstacles to client growth discussed above may be seen. Obstacles to client growth are particularly relevant

for consideration at initial stages of therapy but may deserve attention at later points in the therapeutic process as well. Client needs permeate the entire process of therapy and can be looked at from a number of different perspectives. In this section, they will first be examined as stemming from the obstacles to growth discussed previously. Client needs which are more general and which are referred to in theoretical formulations by Carkhuff, Truax and Berenson will then be briefly described in relation to the purposes of this study.

In order for a client to begin the process of self-exploration and to examine his situation so that a change process can begin, his anxiety about entering counseling needs to be dealt with. This can be done within the context of the client-counselor relationship which begins to be established at the onset of counseling. One counselor set (among others) is proposed by Kell and Borow (1970) as necessary for this relationship to be established:

> . . . As human beings we need to be understood phenomenologically, or subjectively. . . . The need to be understood in this way is heightened in the person seeking help with his emotional problems. At such times he has frightening feelings of apartness which stem from past and present conflict with significant others. Fears of abandonment and isolation are common. . . . Careful listening and sensitive responses by us to these thoughts and feelings of the client help him to feel there is someone who can know and share with him something of how he feels within himself (pp. 11 & 12).

The need to be phenomenologically understood is basic to the establishment of a relationship, and consequently, to the success of counseling. This is not to say that counselor understanding and empathy necessarily resolves the client's concern. It does however, help alleviate some of the client's feelings of helplessness and aloneness, and rouses in him some feelings of hopefulness, of being with someone who understands, and possible thoughts of coping and mastery, rather than despair (Kell and Borow, 1970). From this point, the counselor and the client can continue in attempts to alleviate the client's discomfort and resolve his concern.

The term accurate empathy has been coined by Truax and Carkhuff to describe what is necessary at this and later stages of the counseling relationship. From theoretical formulations of Rogers (1957) and studies by Truax and Carkhuff, accurate empathy has been presumed to be a facilitative dimension in therapeutic relationships (Truax and Carkhuff, 1969 a,b).

According to Truax and Carkhuff (1967):

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

> in a language attuned to the client's current feelings. . . . His responses not only indicate his sensitive understanding of the obvious feelings, but also serve to clarify and expand the client's awareness of his own feelings or experiences (p. 46).

Accurate empathy on the part of the counselor is therefore seen as necessary to client growth and is needed by the client upon entering therapy.

It was mentioned earlier that an obstacle to client growth is the fact that many of the client's prior experiences have been compressed, or compacted, and that the affect associated with each of these experiences has been compressed similarly (Kell and Mueller, 1966). It may be helpful in order for the client and counselor to examine these general and affective experiences, that they be expanded, and in a sense, relived in the therapeutic experience. By perceiving and responding at the most general level possible to the dynamic meaning of the client's previous experiences, the counselor may be able to find the recurring affective theme that pervades the client's verbal material.

> The client then has the most freedom possible to expand his experiences and feelings in the ways that have the most significance to him. As the client begins to expand the associated feelings, the counselor can follow the course of the client's lead as to which experiences have the most meaning for him, the counselor can more effectively track the development of the client's conflicts (Kell and Mueller, 1966, p. 36).

Through this expansion process, the client also is encouraged to undergo a process of self-discovery. The client leads himself to see that the way in which he views

himself within the presenting content represents very basic attitudes that he has toward himself. When the client can perceive these attitudes which he possesses toward himself, he may be able to isolate areas of conflict which produce the discomfort and concerns of the present. The client has a need to expand these compressed experiences in order to look at them as factors contributing to his current concern. One of the tasks of the counselor, therefore, is to assist in this expansion process. The specific methodology used in this treatment program was intended to assist the counselor in helping the client regain contact with the totality of his prior experiences. By reliving, through videotape technology, previously undergone counseling experiences, the client is able to expand and examine his own awareness of that experience. In this way he is able to see how he has coped and dealt with situations in the past and how feelings about events may influence his behavior within a particular experience.

A third obstacle to client growth discussed above was the subjectivity about his concern and himself with which the client enters therapy. The client, in order to accurately examine himself and his problem has need of an "unbiased objectifier," a person who can view the situation relatively objectively (that is, without the client's self-defeating needs) and assist the client in observing, identifying, and labeling the affective components of prior

and present events without bias. With the help of the counselor, an inquirer, and the videotape, the client may be able to see precipitating conditions, reactions to experiences and modes of operation more clearly. This need of a means to help the client in being able to objectively observe and evaluate his situation is fulfilled in this project through the use of videotape and the IPR procedure.

A fourth need which a client brings to therapy and which may prove to be an obstacle if not overcome is that of at least recognition, if not resolution, of the fear of psychological closeness to the counselor. The theory underlying this program of study is a relationship theory of counseling. In this framework the client-counselor relationship is considered a medium in which client concerns can be examined and worked through as well as a potent force in getting at the true concerns with relationships which many college students have. This approach adheres to the concept of a dynamic, interactional process in counseling which is more fully described by Kell and Mueller (1966):

> We have developed our ideas about the ways that clients change in terms of the dynamic consequences of the client-counselor interaction in the relationship. Our constructs reflect both the reciprocal impact of their communication on each other and the lengths to which both participants may go to keep the communication intact so that the counselor may be helpful.

Thus the relationship between client and counselor is important. A part of this relationship is the affective bases from which the participants operate. Clients, as has been observed earlier, come to the counseling setting with basic fears, four of which have been found to be nearly universal: fear of being hostile, fear of being affectionate, fear of receiving hostility and fear of receiving affection. All of these fears in moderation are relatively "normal" and to be expected within the therapeutic situation. The client needs, however, to be able to gain contact with these emotions and not allow them to operate outside the realm of his awareness. The client needs assistance in getting in touch with these fears and in recognizing and dealing with them, for the fear of closeness makes continued expression and exploration of emotion unlikely in the early stages of the counseling relationship (Schauble, 1970).

In this treatment program, it was expected that the methodology outlined would assist both the client and the counselor in discovering and dealing with the above mentioned fears. The so-called "process of approximation" in approaching these interpersonal threats will be described in a subsequent discussion (see page 32).

More generally, however, client needs can also be viewed from the standpoint of what accounts for and what can predict constructive personality change. Many orientations to counseling and therapy have emphasized

the critical nature of counselor and client process variables. Rogers (1957) has proposed six conditions as being "necessary to initiate constructive personality change."

1. Two persons are in psychological contact.
2. The first . . . , the client, is in a state of incongruence, being vulnerable or anxious.
3. The second . . . , the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding is to a minimal degree achieved (pp. 95-96).

From these necessary conditions have evolved further theoretical formulations which have since gathered some evidence as being descriptive of factors which can be facilitative of positive client growth in therapy. Though given different labels at times, counselor variables have included: (1) empathic understanding, (2) positive regard or warmth, (3) genuineness, (4) self-disclosure, (5) specificity of emotional experience, (6) concreteness in problem solving, (7) appropriate confrontation, and (8) interpretation of the immediate helping experience (Carkhuff, 1969 b). Client variables have included: (1) self exploration (Truax and Carkhuff, 1967), (2) owning of feelings, (3) committment to change, (4) differentiation of stimuli, and (5) changing behavior with the helper (Kagan, et al.,

1967, 1969). Constructive client change has been reported when these variables are present at facilitative levels in the counseling setting, and it appears that improved mental health can be facilitated through helping the client and counselor carry out the above behaviors. Of the above client variables, the following are examined in this project: (1) self exploration, (2) owning of feelings, (3) commitment to change, and (4) differentiation of stimuli. As Schauble (1970) states, "Most theoretical schools in counseling and psychotherapy agree that client behaviors which reflect owning of feelings, or discomfort . . . , motivation and committment to change, delineation and clarification of problem areas, and self-exploration are essential ingredients to client progress in a therapy relationship" (pp. 150-151). In this study, another attempt is made to fulfill these client needs and thus facilitate client progress in therapy.

Client Growth

The above discussion serves to illustrate what recent literature in counseling and therapy postulates--that clients typically enter therapy without having access to many basic emotions. Because of client subjective bias, compression of experiences, lapses of time, and other client, counselor, and relationship variables, the client's attempt to convey prior emotional experiences to the

counselor may take on entirely different meanings than those of the original experience (Schauble, 1970). Because of the client's inability to recognize and deal with feelings, the client is anxious and has difficulty coping. He cannot identify and/or experience his feelings nor can he know and understand them. As a result, the client cannot change the behavior they cause--behavior that is dissatisfying to him and which he wishes to change.

There is little disagreement about the statement that the purpose of counseling is to change people's behavior (Kell and Mueller, 1966). In insight therapy behavior change is assumed to come about as a result of client exploration of anxiety laden areas with the counselor. The counseling progresses from a more superficial level of relationship and experience to a deeper level; it moves from a point at which the client and counselor are exploring relatively non-threatening areas to a point where they are dealing with areas of thought and feelings which are frightening to the client. The client becomes progressively more able to deal with these threatening areas. This process of gradual movement to a more in-depth relationship and experience is often referred to in the vernacular as "getting down to gut level."

In his description of the change process which occurs in seven stages, Rogers (1958) pictures the goal of therapy which is reached in the final stage as when

> New feelings are experienced with immediacy and richness of detail, both in the therapeutic relationship and outside. . . . The situation is experienced and interpreted in its newness, not as in the past.

Client growth in counseling, then, is defined as an increasing capacity to gain access to, communicate and fully experience feelings (Schauble, 1970). When the client is able to accomplish this, he is able to see more clearly the behaviors he wishes to change and can be helped to resolve his concerns. Thus the principal task of the counselor is to increase client insight and understanding and help the client experience his feelings in an appropriate way (Howard, Orlinsky and Hill, 1968). The treatment program used here has this as its primary goal.

Basic Experimental Method: Description and Theory

In this section Interpersonal Process Recall and affect simulation are further described and the theory underlying their use is discussed.

Interpersonal Process Recall.--Interpersonal Process Recall (IPR) was developed at Michigan State University by Norman Kagan and his associates as a means of assisting a counselor-in-training to better examine his feelings about himself and his interactions with his clients and thus look at the dynamics of his relationships with his clients (Kagan, Krathwohl, et al., 1967). It has since been used not only with counselor trainees, but also with teachers,

social workers, medical students and clients in therapy The actual use of IPR with a client is as follows. The interaction of a counseling interview is videotaped by a partially hidden or revealed camera of which both the client and counselor are aware. At the conclusion of the interview, an "inquirer" meets with the same client and the videotape of the just completed counseling interview is replayed. Either the client or the inquirer may stop the playback, especially at times when the client recalls specific events occurring at that point in the counseling session. The inquirer then assists the client, through a specific kind of probing, from a relatively neutral frame of reference (see Kagan, Krathwohl, et al., 1967, p. 11), to recall, examine and explore the feelings, thoughts and reactions he was having during the counseling session.

The use of the IPR method provides a maximum of cues, both verbal and non-verbal, to the individual so that the likelihood of a complete reliving of the original experience is increased. The heart of the methodology lies in two dimensions. The first is the immediate videotaped replay of the totality of the counseling session which provides the client with an opportunity to see and hear the entire prior interaction. Second is the introduction of a person especially trained and experienced in helping a subject concentrate and relate his own recalled thoughts and feelings.

While there is some evidence to indicate that the basic IPR method can be a potent tool to accelerate therapy, there is need for a reliable, stringent examination of the method as a therapeutic tool. Many recent studies have examined the effectiveness of IPR as a tool in the training of professional and paraprofessional counselors; some initial investigations were undertaken to examine the impact of IPR on client progress and a more recent study also examined client movement as a result of IPR intervention in the therapy process. In this later study Schauble (1970) evaluated the potency of IPR used in conjunction with another potential method of producing accelerative effects in therapy, affect simulation films. He found significant accelerative effects from the use of IPR and affect simulation films for a group of experimental subject-clients compared with the effects of "traditional" therapy with a group of control subjects. In his conclusions, Schauble states, "With an indication of the initial value of the program, ongoing studies should be initiated which would provide more substantial evidence as to whether or not the technique results in accelerated movement in therapy" (Schauble, 1970). In this study the effects of the application of simulation and IPR to the therapy process are further examined.

Affect Simulation.--Affect simulation was developed out of the observation that the potency of the IPR method for client learning and growth hinged at least partly on the quality of the counseling session (Kagan, Krathwohl, et al.,

1967). The recall of the counseling session seemed to have more effect if the counseling session contained intense client-counselor interaction over matters of concern to the client than if the session consisted of bland exchanges. Recognition of this limitation led to the reasoning that if a client could be helped to focus on his reaction to a series of planned threatening behaviors of another person, he would be better able to know about his own dynamics in the face of these behaviors and obtain valuable feedback about himself which would be useful for both himself and his counselor.

As a result, a series of filmed vignettes was created, and later reproduced on videotape. The vignettes incorporate four dimensions of the approach-avoidance dynamic which seems characteristic of clients, especially at entry into counseling (Kagan, Krathwohl, et al., 1967; Kell and Mueller, 1966). The four emotions portrayed in varying degrees of intensity are hostility, affection, fear of hostility and fear of affection. By examining their reactions to these types of affect, both client and counselor (particularly the client, for purposes of this study) can better know the ways in which they might react to the behaviors, feelings, and actions of the other person in the counseling relationship and everyday interactions. These feelings are typically evidenced by client concerns such as: (1) The counselor might hurt or reject him; (2) The

counselor might make an affectionate, dependent or seductive approach toward him; (3) the client's own hostile impulses toward the counselor might emerge; or (4) The client's own affectionate, dependent or seductive impulses toward the counselor might be expressed or acted out. Unless these feelings are brought out and dealt with, or at least recognized for what they are, the general fear of closeness will not be overcome and continued expression and exploration of emotion is unlikely. As a result, the client's progress in therapy will be limited.

In an effort to accelerate the progress of a client through therapy then, affect simulation films were also used as a means of assisting the individual in examining his own intra- and interpersonal dynamics. The client watched the films and explored his feelings, thoughts and reactions to them with his counselor.

Organization of Treatments: Successive Approximation

The treatment program formulated for this study was designed to accelerate client growth in counseling by taking the client through a series of therapeutic tasks, thereby "successively approximating" the desired goal of client self-exploration and eventually, positive mental health. This series of tasks takes the client from a position of relatively more interpersonal safety (from

the client's perception) to a position of more risk. It moves the client from participation in a simulated, "low key" activity (film simulation) in which his feelings and emotions are stimulated but he is clearly safe to a point where the client is an active participant in the process of dealing with himself and his world in the immediacy of its occurrence.

The program of therapy used in this study represents an attempt to replicate the acceleration of therapy study carried out by Schauble in 1970; it will be seen that the four stages of treatment are similar to the three used previously by Schauble. The following general stages are comprised in the treatment program developed for this study:

1. Simulation Viewing
2. Simulation Video Recall (SVR)
3. Client Recall (ClR)
4. Mutual Recall (MuR)

In the first phase--Simulation Viewing--the client and the counselor watched a series of filmed vignettes together, without being videotaped. The films were designed to simulate various interpersonal stress situations and were intended to provide a beginning means of assisting the client to gain contact with and examine the feelings he was having as he watched the film. During and after the viewing of the vignettes, the counselor and client discussed and explored further the client's reactions to the

vignettes. The counselor, in this phase, made use of some of the questions used by the inquirer (see Appendix F), but was not strictly limited to the inquirer role.

In the second phase--Simulation Video Recall--each client was shown a similar film to that of phase one, but which had a different content. The client was videotaped as he watched the film. The videotape of the client, with the accompanying audio portion of the simulation film, was played back immediately to provide the client and his counselor with what was assumed to be a sample of the client's reactive behavior in an actual emotional stress situation. The examination of this videotape served as the focal point for the ensuing counseling session. In this phase, it was expected that the client would become increasingly more able to identify and deal with simulated emotional confrontation and would become more at ease with his own feelings and behavior. He would become more aware that he and the counselor are both capable of dealing with his emotional stress, and openness and access to feelings would be defined as desirable and attainable goals of the counseling experience (Schauble, 1970). The client is in a relatively "safe" position at this point; he is allowed to look at his reactions without having to be responsible for their impact or comsequences. He is dealing with interpersonal threat, but from a position of relative safety.

In the third phase--Client Recall--the counselor and the client were videotaped while engaged in a regular counseling session. Immediately after completion of the session, the counselor left the room and a third person--the inquirer--conducted a recall session with the client. At this stage, the role of the recall worker, or inquirer, was strictly adhered to, and considered crucial.

During the client recall the inquirer can be very instrumental in the process of assisting the client with self-exploration and examination. Most clients in recall cannot tell certain feelings which they had during the interview (e.g., affection or hostility) directly to their counselor, since he was and still is the object of those feelings. That is, at this stage, many clients would tend to avoid in recall (with their counselors) the very areas they avoided in the counseling interview. A second counselor in the role of inquirer may help the client overcome this behavior by keeping the client's attention focused on the videotape and by limiting discussion to that which had transpired in the counseling session. Clients typically find it easier to tell the second person about their feelings and behaviors with the first person than to tell the first person directly. By trying to remain neutral the inquirer avoids establishing another client-counselor relationship; instead, he keeps the client focused on the feelings or content of the original relationship. In this

way the inquirer seems to help the client move one step closer to achieving concurrent, "here and now" awareness of his affect.

This inquirer-client interaction in the recall process is structured to enable the client to become aware of his behavior in relating to the counselor. The client is provided the opportunity to learn how his feelings originate and develop. He can learn what he likes and dislikes about himself in the counseling interaction. He can also learn to recognize the feelings he has about the counselor and the ways he expects or hopes the counselor will feel and act toward him. Because the client is still not confronting the counselor in this stage (the counselor is observing, with the client's knowledge and consent, from another room, but is not participating) and thus still has minimal responsibility for the consequences of his feelings, the anxiety which normally attends recognizing and examining these feelings is reduced.

In the fourth phase--Mutual Recall--a regular counseling session was again videotaped (as in phase three) and the inquirer entered to conduct a mutual recall with both the counselor and client. The videotape of the just-completed counseling session was replayed, with the counselor remaining in the background initially. As the client began to identify affective material in the videotaped session, the inquirer involved the counselor by inviting him to comment on what he thought was occurring.

As the counselor and the client communicated their reactions more and more during the recall session, the inquirer played a less active role. When, near the end of the recall session, the interaction between the client and the counselor began to move from the "there and then" of the videotaped session to the "here and now" of the recall session, the inquirer found an appropriate time to quite literally withdraw from the session. The client, hopefully, was thus engaged with the counselor in honest, open communication about feelings and reactions. He was starting to experience and label immediate in-relationship feelings and had reached the "working through" stage (Brammer and Shostrom, 1960) where the greatest gains can be made and consolidated.

Thus in the experimental treatment program, it was expected that clients would be taken through a series of four stages designed to successively approximate some types of client behaviors thought to be representative of and conducive to positive mental health.

Overview

In this chapter an introduction to the study was given. The purpose and problem were presented, terms were defined, the need for the study was outlined and general hypotheses and basic assumptions were stated. The theory underlying the approach, including discussion of obstacles to client growth, client needs and how client growth occurs was discussed. The theoretical base for the basic experimental method and organization of treatments was also described.

In Chapter II a review of pertinent literature and research dealing with client movement, problems of assessment of client movement and acceleration of client movement through self-confrontation, use of videotape, stimulated recall and affect simulation will be presented.

The design and methodology of the study, including specific descriptions of treatments and instrumentation will be given in Chapter III and the resulting data will be presented in Chapter IV.

In Chapter V the results, conclusions and implications of the study will be discussed, along with directions for further research.

CHAPTER II

REVIEW OF LITERATURE

Introduction

The review of literature in this chapter will be focused on the following areas relevant to the present study: (1) Client movement; (2) Problems of assessment of client movement; (3) Acceleration of client movement, including the use of self confrontation in general and use of videotape, stimulated recall and affect simulation in particular, and (4) Conclusions and implications of the literature.

Client Movement

Prior to examination of attempts to accelerate client movement in therapy, it is necessary to consider if positive client movement can be brought about at all. Since Eysenck's (1952) classic paper, investigation of the efficacy of counseling has been a major activity of many theorists and practitioners. In spite of these efforts to determine an answer to the question of whether counseling works, the issue has not been entirely resolved. Findings of studies relevant to the problem lend slightly

more support to the conclusion that counseling produces no change in a positive direction (Schauble, 1970).

However, the difficulty in evaluating the effects of therapy is an important factor in the consideration of whether therapy is or is not effective. The two most frequently reported obstacles to satisfactory evaluation of therapy are; (1) the inability of various schools of counseling and psychotherapy to agree clearly upon processes and specific goals, and (2) the inability to put such definitions as exist into operation so as to measure adequately and reliably, whether the goals have been obtained (Stollak, Guerney and Rothberg, 1966). The difficulty of evaluation of therapy, coupled with a lack of agreement of what constitutes adequate examination of therapeutic movement results in the state of relative unknowing experienced by the profession now.

Problems of Assessment of Client Movement

There are two types of criteria by which the impact of therapy on client behavior can be evaluated. They are external criteria, or client behavior outside of the therapy interaction (in situ) and internal criteria, or client behavior within the therapy setting. The use of these two differing types of criteria has typically represented the dichotomy which has resulted from two differing types of interests: examination of how changes took place in therapy, with focus on the interchange between client and

therapist (i.e., the process), and examination of the end point of therapy, with focus on what change took place (i.e., the outcome) (Luborsky, 1959, pp. 320-321).

The client's behavior in his everyday life is typically that which brings him to therapy, and positive change in this behavior is, of course, the purpose of the therapy process. External criteria are therefore important in measuring the effects of therapy. A measurement problem becomes evident when external criteria are used however. The development of sufficiently broad criteria which are at the same time delineated is a difficult task. Criteria should be of "sufficient breadth that they are meaningful and representative of a wide range of functioning and yet, at the same time, circumscribed enough to be measured with reliability" (Zax and Klein, 1960, p. 445). One way of attempting to get around the problem of having limited criteria to use has been to develop implications for wide ranges of functioning from the observations obtained from narrow criteria. An example of this type of research is that done by Tuebor and Powers (1953). Using the number of court appearances following treatment, Tuebor and Powers compared a group of potential juvenile delinquents who had received treatment with a matched control group who had not received treatment. The use of the number of court appearances is certainly a

meaningful criterion for therapy with juvenile delinquents, but a broader range of criteria in this study may have revealed differences obscured by the use of this one criterion measure. Since Tuebor and Powers found no significant differences in their study, the reader is left with the question of whether the treatment, the criterion, or both were ineffective. And when comparisons between results of different studies, where different populations, treatments and designs may have been used are desired, issues of criteria become even more important.

The above mentioned study serves to point out another problem--that of the insufficiency of an individual criterion for attempts to assess the effectiveness of therapy which can be done with a variety of populations. That is, the criterion used in the Tuebor and Powers study, for example, would not be relevant for assessment of therapy done with other groups, such as undergraduate students or married couples.

Attempts to measure broader areas of functioning have been made primarily in institutional settings, where the subject's range of behavior is limited. In these settings multiple, but individually meaningful criteria can be applied. Such dependent variables as the number of times hospitalized patients received electroconvulsive shock, discharge from the hospital (Cowden, Zax, Hague and Tinney, 1956), reports from the prison chaplain, and

return to prison as a parole violator (Fox, 1954) have been used. The lack of a unifying framework in which to integrate these observations for comparisons across different populations results in fragmented results. A variety of behavioral changes are reported, but different changes, usually singular, appear in many different studies. Possible valid measures are reported, but only for specific purposes. It can only be concluded that a satisfactory criterion, set of criteria, or even a conceptual framework in which to evaluate different forms of therapy with different populations has not yet been found.

The notion of using internal criteria, or those based upon a client's in-counseling behavior stems largely from the client-centered approach to therapy. Since the first use of internal criteria, many researchers have refined and specified these criteria, to a point where much recent literature reports their use as measures of client change.

Data provided by Rogers and Dymond in 1954 indicated that the primary changes occurring during client-centered therapy consisted of changes in client self concept rather than changes in overt or visible behavior. This raises the question of whether therapy can be justified by the argument that in spite of lack of observable behavior change, therapy results in a more realistic and self-satisfying self concept. The issue is further complicated by the

fact that Rogers' and Dymond's statements are not substantiated by the results of their research. No significant differences between behavior before and after therapy for the treatment group were found when observations and reports by friends of the clients were examined, nor were differences found in change in self concept between patients receiving therapy and those who did not. Although Dymond (1955) later stated that positive adjustment changes are not identical to changes which took place in therapy, and are characterized by "a strengthening of neurotic defenses and a denial of the need for help," neither the statement that changes in self concept occur nor the statement that changes which do occur in untreated clients are different than those for treated clients are substantiated yet and still deserve further attention.

Although the Q-sort instrument has been widely used for the type of studies done by Rogers and Dymond (e.g., Butler and Haigh, 1954; Cartwright, 1959; Rosenthal, 1955; Dymond, 1953; Cartwright and Roth, 1957; Butler, 1960; and Lesser, 1961) a number of other instruments have been developed which were intended to serve as outcome criteria through client feedback. Such instruments as the Client Post-Therapy Scale (Tucker, 1953), the Therapy Session Report (Orlinsky and Howard, 1968), a self-rating scale (Fiedler, 1949) and a Personal Orientation Inventory (Shostrom, 1968) purport to provide criteria by which to

assess client progress in therapy. This type of measure does have shortcomings, however, since the extent to which evaluative approaches depend on client feedback may determine the reliability of the assessment (Schauble, 1970). Cowen and Combs (1950) further state that when a client enters treatment he feels bound to justify seeking help and when terminating counseling he feels obligated to prove to himself and to the therapist that he has indeed made movement. This "hello-goodbye" effect (Hathaway, 1948) may be reflected in any report of reduction in discomfort or of positive growth. The limitations of the use of client reports of therapeutic outcome are aptly summarized by Zax and Klein (1960) in the following statement:

> Unfortunately, on close analysis, this deceptively simple procedure is seen to be fraught with serious pitfalls. Standards for such assessments will vary both among clients and between client and researcher; clients will vary in the extent to which they can report what they feel; the reports of many clients will be subject to many distortions; finally, the client's evaluation of his condition may be affected by conscious or semi-conscious motives (p. 443).

In addition, this type of measure may produce spurious results since, when an active control group is used, reporting individuals may be insensitive to treatment differences and rate higher than what their actual experiences warrant (Porter, 1972).

It can be seen that another, or additional method of assessment is necessary. One promising approach to the

evaluation of change in behavior in counseling and therapy is the rating of behavior, usually verbal, by outside observers. This method has been shown to be potentially effective, especially in the assessment of therapist behavior considered essential to effective counseling and therapy; considerable research has shown, for example, that variables such as therapist empathy, positive regard, genuineness and concreteness can be reliably rated and consistently related to positive change in the client (Truax and Carkhuff, 1967; Carkhuff and Berenson, 1967).

The concept of self exploration has been the most used of the many dimensions upon which ratings of client behavior are made. One reason for this seems to be the fact that a number of research studies tend to verify the significance for outcome of the concept of self exploration. Wagstaff, Rice and Butler (1960), for example, reported that patients with successful outcomes in therapy (client-centered) tended to explore themselves more in the course of therapy than did patients who could be classified as therapeutic failures. Several other examinations of the degree of client self exploration in client-centered therapy further indicated that more successful clients increasingly explored their problems as therapy proceeded, while less successful ones tended to decrease in the exploration of their problems (Steele, 1948; Seeman, 1949).

The Depth of Intrapersonal Exploration Scale, developed by Truax and Carkhuff (1964) and later revised (Carkhuff and Berenson, 1967) has been found to be a reliable and promising research instrument. However, it still remains somewhat crude and has been criticized on the grounds that it is a global measure of behavior, derived from a single (client-centered) therapeutic approach; it has also been used primarily by researchers disposed toward client-centered techniques.

Kagan et al. (1967) have proposed a possible solution to the problem of shortcomings of the Depth of Intrapersonal Exploration Scale by devising a set of outcome criteria to be used in the ongoing counseling process. These criteria possess the following characteristics:

1. They are not identified with a particular counseling theory.
2. They are operationally definable and thus have research utility.
3. They do not necessarily represent discreet entities, i.e., a client may display two or more of the characteristics at a given moment.
4. They are not intended to describe everything that goes on in the counseling relationship.

The intent behind this approach was to develop a set of criteria for client change which was acceptable to most theoretical positions without defining all client change. Representative of some of the most obvious tasks a client experiences in successfully moving through the counseling process, component elements are:

1. The client owns his discomfort.
2. The client commits himself to change.
3. The client differentiates stimuli.
4. The client behaves differently.

Kagan and his associates operationalized these criteria in a rating scale--The Characteristics of Client Growth Scales (Kagan, Krathwohl, et al., 1967)--on which independent judges rate client behavior in taped sessions. The scale has been found useful in scanning client movement in a variety of individual counseling situations (Resnikoff, Schauble and Kagan, 1969; Schauble, 1968; Kagan, Krathwohl, et al., 1967).

Since it is reasonable to assert that the client establishes a relationship with his therapist which is similar to those which he forms with other people in his environment (in that he makes use of the same dynamics), it would follow that observable behavior change in therapy would be a valuable source of information for evaluating the success of the therapy process. In spite of the ambiguity surrounding research findings resulting from the use of external criteria, it would seem that both internal or "process" measures and external criterion measures have value for an attempt to evaluate the influence of counseling or therapy on client movement.

Acceleration of Client Movement

The following consideration of the literature is devoted to ways of accelerating client movement through

specific techniques. The concept of self confrontation is considered and uses of videotape techniques, specifically Kagan's Interpersonal Process Recall (Kagan, Krathwohl, et al., 1967) method are reviewed. Consideration is also given to previous uses of stimulated recall and affect simulation, and conclusions and implications of the literature are cited.

Self Confrontation

The use of recording as a medium for client self examination and confrontation is certainly not new. Rogers used recordings to analyze and teach non-directive psychotherapy as early as 1942 and Covner (1942a, 1942b, 1944a, 1944b) also reported the use of self confrontation techniques in counseling practice and research.

Freed (1948) however, seems to have been the first American therapist to report the use of sound recordings as an integral part of the therapy process. By playing each recording to the client immediately after they were made, a discussion of the client's reaction to this self confrontation was initiated. This technique was found to be particularly effective in play therapy with children and in the treatment of character disorders. The particular advantage of this type of self confrontation technique for treating the latter (character disorders) seemed to be because of the difficulty the therapist often encounters

with usual techniques in verbalizing back to the client the subtle nuances of the manner in which the client behaves and relates, rather than the content of the material.

In 1958, Cameron also reported success in long-term group psychotherapy through the use of repeated audio-tape playback. He noted that both patients and therapists were better able to perceive and understand meanings in communications which they could not detect during the first playback of the material. One apparent result of this process was that group members were unable to defend against repeated self confrontation experiences.

Subsequent to initial uses of audiotapes in therapy, some uses of visual images were also made. Miskimins and Braucht (1971) report that Carrere (1954, 1955) made the initial use of self confrontation techniques in the treatment of alcoholics. They further state that a significant increase in the rate of success over standard methods was shown by Carrere (1958). "Self image experiences" by psychotic patients and changes in their psychotic states are also reported by Cornelison and Arsenian (1960), who photographed patients and then observed and discussed their responses with them. Improvement on a variety of measures, including personal appearance and projective techniques was noted. In spite of obvious shortcomings in control and design, the authors were optimistic about the possibilities of the use of this technique in therapy.

Cornelison (1966), in commenting on his further use of self confrontive techniques with alcoholics, psychotics, and individuals with psychosomatic disorders, states, "Without any qualification I would say that in nearly every instance there has been some positive response, perhaps as great or greater than you usually get in one-to-one therapy."

The advent of videotape provided an even more potentially effective means of using self investigation and confrontation in counseling and therapy, but its appearance raises a question of whether seeing one's own behavior in therapy via the videotape would evoke feelings of threat or extreme anxiety in the client. This result may be something akin to the "psychic shock" reactions observed by Cornelison and Arsenian (1960) when their hospitalized patients were confronted with motion pictures and still photographs of themselves. A few practitioners have noted increases in the level of anxiety of patients on viewing a tape of themselves. Moore, et al., (1965) noted this with psychiatric patients and Geertsma and Reivich (1965) with a psychiatric outpatient. Poling (1968), however, did not find this to be the case. He investigated the impact of videotaping under three different conditions, finding that while counselors who participated in the project did not perceive much difference in the three interview environments used for videotaping,

the clients involved actually viewed the environments as less threatening and more conducive to counseling than did their counselors.

> . . . For each of the situations, counselees rated the interview environments more positively than did the counselors. Statistical significance was observed in each of the comparisons which tended to support the conclusion that counselees appeared to have been less threatened by the videotaping of counseling interviews than counselors (p. 352).

While the different environments were not compared with a no-videotape control in the Poling study, the results of the study seem to confirm the author's conclusion that when counseling was conducted "in a professional manner" the physical environment had little effect on the degree of success of the interview. Further support for this conclusion is given by the research conducted by Kagan, Krathwohl, et al. (1967), in which little difference has been observed in the behavior or anxiety level of clients in sessions in which they are videotaped as compared to sessions in which they are not. Thus, it appears that environments containing videotape equipment are not perceived as particularly threatening or anxiety-provoking to clients and that clients are, in fact, eager to view their videotapes (Ryan, 1969).

Use of Videotape

In the majority of studies of videotape media as an accelerative therapeutic tool, the client has been unable to view the videotape immediately after the completion of

the counseling session. In the few studies in which clients were able to see themselves on the videotape after the counseling session (e.g., Schmeding, 1962; Pascal, 1967 and Walz and Johnston, 1963) with one exception (Schauble, 1970), the effects of this practice were not examined; the writers did not look at the influence which the viewing of the videotapes had on client behavior. Ryan (1969), however, does indicate that clients are eager to view their videotapes and that the client, counselor-in-training and supervisor should work together as a team in analyzing the session. Yet, he does not explore the possibility of various roles or behaviors for each of the participants in this type of experience, nor does he speak to the potential impact of this procedure on client behavior.

One structured approach to the use of all of the participants in the counselor training process was taken by Goldberg (1967). He used the approach developed by Kagan, Krathwohl, et al. (1967), in which the counselor-trainee was able to observe the client's "stimulated recall" of the completed counseling session and thus maximize his feedback about the client's perceptions of the therapy session. At a later session, the client, counselor and supervisor engaged in a "mutual recall" where the client and counselor were able to share their perceptions more directly. Goldberg found that his training program resulted in a significantly improved performance for counselor trainees when compared with a control group of

trainees who received intensive traditional supervision. Although trainees in both groups were rated as more affective, understanding, specific, exploratory and effective as a result of the project, treatment group trainees evidenced significantly greater positive behavior change than control group counselors.

Other counselor training programs in which videotape methods were used have shown similarly positive results. In a series of related research projects (Dendy, 1971; Scharf, 1971; Archer, 1971), evidence favoring the use of videotape and Kagan's Interpersonal Process Recall technique for the training of residence hall advisors as paraprofessional helpers was found. Similarly, some studies conducted on the use of IPR as a training tool for master's level counseling students (Spivack, 1970) and for prison counselors (Grzegorek, 1971) indicated that the IPR method with videotape usage produced significantly higher performance than more traditional types of training which taught similar subject matter in a more didactic manner. However, in a study conducted by Heiserman (1971) in which juvenile court workers were trained in interpersonal communication skills, results favoring an experiential-videotape training program over a cognitive-classroom program were not found.

Many studies of counselor training techniques have dealt specifically with the supervision process. Suess (1966) and Schiff and Reivich (1964) indicate the apparent

value of videotape for understanding counselor and client dynamics. The record of non-verbal communication within the interview was especially important for supervisors, since this is not available through the traditional techniques of notes or audiotapes. Another advantage to the use of videotapes is pointed out by Gruenberg, Liston and Wayne (1969), viz., supervision becomes more complete and honest, providing the necessary feedback with which to determine the progress of the patient and therapist. They go on to cite specific advantages to the use of videotape over traditional supervisory techniques: (1) The supervisor has a genuine source of encounter with the patient. He is able to obtain specific, first-hand knowledge of the client; and (2) The therapist trainee need not concern himself with taking notes, since the videotape provides a complete record of the session for supervision. The authors claim a twofold advantage to this. Both the therapist's concern over completeness of notes, and the client's concern (brought on by the therapist's notetaking) over the amount of interest the therapist has in him are alleviated. Finally, Gruenberg, et al. indicate that the pace of therapy is increased with the use of videotape.

> The cessation and resumption of videotaping were clearly related to the effectiveness of therapeutic activity. Succinctly stated, when one is under intense scrutiny, whether it be in doing psychotherapy or surgery, it is reasonable to expect a more intense investment of attention to the problem at hand (p. 104).

It could be expected that this statement holds true for the client as well as the therapist. That is, if the client were aware that he were under "intense scrutiny," his "performance" as a client might be improved.

It also appears that clients may experience other gains in therapy, just as counselors appear to do as a result of videotape application. Two separate studies (Landsman and Lane, 1963; Walz and Johnston, 1963) have suggested that counselors-in-training gained new insights and greater self-awareness as a result of viewing a videotape replay of their counseling behavior, although no evidence was provided supporting the notion that these insights were translated into new or effective counseling behaviors. However, it seems logical to expect that if counselors can gain insight and self awareness from watching their sessions on videotape, clients would be able to obtain similar gains.

Yet, only a few studies have examined directly the therapeutic potential of videotape on client movement in therapy. Moore, Chenell and West (1965) found that patients who were allowed to see themselves on videotapes made of counseling sessions over a period of several weeks made more rapid changes in the "direction of health" than did patients who were videotaped but who did not see themselves. Similarly, Paul (1965) and Geertsma and Reivich (1965) report on the technique of exposing the patient to videotapes of previous behavior. These studies seem to lack

adequate controls, however, and did not make maximum use of the videotape as a therapeutic tool. In most cases videotapes have been made and provided to the client merely for him to view. Few attempts have been made to use videotape methods as a way to assist a client examine the dynamics underlying his behavior.

In a series of studies by Kagan, et al., however, there were some indications that by applying a structured approach to the examination of the videotape, accelerated movement in therapy could occur (Kagan, Krathwohl, et al., 1967; Kagan, Krathwohl and Miller, 1963; Resnikoff, Kagan and Schauble, 1970). In these studies and in a subsequent investigation by Schauble (1970), a structured method of stimulation of client recall of events in an immediately preceding counseling session was found to increase positive client movement in therapy.

Stimulated Recall in Counseling and Therapy--Kagan's IPR

The Interpersonal Process Recall (IPR) method developed by Kagan et al. (1963, 1967, 1969) makes use of the technique of stimulated recall by videotape within a structured approach. The IPR technique was derived from Bloom's (1954) use of stimulated recall as a means of examining the thought processes of students via audiotapes, as well as from Nielson's (1962) investigation of perceptual change through self-confrontation.

The actual use of IPR is as follows: During a counseling interview the interaction is videotaped by a partially hidden camera of which both the client and counselor are aware. At the conclusion of the interview a "recaller" meets with the same client and replays the videotape of the just completed counseling session. Either the recaller or the client may stop the playback by means of a remote switch at points which seem pertinent. The recall worker then assists the client, through gentle probing from a relatively neutral frame of reference, to recall, examine and explore the feelings, thoughts and reactions he was having during the counseling session.

The use of the IPR method allows for the provision of maximum cues, both verbal and non-verbal, to the individual so that the likelihood of a complete reliving of the original experience will be increased. The heart of the methodology lies in two dimensions: the immediate videotape replay and a person especially trained and experienced in helping a person concentrate and relate his recalled thoughts and feelings (Archer, et al., 1971).

A special value of the IPR technique seems to be that it contains a clear formulation of an approach in which the videotape of the client's own in-therapy behavior serves as the stimulus for client investigation of the dynamics underlying that behavior (Schauble, 1970). Through the recall process, both client and counselor seem to gain a great deal of understanding of the nature of the client's problems and of the client's interpersonal relationships,

the latter in particular through the observation of the kind of interpersonal relationship the client has established with the counselor. The counselor is able to observe the client's projections, fears and aspirations about him (the counselor), thus better understanding the client's interpersonal behavior and some of the more central qualities of the client's presenting problem. Similarly, the client begins to understand his own general perceptions and reactions to people by observing the way in which he interacted with the counselor.

Kagan and his associates conducted intensive case studies using the IPR approach, but also carried out controlled studies (Kagan, Krathwohl, et al., 1967) which led them to two general conclusions:

1. When IPR is introduced as an intervention in the counseling process, client growth can be accelerated, but only when the counselor is actively involved in the recall process. In two studies examining the effect of IPR on counseling with prison inmates, it was observed that unless the counselor was a participant in the recall process through a "mutual recall" method, clients did not evidence growth in therapy in spite of there being much apparent productivity in the sessions.

2. Different variations of IPR intervention may be appropriate, based on the functioning level of the therapist. In a study comparing the regular IPR session for two counselors, the results indicated that the higher

functioning counselor (who was more effective than the other on all criteria for each method of treatment) benefitted more from the regular IPR than the mutual IPR. For the lower functioning counselor these results were reversed. The writers concluded:

> The IPR procedure provides the client with insights into his interpersonal behavior but it is necessary that the counselor be able to integrate these insights into his ongoing relationship with the client if growth is to be accelerated. It would appear that the more competent counselors under such conditions, gain new understanding from studying the session between the interrogator and his client, and gain less from taking part in the interrogation. The less competent therapist, on the other hand, may either not understand the dynamics uncovered in recall or may not be able to implement them, thus frustrating the client's new understandings--perhaps even retarding client growth (pp. 319-320).

Kagan et al. go on to state that the less competent counselor becomes more effective with his client by participating directly in the recall session, where the presence of the recaller may serve to reduce the anxiety of the counselor so that he becomes more comfortable in dealing directly with the interpersonal dynamics and conflicts between his client and himself.

Other research has supported this conclusion. Piaget, Berenson and Carkhuff (1967) have indicated that counselors functioning at low levels of facilitation have a negative effect on well motivated clients. That is, clients who attempt to deal with interpersonal dynamics within the therapy relationship receive negative

reinforcement from low functioning counselors to the extent that such positive client activity in therapy eventually disappears.

Taking counselor involvement and functioning level of counselors into account, preliminary evidence indicates that the use of stimulated recall with videotape can be an effective influence in accelerating client growth in therapy. There is further evidence for this statement.

Schauble (1970) has carried out a major study of the use of IPR and affect simulation as an accelerative technique for client growth in therapy, the purpose of which was to investigate the effects of affect simulation films together with stimulated recall on client movement in counseling. He compared the effects of IPR and affect simulation treatment with more traditional counseling methods for two groups on a variety of measures including audiotape ratings of client in-therapy behavior, the Tennessee Self Concept Scale, the Wisconsin Relationship Orientation Scale and the Therapy Session Report. Since the Schauble study is being replicated with modifications in the present study, it will be discussed in some detail here.

In the Schauble study, a treatment program similar to that used in the present study was used, namely a three-stage treatment program in which both affect simulation and Interpersonal Process Recall were incorporated as a method

to accelerate client movement in therapy. In the first phase, the client was videotaped while watching an affect simulation film--a film designed to stimulate and elicit emotional reactions from the client. This videotape was played back and the client's videotaped behavior served as the focus for the ensuing counseling session. In this way the client could look at his emotional reactions from a position of relative personal safety. That is, he did not have to be responsible for the impact and consequences of his reactions. In the second phase, client and counselor were videotaped while conducting a counseling session, and during its replay, a trained recall worker conducted an IPR session with the client while the counselor observed through a one-way mirror. After the recall session the client and counselor resumed their counseling session, incorporating insights gained from the recall. In the third phase of the Schauble study, both client and counselor viewed a replay of the counseling session together, while the recall worker encouraged them to share their feelings as they occurred in the original counseling session. As counselor and client communication about their feelings and reactions increased, the recaller played a progressively less active role. When the interaction between the client and counselor shifted from a focus on the videotape to the immediacy of the recall session, the recaller left the room and counselor and client continued

in the therapy session. While both treatment and control group therapy focused on effective client/counselor interaction and communication, no IPR interventions were used for the control group. In this control, or traditional counseling group, the therapists concentrated on client/counselor interaction in an attempt to help the client achieve greater self awareness and understanding of his own dynamics.

Twelve female undergraduates were used as clients for the Schauble study. All had requested personal counseling from the university counseling center and had agreed to participate in the research. The two therapists were pre-doctoral interns at the counseling center, both of whom had had training in both IPR techniques and in traditional counseling methods. Both therapists were also rated on scales measuring facilitative behavior in therapy and found to be functioning above or near the 3.0 level across dimensions on a five point scale where a rating of 3.0 is considered the minimum level of counselor performance for client growth to occur.

Clients were randomly assigned to therapist and treatment groups and each interview for both groups was audiorecorded for subsequent rating by judges. Ratings of the initial counseling sessions served as a pre-measure in Schauble's design, and analysis of these initial ratings indicated no significant differences between groups on any

of the rated dimensions, suggesting that the treatment groups were equivalent in their initial level of functioning as rated by judges.

The judges rated client functioning on four dimensions of client behavior in therapy which were considered to be characteristic of client growth: Owning of Feelings (OF), Committment to Change (CH), Differentiation of Stimuli (DS) and Depth of Self Exploration (DX). Ratings of the sixth and final session served as a post measure of client functioning on these criteria.

In addition to the ratings, the Tennessee Self Concept Scale and the Wisconsin Relationship Orientation Scale were used as pre-to post-treatment measures of client growth (applied before and after treatment), and both clients and therapists completed a shortened form of the Therapy Session Report (TSR) immediately after each session.

Analyses of pre-to post-therapy changes in client behavior during therapy were carried out on each of the Characteristics of Client Growth Scales dimensions. Change scores for the two groups were significantly different at the .05 level in favor of the IPR group. After treatment the clients in the IPR treatment group were rated higher on the OF, CH, Ds, and DX dimensions than at the beginning of treatment. No differences were found for the traditional

treatment group, pre- to post-treatment. Analysis of variance of change scores between groups also indicated significant differences (.05 level) in the hypothesized direction on each of the client growth dimensions.

No significant differences were found on the WROS through analyses of pre to post changes in the Schauble study, but change scores between groups were found to be significant and favored the experimental (IPR) treatment. Differences in client perceptions of treatment as measured by the TSR were found on only two of the six dimensions when pre to post changes were analyzed. Significant changes were noted on the dimensions of client feelings about coming to the session and client feelings about progress made in the session. In both cases, changes were noted only for the IPR treatment group, with significant between group differences on change scores. With regard to therapist perception of treatment, a change score difference was found on only one dimension: therapist looking forward to coming to the session. Finally, a descriptive analysis of Tennessee Self Concept Scale scores provided little indication of any meaningful change in self concept; change score differences on all dimensions were evenly divided between groups.

Schauble concludes as follows:

> The analysis of data suggests that the IPR treatment had a significant accelerating effect on client movement in therapy, as rated by independent judges. Clients in the IPR group had a greater positive

> difference in the degree to which they felt able to relate to their therapist, when compared with the traditional counseling group. Clients in the IPR group had more positive feelings about coming to their treatment sessions and about the progress that was made within these sessions. Therapists also were found to look forward more positively to the IPR treatment sessions than the traditional treatment sessions (abstract).

It is apparent that significant accelerative effects in therapy were produced by the application of the IPR and affect simulation techniques in the Schauble study. Most therapeutic changes, however, were observed on process dimensions and only a few effects were noted on the Therapy Session Report. The Schauble study provided implications for the directions which need to be taken in the development of adequate criteria by which to measure the effects of therapy, and further research on the use of IPR as an accelerative tool in therapy is needed.

Another study was conducted by Hartson (1971) who used IPR in group work as a training method for three specific group communication skills, namely, self introspection, self disclosure and adequate responding. Hartson compared the IPR process with a traditional T-group model in an attempt to determine the relative effectiveness of each in reaching these goals for the group members. Two groups each of two different types were compared: (1) IPR groups consisting of four two-hour sessions of IPR replay and interrogation followed by two two-hour sessions of open group communication which were video- and audiotaped for

assessment, and (2) growth and development groups consisting of four two-hour sessions of T-group interaction focusing on here-and-now communication, with two two-hour sessions of open communication which were video- and audiotaped for assessment. Each treatment program consisted of two types of subjects--those randomly assigned from a YMCA population requesting a group experience and those randomly assigned from a college student population who had requested a group experience.

Two assessment procedures were used: (1) Individual tests of self-disclosure, acceptance of self, self-rated social behavior, group readiness, satisfaction with the group experience and self-disclosure in the group process, and (2) total group communication assessments using a panel of judges who rated videotaped samples of group communication, and Hill's Interaction Matrix Technique used to analyze the frequencies of verbal statements in interaction categories.

Using an Analysis of Variance Technique for pre- and post tests, difference scores, and rating of participant's behavior, and a Chi Square procedure for analysis of the Hill's Interaction Matrix Technique which was used to assess the frequencies of verbal statements in various categories of interactions, Hartson found the IPR groups to be significantly higher on the variables of self disclosure and group readiness. He also found members in the IPR group to be judged significantly higher on the videotaped samples on communication skills and on group assessment

of therapeutic verbal communication. It was observed that a group leader who is enthusiastic about the use of videotape as a group technique will have a greater impact upon the group members. The study seemed to support the use of IPR as a pre-group training process for group communication skills and for enhancement of group members' readiness to enter into various categories of group communication. It also seemed to indicate that the IPR method, when used in a group situation, can be an effective technique for enhancing the group process, especially when specific goals for the group process are defined.

Simulation in Counseling

Simulation has been used successfully as a training technique for many years, especially in industry and the armed forces (Kersh, 1965). A distinct advantage to its use in these fields has been to avoid damage to equipment or danger to human lives. It has not been until recently, however, that simulation has been considered and adopted as a technique for education and the social sciences.

Greenlaw, Herron and Randon (1962) have spoken about the general benefits of simulation, indicating that through its use time is condensed, understanding of decision-making processes is enhanced, and analytic skills are sharpened through immediate observation by the participants of the results of their decision. Since both clients

and counselors make crucial decisions which are loaded with implications for the future, these benefits would seem to apply to individual needs in counseling and therapy as well. If it is assumed that at least part of a client's coping difficulty has to do with his lack of ability to make appropriate decisions and to take action on them, or with his lack of confidence in his ability, the use of a simulated situation wherein a client can make and examine various behavioral responses without fear of potential disastrous consequences would appear beneficial.

Simulation research has been carried out in the field of teacher education. Simulation has been used to train teachers to more correctly assess each child's functioning level (Utsey, Wallen and Beldin, 1966), to develop referential categories in which to view different behaviors (Wallen, 1966) and to evaluate the impact of individual or innovative approaches on the teaching process (Fattus, 1965). The fact that each of these aims is interchangeable with those of counselor educators is exemplified in the adoption by Delaney (1969) of a proposal for developing the simulation approach in counselor education. He indicates that a number of conclusions are justified on the basis of research to date:

1. Simulation is justified as an instructional technique.

2. The use of a television monitor for stimulus presentation is appropriate.
3. Realism is not a primary requirement for transfer of learning.
4. Simulation positively affects actual performance.
5. Simulation provides economy of time and reduces long term expense.
6. The application of simulation techniques to counselor education has been shown to be feasible and effective.

Delaney's conclusions are derived from the notion that what is effective in teacher education applies to counselor education as well. And while the rationale for the use of simulation in counseling and therapy training programs is present, research into the development and use of simulation techniques for the profession is quite sparse.

In one of the few attempts to provide research evidence, Bierd and Standish (1964) found encouraging results from a project in which audio recordings as simulation stimuli were used. The writers used a simulated environment to train practicum student counselors to discriminate between cognitive and affective responses and then to use counselor response leads to facilitate more affective behavior in clients. The results indicated that the experimental groups demonstrated a significant

performance gain over the control group, as well as differences between the experimental and control groups in post-training interview performance.

If the use of audio simulation evidences positive results, a further question might involve what the application of film or other video techniques could add. Logui, Zenner and Gohman (1968) attempted to evaluate the influence of videotape on the job interview situation, but obtained confusing results. Using a programmed materials group, a programmed materials with videotape group and a control group, each composed of neuropsychiatric in-patients, the authors found results which did not substantiate their hypotheses. The results did not indicate that the programmed materials or materials with videotape facilitated performance in the job interview situation. In fact, the non-significant trend favored the control group. One of the methodological weaknesses of this study was the failure of the researchers to provide more than one simulated interview and viewing of the videotape for the subjects; the single video session in this study may have done more harm than good because, suggest the authors, the self-confronting nature of the videotape produces anxiety.

There is little doubt that simulated situations can produce anxiety in some clients. Earlier in this chapter it was observed that while there is concern among some writers as to whether exposure to the self image can have a

deleterious effect on the client in therapy, this seldom seems to be the case. Client anxiety can be raised by self confrontation, but there is some evidence to suggest that this can be of positive value; client behavior that relates to the client's problem area is stimulated and can thus be dealt with in the therapy situation (Danish and Kagan, 1969; Schauble, 1970).

Conclusions and Implications of the Literature

Despite a lack of controlled, definitive research in many areas of counseling and therapy, a number of implications emerge from a review of those areas related to the acceleration of client growth.

It appears that there are few appropriate or satisfactory criteria or dimensions which accurately reveal the effect of techniques designed to accelerate client growth in therapy. Rogers' work has precipitated the use and investigation of some internal or "process" dimensions which seem to have some value for counseling and therapy research. While there are three potential sources of this process data, the client, the counselor, or an independent observer, the most promising source appears to be the independent observer (Truax and Carkhuff, 1967; Carkhuff and Berenson, 1967). Reliable and useful scales have been developed from several dimensions of desirable in-therapy behavior including

client self exploration (Truax and Carkhuff, 1967), owning of discomfort, committment to change and differentiation of stimuli (Kagan, Krathwohl, et al., 1967; Schauble, 1967, 1970). While this type of process criterion seems more stable and generalizable, its development is rather recent, and it has not been used with any great consistency to date.

One promising way to enhance client growth seems to be by applying videotape and simulation techniques to the therapy process. While these techniques have been used primarily for counselor or helper training since their development, preliminary research evidence indicates that some benefits may accrue to clients in therapy as a result of the application of videotape methodologies and affect simulation (Kagan, Krathwohl, et al., 1967; Schauble, 1970). A technique which clearly maximizes client participation and feedback has been developed (Kagan, Krathwohl, et al., 1967; Resnikoff, Kagan and Schauble, 1970; Schauble, 1970) and has been shown, albeit on a small scale, to result in significantly accelerated client growth (Schauble, 1970).

If the IPR method with videotape increases feedback to the client about his behavior in an interaction, and if simulation experiences provide an opportunity for stimulating a variety of emotional reactions in the client (Cornelison and Arsenian, 1960; Small, 1967), both of

which appear likely (Schauble, 1970), can the use of these procedures when incorporated into a therapeutic interaction, result in a significantly greater benefit to clients than the use of more traditional methods? Preliminary evidence suggests that there is an affirmative answer to this question.

Summary

Primarily because of the lack of development of adequate criteria, there is little controlled research in the area of evaluation of counseling and therapy. When external criteria have been used, difficulties with comparisons of results across different studies have been encountered, at least in part because of an inadequate system of comparison. Although some internal criteria have been used in previous research, they are still in the process of being further developed. Definitions of processes and goals are still being sought, and operationalization of those that have been formulated has been difficult. Some rating scales have been developed, however, which appear to have value for examining dimensions of client behavior which seem essential to client change in therapy. They include the client behaviors of owning of feelings, differentiation of stimuli, committment to change and self exploration.

A variety of approaches have been adopted in attempts to accelerate the influence of therapy on client growth,

each with a seemingly sound theoretical rationale. Little consistent or conclusive empirical support has been seen, however, for the statement that the new approach is any more effective than the usual one-to-one therapy. Videotape and simulation appear to have considerable potential for positively influencing client growth, but most relevant research with these methods has been on their use in counselor education. The one method that has been found to have direct application for counseling and therapy is Interpersonal Process Recall (Kagan, Krathwohl, et al., 1967; Resnikoff, Kagan and Schauble, 1970; Kagan, Krathwohl and Miller, 1963; Schauble, 1970).

In this study scales of client in-therapy behavior, client reports and external criteria have been used to examine the effects of an IPR and affect simulation technique in counseling and therapy. Previous research has indicated that this intervention technique has potential for accelerating growth in therapy, but further validation is needed.

CHAPTER III

DESIGN AND METHODOLOGY

Experimental Design

An experimental research design was used for this study to test the hypotheses posited earlier, namely that: (1) Clients who receive counseling with IPR and affect simulation will evidence higher ratings on dimensions of OF, DS, CCh and DX than will clients who receive traditional counseling, (2) Clients who are counseled with IPR and affect simulation will be more satisfied with their therapy sessions than clients who are counseled with traditional methods, (3) Clients who receive counseling with IPR and affect simulation will reveal less discrepancies between their self concept, goal self concept and the way they think others see them than clients who receive traditional counseling, and (4) Peers of clients will report more positive behavior changes for clients who receive IPR counseling than for clients who receive counseling without IPR. Comparisons between groups on client interview behavior, self reports, self concept assessment and peer reports are permitted by the design, which is presented pictorially in Figure 1.

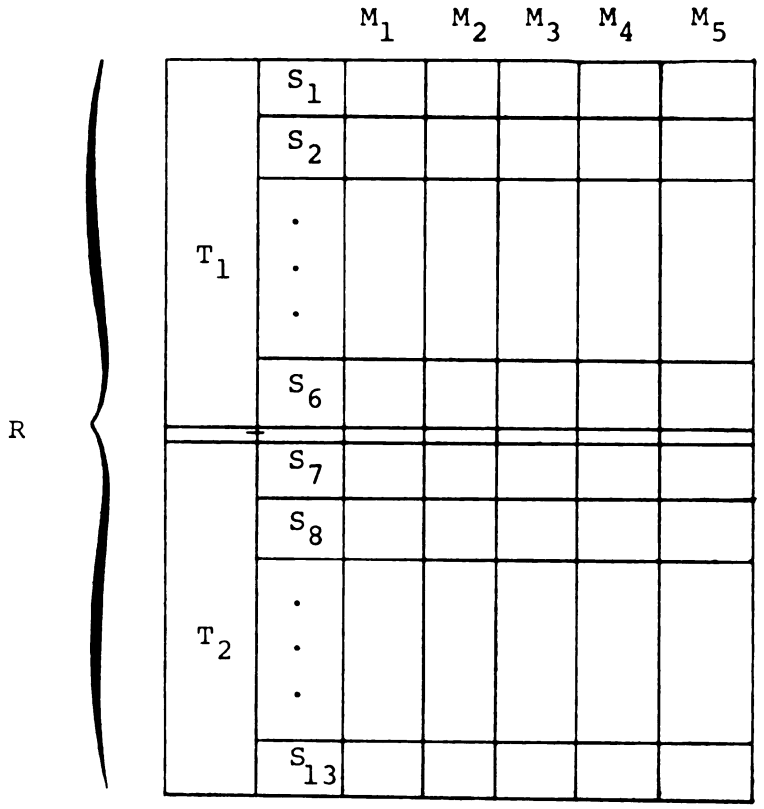

Figure 1.--Pictorial Representation of the Multivariate Analysis of Covariance Design*

*Rated level of Emphatic Understanding of therapists constitutes the Covariable.

R = Random Assignment
S = Subject
T_1= Experimental treatment group (individual counseling with IPR and Affect Simulation)
T_2= Treatment-control group (Individual counseling)
M_1= Level of client functioning -- Characteristics of Client Growth Scales
M_2= Level of client functioning -- Depth of Self Exploration
M_3= Therapy Session Report -- Total Score
M_4= Miskimins Self-Goal-Other Discrepancy Scale -- "Total" scale score
M_5= Peer Information Questionnaire -- Total Score

An elaboration of the "postest only control group design" described by Campbell and Stanley (1963) was used in this experiment. No pretests were considered necessary for the treatment groups in this study since it was assumed that randomization (random assignment of clients and therapists to groups) would fulfill the assumption that any differences between the two groups were a result of chance, rather than any consistent variations. Campbell and Stanley further indicate that the design used in this study is amenable to "covariance analysis . . . , thus providing an increase in the power of the significance test very similar to that provided by a pretest" (p. 26). It should be noted also that the gain in precision obtained by the use of a covariate corresponds directly to the degree of covariance. The use of a covariate, in this case ratings of therapist functioning level, avoids an experimenter-introduced pretest session, thus providing less posttest reactivity to the pretesting than would be the case with a pretest-posttest design.

Sample

Because of the nature of this research project and the fact that the participants volunteered for the project, it was not possible to obtain a truly random sample of clients. For this reason, the sampling and assignment procedures will be described in detail, allowing the reader

to judge whether this sample is appropriate for the population to which he wishes to generalize.

Clients

The clients who participated in this study were undergraduate college students who had come voluntarily to their respective college counseling centers for assistance with personal-social concerns. Twelve of these clients were Michigan State University students; one was a student at the University of Wisconsin at Milwaukee. At MSU, clients who fulfilled the selection criteria for participation in the study were taken in order from a waiting list (necessitated by heavy demands for services). At UWM, the client was asked in a screening interview whether he was willing to participate in the project. Therefore, the initial and subsequent contacts with this client were made in person. For the MSU clients, however, because they had been previously screened, a telephone procedure was used.

At the Michigan State University Counseling Center a client is seen immediately by a screening counselor when a request for services is made by a student. The screening counselor attempts to assess the client's needs and make a determination of how the services of the Center can best be used in meeting those needs. This procedure resulted in a list of clients waiting for counseling. From this list were selected (in order from the list) clients who: (1) had primarily a personal-social concern (rather than

an educational-vocational one), (2) were not considered potentially suicidal or in an extreme crisis situation, and (3) were interested in more than a brief contact with a counselor. These determinations were made on the basis of notes written by the screening counselors. A total of seventeen clients were thus selected for contact about participation in the project.

Each of the clients selected from the M.S.U. list was contacted by telephone by the investigator or his assistant. This contact served a two-fold purpose. It provided an opportunity to explain the research aspects of the project to each prospective client-subject. It also gave each of these individuals an opportunity to give or withhold his preliminary agreement to participate and his consent for the data gathered to be used, in confidence, for research purposes. (Written permission was obtained at the first meeting between the client and his counselor. See Appendix A for consent form.)

Prior to being contacted, all potential subjects were randomly assigned to either the experimental or control group. They were then contacted and asked about their willingness to participate. This telephone conversation typically lasted approximately ten minutes. The standard form letter which would be given to clients in each group (see Appendix B) was used as the outline for the explanation of the project to each prospective

client-participant. Following this contact, clients were assigned to counselors (who had also been randomly assigned to either an experimental or a control group) according to scheduling and case load practicalities.

From the seventeen clients who met the criteria for participation in the project, thirteen agreed to participate when contacted by telephone. Of the remaining four, two individuals had decided against counseling between the time of their screening interview and the telephone contact, one had been able to enter a group counseling experience, and one was out of the area for a week and unable to be contacted. Two of these individuals had been assigned to group A and two to group B. A summary and description of the resulting sample is presented in Table 3.1, and discussion of subject mortality during the project follows.

Subject Mortality

As indicated, thirteen volunteer clients had agreed to participate in the study as part of their therapy experience. These thirteen individuals thus began their respective therapy programs; the IPR group consisted of seven clients and the traditional counseling group was comprised of six clients. Only one client terminated prior to the completion of the treatment program. For several reasons this client was unable to participate in the total experimental treatment.

TABLE 3.1.--Distribution and Description of Sample by Age, Class and Sex within Groups.

Counselors	Number of Subjects	Subject Description		
		Age	Class	Sex
Group A (IPR)				
1	1	20	Junior	Female
2	1	20	Sophomore	Male
3	1	19	Sophomore	Male
4	1	20	Sophomore	Male
5	1	21	Senior	Female
6	1	24	Junior	Male
7*	1*	21	Junior	Female
Total:	7			
Group B (Traditional)				
8	1	21	Junior	Female
9	1	19	Fresh.	Female
10	1	18	Fresh.	Male
11	1	21	Junior	Female
12	1	23	Junior	Male
13	1	21	Senior	Female
Total:	6			

*Deleted during project.

Her counselor was notified in advance that she was unable to meet during the week of session 3, so arrangements were made to resume the program the following week. The appointment for session 5 was also subsequently cancelled by the client, and she was leaving the area the following week. While the fifth session was able to be scheduled, adequate time to schedule the sixth session for this client was not available. In addition, some resistance to the recall during the fifth session was encountered. As a result, the decision was made to allow the client and therapist to examine and

resolve the dynamics of their relationship instead of requesting that the client undergo the recall. In essence, the judgement was made by the researcher and the therapist that the time which would ordinarily be used for a client recall should be spent in resolution of the conflict by the client and therapist together. While the question of client motivation and readiness for therapy was thought to be a legitimate one, there were also practical factors relating to client time and scheduling possibilities which influenced the termination of this client.

Because of the premature termination of this single client, her therapist was also eliminated from the study. The mortality of these individuals thus left a total sample of twelve clients and twelve therapists, with six clients and six therapists in each treatment group. The final client and counselor distribution is summarized in Table 3.2.

Therapists

The therapists used for this study were senior staff members, counseling interns (predoctoral candidates in clinical or counseling psychology) and practicum students (beginning or intermediate level doctoral candidates in clinical or counseling psychology) at one of two midwestern universities--Michigan State University and The University of Wisconsin at Milwaukee. Twelve therapists were employed at MSU and one at UWM. The senior staff members were regular employees of the university, having

TABLE 3.2.--Final Subject and Counselor Distribution Within Treatment Groups.

Counselors	Number of Subjects	Subject Description		
		Age	Class	Sex
Group A (IPR)				
1	1	19	Sophomore	Male
2	1	20	Sophomore	Male
3	1	20	Sophomore	Male
4	1	20	Junior	Female
5	1	21	Senior	Female
6	1	24	Junior	Male
	Total: 6			
Group B (Traditional)				
8	1	18	Freshman	Male
9	1	19	Freshman	Female
10	1	21	Junior	Female
11	1	21	Junior	Female
12	1	21	Senior	Female
13	1	23	Junior	Male
	Total: 6			

had the bulk of their training in the "traditional" form of counseling and therapy. Counseling interns are employees of the MSU Counseling Center while in a doctoral level program in clinical or counseling psychology. They have typically completed all but the dissertation for the Ph. D. degree. Practicum students are also doctoral students who are typically beginning practical, supervised experience with counseling and therapy. The interns and practicum students who participated in this investigation also had the bulk of their training in traditional forms of counseling and therapy. In terms of their general theoretical

orientation, all of the counselors placed some emphasis upon interpersonal dynamics and their developmental antecedents; none of the counselors identified primarily with a behavior modification model.

The therapists used for the study volunteered to participate in response to memos issued at the beginning of Spring term, 1972 (see Appendix C). After volunteers were obtained, therapists were randomly assigned to either the experimental or the control group. To reduce the possibility of a therapist-treatment interaction, each therapist saw only one client who was participating in the study. That is, each client-subject for the study had a different therapist who had been randomly assigned to one of the two groups.

Although most of the therapists in each group had had some experience with Interpersonal Process Recall and/or affect simulation films as a training methodology, only one had used IPR previously as a therapeutic tool. All therapists in the IPR group viewed a videotape (Kagan, 1972) explaining the use of affect simulation films prior to seeing their clients and were given a typescript of the videotaped lecture for any further reference. A description of the therapist sample is given in Table 3.3.

Description of Treatments

The introductory contact and first treatment session were the same for clients in Group A (counseling with IPR

TABLE 3.3.--Description of Therapist Sample by Position, IPR Experience and Sex.

Position			IPR Experience		Sex	
Sr.Staff	Intern	Practicum	Yes	No	Male	Female
Group A (IPR)						
2	2	3	5	2	5	2
Group B (Traditional)						
1	3	2	4	2	4	2

and affect simulation) and Group B (traditional counseling). The introductory contact by telephone with each client was necessary in order to ensure that each participant-client was fully informed of the research aspects of the treatment, and that he was willing to engage in the various data gathering activities.

The initial one and one-half hour session for clients in both groups served the purpose of allowing the client and counselor to meet each other and begin identifying the client's concern. It also provided an opportunity to obtain an audiotape recording of the session for subsequent rating by judges of the counselor's functioning level.

Counseling with IPR and Affect Simulation

As outlined in Table 3.4, the experimental treatment fell into four distinct and sequential phases. In phase 1 (session 2), affect simulation films were used without

TABLE 3.4.--Summary of the Experimental Procedures.

Introductory Contact: A telephone conversation of approximately five to ten minutes duration was held between the investigator and each client.

a. The initial contact by telephone provided the opportunity to orient the participating clients to the special circumstances of the research project and obtain their preliminary verbal agreement to participate. It was explained to each client that he/she would be involved in a study which was designed to help define what goes on in therapy, from both the client's and the therapists's point of view. To do this, it was necessary for the client to cooperate by: (1) Making a committment to see a counselor one and one-half hours per week for at least six weeks; (2) Supply the names and addresses of at least two people whom we may contact after six weeks in regard to the client's behavior which they had observed; (3) Complete two brief (½ hour) inventories after the client's sixth session; (4) Permit the first and sixth sessions to be audiotaped for subsequent rating by judges.

b. In addition, clients in the IPR group were told that some of their sessions would be videotaped and specially developed films would be used as part of their treatment during the first six weeks of counseling.

Treatment A Counseling with IPR	Treatment B Traditional Counseling (no IPR)
Session #1	
a. Client asked to read letter (see Appendix B) outlining requests for participation, provide names of peers (see Appendix E) and sign consent form (see Appendix A).	a. Client asked to read letter (see Appendix B) outlining requests for participation, provide names of peers (see Appendix E) and sign consent forms (see Appendix A).
b. Ninety minute initial counseling session with each client. This interview served to provide audiotape rating of counselor functioning level.	b. Ninety minute initial counseling session with each client. This interview served to provide audiotape rating of counselor functioning level.
Session #2	
a. Thirty minute counseling interview with each client.	Ninety minute counseling interview with each client.
b. Forty minute session in which affect simulation films were shown to each client. During this time counselor and client use simulation film as focal point for discussion of client's reactions to filmed vignettes.	
c. Twenty minute counseling interview conducted without use of videotape or film.	
Session #3	
a. Thirty minute counseling interview with each client.	Ninety minute counseling session with each client.
b. Forty minute segment during which affect simulation films were shown to client, videotape of client made, and tape played back for client and counselor to use in discussing client reaction to filmed stimuli. Counselor attempts to use videotape to help client explore his reactions.	
c. Twenty minute counseling interview conducted without use of videotape or film.	
Session #4	
a. Thirty minute counseling interviews with each client, videotaped.	Ninety minute counseling session with each client.
b. Forty minute client recall of videotape made of first thirty minutes.	
c. Twenty minute counseling interview conducted without use of video.	
Session #5	
a. Thirty minute counseling interview with each client, videotaped.	Ninety minute counseling session with each client
b. Forty minute client recall of videotape made of first thirty minutes.	
c. Twenty minute counseling interview conducted without the use of video.	
Session #6	
a. Thirty minute counseling interview with each client which was videotaped.	a. Ninety minute counseling session with each client.
b. Forty minute client and counselor (mutual) recall of videotape made of first thirty minutes.	b. Client completes inventories--TSR and MSGO.
c. Twenty minute counseling interview conducted without the use of video.	
d. Client completes inventories--TSR and MSGO.	

videotape and in phase 2 (session 3), affect simulation films and video-recall were combined (VRAS). In phase 3 (sessions 4 and 5), the client underwent a stimulated recall of his own in-counseling interaction with his therapist which had been recorded on videotape (i.e., a traditional IPR recall session, conducted by a trained inquirer). In phase 4 (session 6), the therapist remained with his client as a mutual recall was conducted by an inquirer.

Phase 1

During session 2, the first thirty minutes of the counseling interaction were conducted by the counselor as a "standard" personal counseling session. The next forty minutes included use of the simulation films. As in the Schauble (1970) study, not more than five vignettes were shown to a client in any one session, and none of the scenes were longer than two minutes in length.

During this forty-minute segment in which affect simulation was used as a stimulus for discussion, no videotape procedures were used. Each IPR group counselor was asked to use a modified inquirer role during this session, and to follow the type of questioning found in Appendix F, "Sample Questions for Use with Affect Simulation Films." Counselors were not limited to this role; however, they were asked to use the films as a stimulus for exploration

by the client within the context of the client's concern. That is, they were not asked to refrain from interpretation or reflection of client statements, nor to attempt to keep from engaging in a counseling relationship with the client, as the inquirer typically does. Thus, the client's reactive behavior was used as a means of exploring the nature of, and feelings about actual and existing interpersonal relationships. When the forty minutes had passed, the client and counselor returned to a traditional counseling interaction.

Phase 2

For session 3, the first thirty minutes of the total hour and one-half were again conducted as a traditional personal counseling session. The next forty minutes were spent with the use of affect simulation films and VRAS--video recall of affect simulation. During these forty minutes the client was videotaped while watching a total of five affect simulation vignettes. The tape, containing an image of the client and the accompanying audio portion of the simulation vignettes, was played back for a "recall" of the client's reactions to the film (VRAS session). During this segment of the meeting, the counselor again made use of, but was not limited to, the type of questions found in Appendix F. The VRAS session was intended to assist the

client in examining his reactions to the films through the use of the videotape. The videotaped sample of the client's reactive behavior was kept to a maximum of ten minutes, and the sample served as the focus for a personal counseling session. After the forty minute time segment was over, the counselor and client again returned to a traditional counseling interaction for the remaining twenty minutes.

Phase 3

For sessions four and five, which comprised the third phase of the experimental treatment, the first thirty minutes of the session were conducted again as a traditional counseling session. This thirty-minute session was videotaped for the subsequent client recall session, producing an image, with accompanying audio, of the counselor and client. At the conclusion of this thirty-minute session another counselor (trained in recall or "inquiry" techniques) entered the room to conduct a recall of the videotaped counseling session. At this point the counselor left the room to observe the recall session, with the client's knowledge, from an adjacent room. A television monitor with accompanying audio arrangements had been set up to enable the counselor to observe and hear the recall session.

During the recall session, the task of the inquirer was to encourage the client to explore his behavior <u>in the counseling relationship</u>. The inquirer attempted to keep

the client's attention and concentration on the "there-and-then" of the counseling relationship, rather than enter into another counseling relationship with the client. Through his observation of the recall session, the counselor could observe the client's exploration of his own behavior and incorporate this information into that which he already had about the client. He could also obtain the client's preceptions of the counselor, if that too was discussed during the recall session. This "client recall" procedure was used for both the fourth and fifth IPR treatment session.

Phase 4

Session 6, the final phase of the IPR and affect simulation treatment program, again began with thirty minutes of standard counseling. This session was also videotaped for playback to both the client and the counselor. That is, during the recall session in this phase, the counselor not only remained in the room during the inquiry session, but participated in the recall of the previously completed counseling session. The inquirer conducted a "mutual recall," in which the client and counselor were encouraged to share their thoughts and feelings about the counseling interaction contained on the videotape (the "then-and-there" of the just completed session). It was expected that this interaction would then develop into a more direct communication between the client and the counselor about the immediate client

counselor relationship. Within this forty-minute process, the inquirer became progressively less active in the recall session, until he was able to leave the client and counselor to continue the counseling session, hopefully engaged in immediate, face-to-face communication about ongoing thoughts, feelings and reactions. A week-by-week outline of the experimental procedures followed by weekly procedural memos to experimental group counselors may be found in Appendix G.

Inquiry (Recall) Procedures

Each IPR group client underwent three formal recall sessions during the course of his counseling treatment. The fourth and fifth counseling sessions for IPR group clients included a client recall process, during which the counselor left the room and an inquirer conducted a recall session with the client. The sixth session for IPR group clients included a mutual recall, in which the client and counselor were joined by an inquirer for examination of the videotaped counseling session and of client and counselor reactions, impressions, thoughts and feelings.

Recall sessions were conducted by either the investigator, another second-year counseling intern at the MSU Counseling Center, or one of four doctoral practicum students in counseling. Attempts were made

to vary the schedules for each IPR group client so that each would experience recall with at least two different inquirers.

A total of nineteen recall sessions were conducted, three for each IPR-counseled client, with the exception of one client who terminated the project prior to the fifth-session recall (see page 81). Frequencies of conducted inquiries by inquirers are found in Table 3.5.

TABLE 3.5.--Frequency of Conducted Inquiries by Inquirers.

Recaller	Recaller Sex	Number of Inquiries Conducted
1	Male	10
2	Male	3
3	Female	2
4	Female	2
5	Male	1
6	Male	1

Traditional Counseling (without IPR)

Clients receiving traditional counseling were seen for six counseling sessions of one and one-half hours each, the same amount of time as that spent with each client in the experimental group. Typical traditional sessions last about one hour. The additional time not only equated the time for each group, but provided the traditional group

counselors and clients with a "special," somewhat luxurious treatment situation. The goals of counseling for this group were the same as those for the IPR and affect simulation group, namely, concentration on the client-counselor interaction in an attempt to help the client in self-exploration, leading to greater self-awareness and understanding of his own dynamics. It was expected that these counseling sessions would be responsive to individual client needs, as were the experimental treatment sessions, and that they would be as intensive as possible. Counselors for the traditional counseling group were instructed to meet their clients weekly for one and one-half hours and to audiorecord their first and sixth sessions. No other instructions as to type of counseling approach were given. Instructional memos to control group counselors are contained in Appendix H.

A comparative summary of the experimental procedures is found in Table 3.4.

Physical Environments

All counseling sessions for both the IPR and traditional counseling groups were held in rooms in the Michigan State University Counseling Center. Because of space limitations and lack of availability of videotape recording equipment, it was necessary that different types of rooms be used for each treatment group. While all first sessions

for both groups were held in regular offices of the Counseling Center, subsequent sessions for the IPR group clients were conducted in a research room of the Center in order to apply the affect simulation and IPR-videotape techniques. All sessions for traditional group clients were conducted in regular offices of the Center.

The research room in which experimental counseling sessions were held contained a desk, two comfortable chairs, a 35 millimeter projector and screen for showing of simulation films, an unconcealed microphone and television camera, and a television monitor which was used for viewing the recorded videotapes. A videotape recorder was contained in an adjacent room during recording of sessions, then wheeled into the interview room for playback. The adjacent room also contained an audio console for routing of audio impulses to the videotape recorder and for audio recording of the sixth session for IPR clients.

A typical office used for traditional group clients contained a desk, two comfortable chairs, a small table, and an unconcealed audiorecorder and microphone.

While the physical environments were slightly different for the two groups, in that the offices used for control clients did not contain video recording or playback equipment, it was apparent that control clients were very much aware that they were involved in a project of a "special" nature, primarily because they were meeting

for one-half hour more than the customary one hour session. Traditional group counselors indicated that their clients often commented to this effect over the course of the six-week program. It was assumed that a difference in effects due to slightly different environments for the groups was minimal, since clients in both groups felt the "special" nature of their treatment.

Instrumentation

Five measures were used as criteria for this study: (1) The Characteristics of Client Growth Scales (COGS, defined by Kagan, Krathwohl, et al., 1967; revised into a five-point scale by Schauble and Pierce, 1969), (2) The Degree of Self Exploration Scales (DX, Truax and Carkhuff, 1966; Carkhuff and Berenson, 1967), (3) Selected items from the Therapy Session Report (TSR, Orlinsky and Howard, 1968), (4) Selected scales from the Miskimins Self-Goal-Other Discrepancy Scale (MSGO, Miskimins and Braucht, 1971) and (5) A peer information questionnaire (PIQ) developed for this study by which the opinions of clients' peers could be obtained.

The Characteristics of Client Growth Scales (COGS)

The COGS consist of three separate scales (Owning of Feelings, Committment to Change and Differentiation of Stimuli) which characterize productive client growth in

counseling.* Each of these scales is operationalized into a five-point scale with 1.0 being the lowest possible rating and 5.0 the highest rating. 3.0 is defined as being the minimal level at which constructive change can occur.

Owning of Feelings Scale (OF)

The Owning of Feelings scale of the COGS is the dimension on which a rating of the extent to which a client admits and "owns" his feelings as coming from himself is given. While some clients in therapy are quite aware of the affective levels of their experiences, others have only vague feelings which pervade their perspective of life and which are not tied to specific behaviors or interactions. It is purported that progress can occur in therapy when the client is able to identify his feelings and tie them to their source.

At level one of the owning of feelings scale the client seems to avoid any acceptance of his feelings. His in-therapy behavior is usually characterized by a denial of his having any feelings or by silence. He may appear to believe he is not part of the world of feelings. At level two the client's feelings are expressed in a vague manner which makes them seem intellectualized and distant. At level three feelings are identified by the client and he can usually tie them to their source but does so in an intellectual manner. At level four he almost always

*See Appendix I for complete COGS.

acknowledges his feelings and expresses them with emotional proximity but at times has difficulty connecting the feelings to their source. The client clearly expresses his feelings with emotional proximity at level five. At the same time he demonstrates awareness of the fact that they are tied to specific behaviors of his own and others.

Committment to Change Scale (CCh)

The committment to change scale of the COGS is that on which the client is rated according to his decision that he wants to change and his willingness to deal with his problems and face the consequences of his changing. This willingness is evidenced by increased cooperation with his therapist. Purportedly, when the client evidences a maintainence of his motivation to change, progress can occur.

At level one of the committment to change scale the client shows no motivation to change and is resistive to the counselor's attempts to promote change. Client behavior at this level may take the form of complete passivity or defensive hostility. At level two the client's committment to changing is noticeably questionable, even though he may be somewhat passive or evasive, or he may seem more interested in rationalizing his behavior than in changing it. At level three the client may deal with feelings which are centrally involved with

his problem but has a tendency to rationalize or move from topic to topic. He vascillates between an overt desire to change and the desire to resist change.* In sum, the client varies in his motivation to change. The client expresses a clear desire to change at level four, and while he may be reluctant to experience painful feelings at times, he almost actively cooperates with the change process. When the client actively cooperates in the counseling process and continually engages in the process of confronting his problems and feelings directly, he is functioning at level five of the committment to change scale.

Differentiation of Stimuli Scale (DS)

The third Characteristics of Client Growth scale is that which indicates the level at which the client's in-counseling behavior is characterized by differentiation of stimuli. When clients progress in counseling they typically learn to perceive more of the stimuli in their environment and react to those stimuli as discrete, individual factors rather than stereotyped, similar ones. It is purported that, as a result, clients are better able to identify and differentiate their emotions and reactions to these stimuli.

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*See also Kell and Mueller (1966) for a discussion of client ambivalence.

At level one of the differentiation of stimuli scale the client tends to use stereotyped categories in lumping differentiable stimuli, e.g., all girls, all professors, all roommates, all adults etc. He seems unable to differentiate his problems, feelings or concerns, and is unwilling to make attempts to do so. At level two the client may talk about different feelings and problems, but does so without an apparent realization of any differences between them or their effect on him as an individual. He talks about his feelings and problems in an intellectualized, global way. Level three typically indicates a vascillation by the client between discussing different stimuli and their effect on him as a person and responding in a general, unclear fashion. That is, he may start out making clear differentiations but is unable to persist, lapsing back into hazy generalizations. At level four the client actively attempts to become more aware of his various emotions and their sources. He is almost always aware of the differences between stimuli in his world and responds to them differentially. At level five the client seems always to perceive the different stimuli in his world and reacts to them in a variety of differential manners. He shows immediate awareness of his own unique characteristics and the reactions he stimulates in others.

The Depth of Client Self Exploration Scale (DX)

The DX Scale in its most recent form consists of five levels, with level one being the lowest possible score and level five being the highest possible score.* Within the scale are incorporated several dimensions of client in-therapy behavior, including intrapersonal probing of matters of personal relevance, accompanied by the immediate, or spontaneous expression of feelings. Some findings of Rogers and Truax (1961) suggest that this scale may be one which measures something akin to readiness for help. That is, low levels of rating on the scale may describe clients who are relatively rigid and unready for help while high levels may describe clients with a readiness to change.

On the DX scale, level one indicates that the client's behavior shows no evidence of self-exploration. At level two the client may respond to the introduction of personally relevant material by the counselor but does so in a remote and mechanical manner. At level three the client may be found to introduce personally relevant material but does so with no spontaneity or inward probing to discover new feelings or experiences. The client introduces personally relevant material at level four, but does so without a distinct tendency toward

*See Appendix J for the complete DX scale.

self-exploration to discover new feelings and experiences. At level five the client is actively focusing on himself and exploring himself and his world.

The Therapy Session Report (TSR)

In an attempt to obtain information from an often neglected source, the participants in the therapy session, items from the Therapy Session Report (TSR) were also as evaluation instruments in this investigation.

The Psychotherapy Session Project (Orlinsky and Howard, 1968), as a way of surveying various aspects of the therapy experience, devised two parallel questionnaires, one for patients and one for therapists. The questionnaires are completed independently by each client (patient) and therapist and have resulted in a useful structure with which to examine the therapy relationship and experiences for each participant. Each form of the TSR consists of simple descriptions and evaluations covering various dimensions of experience. The form of the TSR to be used in this study (see Appendix D) is modification of the original instrument and represents an attempt to evaluate the influence of the two types of treatment as seen by the client.

The Miskimins Self-Goal-Other Discrepancy Scale (MSGO)*

The use of the term "self concept" has become a popular way of studying and understanding human behavior, and seems to have applicability to this investigation for assessment of movement and change in therapy. As Schauble (1970) states:

> People who see themselves as being undesirable, inadequate or inferior often act accordingly; and those whose concept of self is unrealistic tend to deal with life in unrealistic ways. Thus a knowledge of how an individual perceives himself should be useful in evaluating or helping that individual (p. 74).

Consequently, a measure of self concept change was applied in this study.

The Miskimins Self-Goal-Other Discrepancy Scale (MSGO) was used in this study to assess changes in discrepancies between subjects' actual self concepts, the ways they think others view their behaviors, and the ways they would actually like to be (their "goal self concept"). The reasoning behind the use of a self concept discrepancy measure rather than a measure of magnitude of self concept or "strength" of self concept relates to the very core of the treatment program intended, i.e., the notion of increasing self awareness in order to examine the dynamics

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underlying a person's maladaptive behavior. By examining the discrepancy between the way a person actually behaves and the way others see him as behaving, for example, differences should become obvious between treatment group subjects and control group subjects if, in fact, the IPR treatment is more effective than traditional counseling. It was assumed that by becoming aware of differences between his actual self concept and the perceived responses of others, a client would revise his own concept of self toward more similarity to the way others see him.

The MSGO is a twenty item questionnaire which "serves to systematize observation of three . . . aspects of self . . . (SC, GSC, and PRO)" (Miskimins and Braucht, 1971, pp. 66-67). That is, it is a means of assessing the self concept, the goal self concept, and the perceived response of others, in order to calculate congruency among the three. The 20 items consist of polar constructs (e.g., Relaxed-Tense) on a nine point scale. The client is asked to indicate his rating of his own position for all three concepts--SC,GSC,and PRO--thus transferring his "perceived" discrepancies onto the polar construct pair (Miskimins and Braucht, 1971). The final form of the scale contains four categories, general, social, emotional and personal, with each category containing five test items. The general, social and emotional categories are standardized in the test booklet; for the personal category, the test-taker is asked to formulate his own list of five constructs.

Correlative validation studies have been done on the MSGO through a number of different approaches. Coefficients were obtained between MSGO scores and established psychological measurements (Taylor Manifest Anxiety Scale and Minnesota Multiphasic Personality Inventory), clinical judgments and objective behavioral criteria.

When the 20 item MSGO was correlated with the Taylor Manifest Anxiety Scale (TMAS) using scores of 63 college students, coefficients ranging from -.06 to +.72 were obtained for the various MSGO scores. For the two MSGO scales which measure total discrepancies (GRT [15] and GRT [20]) validity coefficients of +.67 and +.71, respectively, were noted. The scale which indicates the total discrepancies for the first 15 items (GRT [15]) is the one of interest in the formal analysis used for this study.

In an attempt to assess the relationship of MSGO scores to various psychological disturbances, the MMPI was administered to the same group of 63 college students on the same day that the MSGO was administered. The analysis of the relationship between MSGO and MMPI scores were reflected in 738 individual correlations (13 MMPI subscales X 56 MSGO scores). Correlation coefficients obtained between the 13 MMPI subscales and the MSGO score used in this study are presented in Table 3.6.

Further validity assessment was carried out by the MSGO authors to test the ability of the MSGO to

TABLE 3.6.--Correlations between the MSGO GRT(15) Scale and 13 MMPI Subscales.

MSGO Variable	MMPI Subscales												
	L	F	K	Hst.+ .5k	D	Hy	Pd+ .4k	Mf	Pa	Pt+ 1k	Sc+ 1k	Ma+ .2k	Si
GRT(15)	-.15	.47*	-.58	.08	.50*	.07	.38	.16	.28	.38	.47*	.12	.56*

*P <.001

distinguish "normal" from "abnormal psychological states. A group of subjects (N=29) which had no history of psychiatric treatment was compared with a group of subjects who were undergoing psychiatric treatment (N=29). With a matched pairs design, three MSGO values, including the one used for this study, were found to demonstrate exceptional ability to differentiate normals from psychiatric patients: GRT (15), SC--PRO, T (15), and SC--PRO, GT. All scales showed differences in the predicted direction between the two groups, with 19 of the 28 variables employed being found to differentiate the two groups at statistically significant levels. The mean score for patients was found to be 56.07 compared with 29.31 on the GRT (15) variable, a difference which was statistically significant at the .001 level. And in a similar study designed to assess the ability of the MSGO to differentiate between varying degrees of psychopathology, similarly favorable results were observed for the GRT (15) scale. The mean for 47 subjects judged to be "severely" pathological was found to be significantly higher than the mean for a matched group of individuals judged as being of "moderate" pathology ($p < .05$). When an operational definition of psychopathology (length of stay in the hospital and form of discharge) was used for 94 patients in another study, mean score differences between groups were in the predicted direction, but not statistically significant.

The MSGO was also subjected to test-retest reliability studies. A group of 51 college students completed the scale on two different occasions separated by a 14 day time span. Test-retest reliability coefficients ranging from +.87 to +.24 were obtained for 28 summary MSGO variables. Test-retest r for the GRT (15) variable was found to be .80.

The MSGO scoring profile allows comparison of individual scores with means and standard deviation units for a sample of 63 non-student "normals" (see Appendix K for MSGO Hand Scoring Summary Sheet and Profile Summary). For this study, the scale which reflects all discrepancies for the first 15 items (the Total Scale) will be used for comparison of experimental and control group scores.

The Peer Information Questionnaire

In an attempt to obtain information about each client's observed behavior outside of the therapy session a Peer Information Questionnaire was formulated. 15 items consisting of statements about inter-and intra-personal behaviors was constructed. Added to these 15 items was a sixteenth item which related to the informant's confidence in his ratings. An attempt was made to structure these items so that a variety of behaviors was assessed, including those also examined through the use of judges' ratings of client's in-therapy verbal behavior.

Peer-informants were asked to indicate their responses to each item on the PIQ with a number between one and six; a rating of one represented strong disagreement with the statement, six represented strong agreement and intervening numbers ranged between these opinions.

A questionnaire and explanatory cover letter (see Appendix L) was mailed to each of the peers whose name the participating clients had provided earlier. It was thought that with the approaching term-end and final exams week, a higher percentage of responses could be obtained through personal telephone contacts than through reliance on the peer-informants to return their responses by mail. Each informant, therefore, was asked to provide his/her responses to the written form mailed to him when called by telephone. An independent assistant who had no knowledge of each client's experimental or control status telephoned each informant for his responses during the week following the last of the six treatment sessions (before the client had met again with his counselor, if further meetings had been arranged). The telephone assistant recorded each response on a data sheet as it was given to her by the informant (see Appendix M for Response Sheet). Thus, responses were obtained from two peer-informants for each client in each group. The Peer Information Questionnaire to which each informant responded is contained in Appendix N.

Client Written Comments

The above instruments were used to obtain data for formal analysis. In order to obtain information of a more subjective nature which was not amenable to analysis but nevertheless valuable, subjective reactions, impressions and opinions about the treatment programs were solicited from each client when he completed the TSR and MSGO. This provision of a page for client subjective comments also provided an opportunity for the researcher to give final instructions to each client and express appreciation for their participation in the project. The subjective comments form is found in Appendix O.

Ratings of Counselor Functioning--The Empathic Understanding Scale

While random assignment of clients and therapists to groups was used in this study in an attempt to equate the two treatment groups, it was also thought that differential functioning levels of therapists may be a factor requiring control in the experimental design. Because therapists with three different levels of experience and expertise could logically be expected to function at different levels, and because of recent literature (Carkhuff, 1969a) describing the importance of helper functioning level for client growth, therapist level of functioning was used as a covariate in the analysis of data for this study. The particular dimension upon which therapist

functioning level was assessed was the Empathic Understanding in Interpersonal Processes Scale (Carkhuff, 1969a).* This scale was selected because of indications that empathy is perhaps the most critical of all helping dimensions for counselor effectiveness in facilitating client growth (Carkhuff, 1969a; Berenson and Carkhuff, 1967; Truax and Carkhuff, 1967).

A functional definition of empathic understanding is given in the scale itself, which consists of five levels. At level one, the behavioral expressions of the therapist detract significantly from the communications of the client. They do not indicate that the counselor is listening, understanding or being sensitive to the feelings of the client. At level two on the EU scale, the counselor may respond to the expressed feelings of the client, but does so in a way which detracts from those feelings, distorts their meanings or evidences incongruence between the client's expression and the counselor's idea of that expression. The expressions of the therapist are essentially interchangeable with those of the client at level three. That is, they express essentially the same affect and meaning, without an accurate response to feelings which may be below the surface expression of affect. At level four, the expressions of the counselor add noticeably to the expressions of the

*See Appendix P for complete EU Scale.

client; they add deeper feeling and meaning to the client's expressions of affect. A level five rating indicates that the counselor is responding with full awareness and understanding of the deep feelings of the client. The counselor's responses add significantly to the feelings and meanings of the expressions of the client.

Segments of the audiotapes made of Session 1 for all therapists were presented to judges for rating on levels of therapist empathic understanding. These ratings were then used for a covariate analysis of the dependent variables in an attempt to assess client growth in therapy.

Rating of Criterion Tapes

Two independent raters were used as judges for the scales used as criterion measures for this study. Both judges held the Ph.D. degree in Counseling Psychology, were employed at an eastern university counseling center and were experienced in the use of behavior rating scales. In addition, both judges were functioning themselves at high levels (above 3.0) of facilitative counselor behavior as measured by the Truax and Carkhuff (1967) scales.

A training session of three hours was conducted for the judges (45 minutes for each of the scales), during which a description and review of each of the scales was provided. Practice ratings on therapy tapes were also made during this training session. The practice tapes were stopped

at various points and the ratings of the judges were compared and discussed, until there was apparent close interjudge agreement.

In rating the tapes, neither judge had knowledge of the differences in experimental procedure for each group, nor was he aware of the group to which each client or counselor was assigned. Each judge made an independent rating of client functioning for all sixth-session tapes and of counselor empathic understanding for all first-session tapes.

Selection of Segments and Rating of Client Functioning Levels

From each of the audiotapes made of the sixth (final) therapy session, segments were excerpted for presentation to the judges. In order to obtain a representative sample of the interaction during the session, and to obscure the differences in experimental treatment between the two groups, segments were taken from the first thirty minutes and the last twenty minutes of each sixth session (the presence of the inquirer for experimental group clients would have been obvious to the judges had the intervening forty minutes been used for rating). A seven-minute segment was thus randomly excerpted from the first thirty and the last twenty minutes of each final session. This resulted in a fourteen-minute excerpt for each client. All segments were then randomly ordered and

dubbed onto a master tape for rating by the judges. Ratings of each client statement within the fourteen-minute segment (up to a maximum of twenty statements) were made on the dimensions of OF, DS, CCh and DX.

Selection of Segments and Rating of Counselor Functioning Level

Counselor level of empathic understanding was chosen as a covariate in this study because of the apparent importance of differential levels of counselor functioning for client growth. To obtain this rating, excerpts containing client-counselor interactions were selected from the audiotapes made by all counselors of their initial session. Since the initial session was the same for both experimental and control groups, excerpts could be selected from any portion of the 90-minute tapes. From each first-session tape, therefore, three segments were taken; a three-minute excerpt was randomly drawn from the first, middle and last thirty minutes of each audiotape, resulting in a total of nine minutes for each tape. The three three-minute segments for each counselor were then dubbed in random order onto a master tape for rating by the judges. Each of the three-minute segments was then given one global rating on empathic understanding by each of the same two judges who rated the dependent variable tapes.

Reliability of Ratings

Reliability estimates for the total audiotape sample (12 posttapes for client ratings and 12 pretapes for counselor ratings) were established on each rated dimension (OF, DS, CCh, DX and EU). Coefficients were obtained through the use of a two-way analysis of variance technique described by Hoyt (1967) and a program developed by Jennrich (1961) for the CDC 6500 computer was used for the analysis of data. Reliabilities of average ratings for each rated dimension are reported in Table 3.7.

TABLE 3.7.--Reliability Coefficients for Judges' Average Ratings of Each Client Dimension and Counselor Empathic Understanding.

Dimension	COGS				
	OF	DS	CCh	DX	EU
Correlation	.8325	.8990	.9445	.9782	.8433

Hypotheses

The specific hypotheses are presented here in research form. They will be designated with the letter H, numbered one through five.

If the theory and methodology of this study are sound, it can be expected that clients who are counseled with affect simulation and IPR (Group 1) will be rated at

higher levels of OF, DS and CCh than traditionally counseled clients (Group 2). Since ratings on these three client dimensions will be added to yield a composite score for each client, the above prediction implies the examination of the following hypothesis:

H_1: The composite posttest ratings for OF, DS and CCh will be higher for the treatment group receiving personal counseling with IPR intervention than for a traditionally counseled group that receives personal counseling alone.

Similarly, it can be expected that IPR-treatment clients will evidence higher DX ratings than clients who receive traditional therapy.

H_2: The posttreatment level of DX ratings for clients in the IPR treatment group will be higher than the posttreatment level of DX ratings of clients who receive traditional counseling.

It is also predicted that clients who receive the experimental (IPR) treatment will express more satisfaction with the counseling process and relationship than will clients who receive traditional treatment.

The twelve items selected from the TSR by Schauble (1970) to measure client and therapist change in perception of treatment processes would yield an additional twelve hypotheses if considered separately. Since only client variables and a more global client opinion about the therapy than that obtained by Schauble is of formal interest in this study, a shortened form of the TSR was applied (see Appendix D for items used). Client feelings about the therapy process were obtained on four dimensions:

1. The client's feelings about the six sessions just completed.
2. The client's feelings about progress made in the session.
3. The client's perception of therapist understanding.
4. The client's perception of therapist helpfulness.

These four dimensions were again added to yield a composite score for purposes of the formal analysis, and the application of this measure implies the examination of a third hypothesis:

> H_3: Clients who are counseled with IPR and affect simulation will evidence more satisfaction with counseling than will clients who receive traditional counseling.

The MSGO was also administered to all clients in an effort to assess the degree of discrepancy between clients' self concept, goal self concept and their perceived responses of others toward them (SC, GSC and PRO, respectively). Only the MSGO TOTAL scale was used for this purpose. The TOTAL scale of the MSGO is explained as follows:

> . . . labeled GRT (15), this dimension refers to the sum of the discrepancies between SC and GSC and between SC and PRO, thereby indicating the total discrepancy for the first 15 test items (Miskimins and Braucht, 1971).

While the use of the TOTAL scale only does not permit diagnostic differentiation or provide as much information

about a client as would be the case were all of the MSGO scales used, the TOTAL scale does incorporate most of the discrepancy areas measured by the scale.

The fourth hypothesis, then, derived from the prediction that IPR treatment will result in less self concept-related discrepancies than traditional treatment, is as follows:

H_4: Clients who receive traditional counseling will reveal higher self concept-related discrepancies on the MSGO than will clients who receive counseling with IPR and affect simulation.

In an effort to determine whether changes in clients' behavior as a result of therapy intervention were noticeable outside of the therapy setting, a Peer Information Questionnaire (PIQ) was devised and sent to two people whom each client had indicated would be willing to comment on his/her behavior at the end of the six-week counseling program (see Appendix E). It was expected that the following hypothesis would be confirmed on the basis of the information gathered through this questionnaire:

H_5: Peers of clients who receive the IPR counseling treatment will report more positive behavior changes for their peers on the PIQ than will peers of clients who receive traditional counseling.

Analysis of Data

The data resulting from this investigation were analyzed by a multivariate analysis of covariance technique. A program developed by Finn and modified by Wright (1968)

for the CDC 3600 computer was used for the analysis of each of the five dependent variables (COGS, DX, TSR, MSGO, and PIQ), and independent sample t-tests were further performed to test for between group differences in frequency of one and six ratings by peers on the PIQ. The subjective comments provided by most clients were also examined in an effort to obtain an informal observation of reactions to the treatment programs.

Delimitations

Because of the nature of this study, there are certain delimitations to it which are discussed briefly here.

The subjects used for this investigation were students enrolled at two major midwestern universities. These subjects were clients who had requested assistance with personal concerns from the staffs of their respective counseling centers. Consequently, they were characterized not only by age level but also by the types of concerns presented. This study is addressed only to an investigation of a way of assisting the college age group and has no direct generalizability for therapy with any other age group.

Also by reason of the population used, it was expected that certain types of maladjustments or concerns would rarely, if ever, be encountered in the study, since

they are not concerns usually related to the mental health of the college population. These are concerns or problems such as those associated with old age, mental retardation, alcoholism, active psychosis, and the like. Therefore, the results of this investigation are not intended to apply to these types of situations.

Neither was this study intended to allow for examination of differential effects of the treatment program on different types of problems. That is, no investigation was made of the varying ways the treatment may affect individuals with differing diagnoses. The only stipulation made in this regard was that the subjects have a personal-social type of concern which they were interested in resolving or attempting to resolve. Further description of the sample was found under that heading.

Finally, formal measures of client functioning subsequent to termination of the treatment program were not included in the research design, although informal post-post measures may be taken in the future.

Summary

The sample for this study consisted of volunteer clients who had requested assistance with personal concerns from the staffs of the Michigan State and the University of Wisconsin-Milwaukee Counseling Centers. Therapists

used for the study were also volunteers from the staffs and practicum groups at the two counseling centers. A posttest only design was used with therapists and clients randomly assigned to one of two groups. Group A received counseling in which videotape, affect simulation and IPR procedures were used; group B received traditional counseling. Comparisons were made between the groups on measures of client in-therapy verbal behavior, client satisfaction with therapy, reports of clients' peers and self concept discrepancy. Hypotheses predicting higher scores for group A on rated client behavior, satisfaction with therapy and peer reports, and lower scores for group A on the self concept discrepancy measure were posited. Clients in each group met for six sessions of one and one-half hours each during Spring term, 1972. The IPR-videotape clients underwent specific procedures, using simulation and stimulated recall, while the traditional group clients received counseling without videotape procedures. The time spent in therapy was equated for both groups. Results were analyzed using a multivariate analysis of covariance on five dependent variables, with counselor functioning level as the covariable. Independent sample *t* tests were also performed to test for differences between the groups in frequency of extreme scores on the PIQ. Finally, subjective comments of clients about the counseling programs were informally examined.

CHAPTER IV

ANALYSIS OF RESULTS

Introduction

The results of analysis and observation of the data are presented in this chapter. Covariable ratings results are given and the results of the analysis of covariance are presented. The results of an additional analysis procedure for the Peer Information Questionnaire results are also evaluated and dependent variable to covariable correlations and dependent variable intercorrelations are presented. Subjective comments of client-participants are also provided.

Covariable Ratings

Level of empathic understanding (EU), the covariable used in the analysis of data for this study, has been claimed to be one of the most crucial counselor characteristics relative to client progress in therapy (Carkhuff, 1969a). It was thought that the addition of this covariable in the analysis of data might not only control for the counselor functioning level variable, but assist in the interpretation of the data after analysis.

The mean score for group A counselors (3.11) was observed to be slightly higher than the mean score for group B counselors (2.97). The raw scores by rater, counselor and treatment group are reported in Table 4.1.

TABLE 4.1.--Rated Level of Empathic Understanding* of Counselors by Rater and Treatment Group.

		Ratings	
	Counselor	Rater 1	Rater 2
Group A (IPR)	1	3.33	3.00
	2	3.00	3.00
	3	2.67	2.00
	4	3.33	4.00
	5	3.33	3.33
	6	3.33	3.00
			$\bar{X}_A = 3.11$
Group B (Traditional)	7	3.00	3.00
	8	2.33	2.67
	9	3.00	3.00
	10	3.00	3.00
	11	3.00	3.33
	12	3.00	3.33
			$\bar{X}_B = 2.97$

*Raw Scores

Multivariate and Univariate Findings

A multivariate analysis of covariance with five dependent variables and one covariable was used for the major analysis of data for this study. Multivariate and univariate analysis results are presented in this section. Significance testing was carried out at the .05 level for each analysis.

In the multivariate analysis of covariance, no difference between groups A and B was noted. As indicated in Table 4.2., the computed F ratio of 1.8126 was not found to be significant at the .05 level with 5 and 5 degrees of freedom.

TABLE 4.2.--F Ratio for Multivariate Test of Equality of Mean Vectors.

df	F	p<
5,5	1.8126	.2649*

*Not Significant.

Since the proposed hypotheses deal with the treatment effects on each dependent variable taken separately, the hypotheses are restated here, and accompanied by the results of the univariate analysis of data relative to each hypothesis. It must be noted that for the overall alpha level of .05 in this analysis, each separate level must be set at .01. Also, since directional significance tests are

desired but the F statistic is non directional, the critical values used are for alpha equal to .02. That is, results would be significant if $p < .02$ in each of the cases to follow. Tables 4.3 and 4.5 through 4.8 contain abbreviated analysis of covariance tables (information printed out through computer analysis) for each one-way analysis.

H_1: Clients who receive counseling with IPR and affect simulation will evidence higher scores on a composite COGS rating than will clients who receive traditional counseling.

Results: No significant difference in treatment effect between group A and group B was found. Therefore, the null hypothesis is not rejected.

TABLE 4.3.--ANCOVA for COGS Ratings.

Source	df	MS	F	p<
Between	1	3.0873	1.5004	.2517*
Within	9	2.0577		

*Not significant.

Since significance was not found in the analyses, the grand means of groups A and B on each dependent variable in this covariate analysis are presented in Table 4.4.

TABLE 4.4.--Grand Means for Dependent Variables (Raw Scores).*

R_1 (COGS)	R_2 (DX)	R_3 (TSR)	R_4 (MSGO)	R_5 (PIQ)
284.70	91.15	14.41	55.08	110.89

*For the COGS and DX ratings the ranges of possible means would be 120-600 and 40-200, respectively (raters x statements x dimensions x 5). It is interesting to note that the average rating was below the 3.0 level for clients in both groups (COGS = 2.37, DX = 2.28).

H_2: Clients who receive counseling with IPR and affect simulation will evidence higher ratings of DX than clients who receive traditional counseling.

Results: No significant difference in treatment effect between group A and group B was found. Therefore, the null hypothesis is not rejected.

TABLE 4.5.--ANCOVA for DX Ratings.

Source	df	MS	F	p<
Between	1	1.8808	1.2359	.2951*
Within	9	1.5218		

*Not significant.

H_3: Clients who are counseled with IPR and affect simulation will be more satisfied with their therapy sessions than clients who are counseled with traditional methods.

Results: No significant difference in treatment effect between group A and group B was found. Therefore, the null hypothesis is not rejected.

TABLE 4.6.--ANCOVA for TSR Scores.

Source	df	MS	F	p<
Between	1	.1134	.1092	.7486*
Within	9	1.0382		

*Not significant.

H_4: Clients who receive counseling with IPR and affect simulation will reveal less discrepancy between their self concepts, their goal self concepts and the way they think others see them than clients who receive traditional counseling.

Results: No significant difference in treatment effect between group A and group B was found. Therefore, the null hypothesis is not rejected.

TABLE 4.7.--ANCOVA for MSGO Scores.

Source	df	MS	F	p<
Between	1	.7377	3.1272	.1109*
Within	9	.2359		

*Not significant.

H_5: Peers of clients will report more positive behavior changes after the treatment period for clients who receive IPR counseling than for clients who receive counseling without IPR.

Results: No significant difference in treatment effect between group A and group B was found. Therefore, the null hypothesis is not rejected.

TABLE 4.8.--ANCOVA for PIQ Scores.

Source	df	MS	F	p<
Between	1	.9532	.5267	.4865*
Within	9	1.6200		

*Not significant.

For this last hypothesis, further analyses were performed. The results of these analyses will be found in the following section of this chapter.

The Peer Information Questionnaire-- Independent t Tests Results

In a further effort to ascertain whether differences existed between the ways peers of group A clients and peers of group B clients responded to the PIQ, two independent one-tailed t tests were performed. Since "one" and "six" responses on the PIQ represented extremes of "strongly feel it is not true" and "strongly feel it is true," respectively, for each PIQ statement, it was assumed that these options would be used by peers only when they felt intensely about their client-peer (relative to a particular item on the PIQ). It was further thought that behaviors of clients of

a particular treatment group may have influenced peers to respond more strongly, positively or negatively, to items on the PIQ when evaluating that peer, this despite the earlier finding that on the average there was no between groups difference.

Two informal hypotheses were formulated. It was expected that peers of group A clients would express more "strongly agree" (six) ratings than peers of group B clients and that peers of group A clients would express less "strongly disagree" (one) responses than peers of group B clients. Comparisons of the frequency of "one" responses between groups A and B and the frequency of "six" responses between groups A and B were thus made.

A significance level of .05 was selected for the two *t* tests taken together; however, since the assumption of independence could not be met for the PIQ results in this case, the .05 level was split, and a *t* distribution score at the .025 level with 10 degrees of freedom was used. For the first *t* test the number of "six" responses across all items on the questionnaire and across the two peers for each client constituted the dependent variable. For the second test the dependent variable consisted of the number of "one" responses across items and peers.

As noted in Table 4.9, the frequency of "one" (negative) responses was not found to be significantly greater for group B than for group A. Neither was the frequency of "six" (positive) responses found to be

significantly greater for group A than for group B. Had a .1 confidence level been selected, however, the frequency of "one" responses would have been found to be significantly greater for group B than for group A, but the frequency of "six" responses would not have been found to be significantly different.

TABLE 4.9.--t Test Table for Frequency of "One" and "Six" PIQ Responses.

		Group A (IPR)	Group B (Traditional)	$t_{n_A+n_B-2}$
Frequency of Ones		2	8	-1.686*
	Mean	.34	1.33	
	S.D.	.47	1.37	
Frequency of Sixes		41	28	1.250*
	Mean	6.83	4.67	
	S.D.	3.02	2.92	

*Not significant.

Dependent Variable to Covariable Correlations

Correlation coefficients between the EU covariable and each dependent variable were computed and varied relationships were noted. As seen in Table 4.10, both positive and negative correlations were found, with one coefficient significant at the .01 confidence level.

TABLE 4.10.--Correlations Between Covariable and Dependent Variables (pooled within groups).

	R_1 (COGS)	R_2 (DX)	R_3 (TSR)	R_4 (MSGO)	R_5 (PIQ)
Cov (EU)	.562	.401	-.258	-.888*	.235

*Significant at the .01 level (d.f. = 10)

A coefficient of .562 was noted between the EU covariable ratings and the COGS ratings. A rather strong, but non-significant (.05 level) positive relationship between the two variables is indicated by this coefficient, suggesting that the level of counselor empathic understanding may be directly related to client in-therapy behaviors (OF, DS, and CCh) as measured by the COGS.

Similarly, a positive correlation of .401 was obtained between the covariable and DX ratings, suggesting that clients of therapists rated higher on EU may engage in the self exploration process more or to a deeper level than clients of therapists who are rated at lower levels of EU. This correlation, however, while relatively high, is non-significant, and caution must be used in its interpretation.

A relatively low negative correlation was found between EU ratings and TSR results. The -.258 coefficient may indicate a slight inverse relationship between counselor empathic understanding and client reported satisfaction with therapy, but the relationship between counselor EU and

client satisfaction on the basis of the data from this study does not appear to be sufficiently strong to warrant a definitive statement.

A significantly high correlation was found, however, between counselor EU and MSGO results. A correlation of -.888 (significant at the .01 level) was obtained, indicating a strong inverse relationship between self concept discrepancies and counselor EU for the data resulting from this study. One conclusion which may be justified on the basis of the coefficient is that higher levels of counselor EU are related to lower self concept discrepancies as reported by clients after therapy on the MSGO. Conversely, lower levels of counselor EU may be related to higher discrepancies between self concept elements on the MSGO.

Little relationship was found between the EU covariable and peer reports of client behavior outside of the therapy setting. A low positive correlation of .235 between EU and PIQ results was noted. This coefficient is not sufficiently high to be found significant at the .05 level and statements of EU to PIQ relationships must be made with great caution on the basis of this correlation. Further discussion of these results will be found in the subsequent chapter.

Dependent Variable Intercorrelations

Correlation coefficients between dependent variables were also computed for the data resulting from this study (see Table 4.11). Both positive and negative dependent

variable intercorrelations were found, with three correlations being significant beyond the .05 level.

TABLE 4.11.--Correlation Matrix--Dependent Variable Intercorrelation Coefficient (pooled with groups).

	COGS	DX	TSR	MSGO	PIQ
COGS	1.000				
DX	.920**	1.000			
TSR	- .121	.026	1.000		
MSGO	- .577*	- .579*	.072	1.000	
PIQ	- .001	- .041	.193	- .272	1.000

* Significant at .05 level.
**Significant at .01 level.

The highest indication of relationship between dependent variables was found to exist for the COGS and DX scales (.920), a correlation significant beyond the .01 confidence level. The results of the COGS and DX ratings for this study were therefore highly related in a positive direction. The COGS correlated negatively with the other three dependent variables; coefficients descriptive of the relationship between the COGS ratings and TSR, MSGO and PIQ results were found to be -.121, -.577 and -.001, respectively. The COGS to MSGO correlation coefficient was further found to be significant at the .05 level.

Although the DX ratings correlated highly with COGS ratings for these data, low correlations were found between DX and TSR results and between DX and PIQ results. Coefficients for these two relationships were found to be .026 and -.041, respectively. A significant (.05 level) negative relationship was observed between DX ratings and MSGO results, however, indicating a relatively strong inverse relationship between these two variables. That is, DX and MSGO data were found to be related in a way which suggests that higher levels of client self exploration were associated with low self concept discrepancy scores, and low levels of client self exploration were associated with higher self concept discrepancy indices.

Low but non-significant correlations (.072 and .193) were found between TSR scores and MSGO scores and PIQ ratings, respectively, indicating little relationship between TSR results and either MSGO or PIQ results. Similarly, little relationship was noted to exist between MSGO and PIQ results; a coefficient of -.272 was obtained for this relationship.

Client Written Comments

As a means of obtaining an informal client evaluation of the treatment programs, a "Comments" page was provided for each participating client at the time of post-testing. Clients were asked to indicate, if they desired, any of their impressions, reactions to, or opinions about the six-week program they had just completed.

Nine of the twelve clients who completed the therapy programs chose to respond with comments about their program or about themselves in the program. Clients in both groups tended to "accentuate the positive;" all comments made about the treatment programs were of a positive nature. Clients in group A (IPR) tended to speak of the benefits of the videotape and the examination of it for their particular experience in therapy while clients in group B (no IPR) typically commented about the importance of their deciding to enter therapy and the beginning benefits of their therapy experience. Many clients from both groups indicated that their six week experience was only the beginning of a new process of self-exploration and examination for them. Observation of the client comments suggests that group A clients tended to speak more about the relationship between them and their therapists in the context of a particular concern than group B clients; group B clients spoke more about their individual feelings about the therapy without referring to their relationship with the therapist. As an example, an IPR group client commented as follows:

> "Working with the video provided an easy path to help the client and therapist get together and understand just exactly how the other person was feeling. At times I felt that I was so wrapped up in trying to say my feelings that I couldn't feel them. The video brought these back and provided us a chance to interact at an even more basic level . . . . The action on the video provided an opportunity to analyze what was happening on the tape which gave us both another chance to look at what we really wanted to say to each other. Thus we were able to be more truthful."

A comment more representative of group B clients, however, does not refer to the client-therapist relationship:

> "I think it has been very good in ways of going over experiences in the past and letting myself feel things that I was unable to recognize in myself then. I think I am a bit more able to accept myself now and to see where some of my feelings originate. Overall, the sessions have been quite helpful to me."

Clients also commented on the length of the sessions, revealing an opinion that the longer sessions were beneficial to them. In this context, however, IPR group clients seemed to indicate more awareness of their own defensive dynamics than traditionally counseled clients. For example, in the following comment, the IPR group client seems to demonstrate an awareness of not only a defense against the counselor's approaches toward him, but also the importance of an interactive relationship between himself and his counselor:

> "The 1½ hour sessions worked well for me. It took me time to get past my opening bullshit. In the early stages I would have wasted most of 50 minute sessions. The use of videotape was very significant for me. Not only did I get the chance to view how I react but by discussing how I thought my therapist was reacting (while he was in the other room) facilitated our relationship. I feel this is a very good method for building up a trust between client and therapist . . . I was very pleased with the project and the therapy."

The following example, however, from a member of the traditionally counseled group, seems to connote more passivity on the client's part, with little awareness of a mutual effort toward problem resolution:

> "My counselor . . . wasn't always able to grasp exactly what I was feeling--although he was usually on the right track. His basic purpose was to give me feedback on what I was saying--how it made him feel--what patterns he saw--where I was coming from. He helped me to become aware of the sources of my problems, and made suggestions as to how to deal with them--which will always be up to me."

Many of the twelve clients made some reference to the importance of entering therapy, and many IPR clients commented on their wish that the program had been longer. For example, "It really seemed like we were just starting to scratch the top of my head," or:

> "I felt good about how the sessions went but it's hard to feel very good with much more to do . . . Over the short period of six sessions I had some difficulty accepting the relationship with the therapist making progress somewhat retarded, cutting down on the effectiveness of the therapist."

A general impression evident was that, since more IPR clients made reference to having more to do, or a clearer notion of what directions they wanted to grow in, the video and IPR may have enhanced the process of clarifying and setting goals for the IPR group over the treatment period.

Finally, in addition to the observation that most clients (regardless of group) saw their therapy experience as a very positive one, IPR group clients seemed to find the video review of their own behavior "interesting" and profitable for their own personal growth; however, differences between the groups with regard to this impression were not found to be reflected in the satisfaction (TSR) reports.

Summary

Five areas of data were examined in this study. A comparison of covariable ratings was made, an analysis of covariance on each of the five dependent variables was carried out, two independent *t* tests were performed in order to compare frequency of extreme responses to client behavior by peers, and dependent variable to covariable correlations and dependent variable intercorrelations were examined.

When comparisons were made between groups on the covariable (counselor empathic understanding), group B counselors (no IPR) were found to be functioning at a slightly, but not significantly higher level than group A counselors. Relationships between the covariable and the dependent variables were observed through examination of correlation coefficients. Correlations between the covariable ratings and each dependent variable ranged from -.888 to +.562; one correlation--that between Empathic Understanding and Miskimins Self-Goal-Other Discrepancy Scale results--was found to be significant (.01 level).

Hypotheses one through five were analyzed and appropriate statistical evidence was presented. No differences between groups A and B were found to exist on the criterion measures when data were examined by analysis of covariance. No differences were noted on Characteristics of Client Growth or Client Degree of Self Exploration dimensions, Therapy Session Report results, Miskimins

Self-Goal-Other Discrepancy Scale scores or Peer Information Questionnaire ratings. Neither did counselor empathic understanding mask possible treatment effects between groups, since this factor was controlled for by the use of counselor EU as the covariable.

When Peer Information Questionnaire results were further examined by the application of two independent *t* tests to the frequencies of extreme scores on the PIQ, numerical differences favoring the IPR group were observed, but were not found to be significant.

Varying intercorrelations were noted among the dependent variables. Correlations ranging from +.920 to -.579 were observed for each dependent variable to dependent variable intercorrelation. Finally, subjective comments of client-participants were noted and reported.

CHAPTER V

DISCUSSION AND CONCLUSIONS

Summary

This research represented an attempt to evaluate a relatively recently developed method for accelerating client growth in counseling and psychotherapy. The specific purpose of the study was to compare the results of the application of two different methods of therapy with college students. One method included an affect simulation/videotape technique; the other consisted of a traditional dyadic approach.

The basic question underlying the research project was whether an integrated affect simulation/Interpersonal Process Recall procedure with videotape could produce a more accelerative effect on client growth in therapy over a six week period of time than a traditional therapeutic approach. In a previous study (Schauble, 1970), in which similar methods were used in a different design, significant results were noted; clients with whom the experimental procedures were used were found to have evidenced greater gains on therapy process variables than clients who underwent traditional therapy.

The therapy model used in this study was derived largely from Kagan's (1967) Interpersonal Process Recall and affect simulation methods. Studies showing applications of these methods in a variety of settings were examined and these, in addition to those in which more general simulation and videotape techniques were used, provided some evidence that the methods could be adapted to the therapy situation and provide a viable approach to the acceleration of client growth in therapy.

The therapy program for the experimental group clients was begun with a regular counseling session. To apply a successively approximative method of assisting clients to move toward confronting and examining their fears and dynamics, additional tasks were then introduced in subsequent sessions. Clients moved next into the use of affect simulation, whereby they could examine their affective reactions to emotional situations and respond to affect within a relatively non-threatening situation. Clients then were videotaped during their affect simulation viewing, and examined their reactions to the simulated experience by reviewing the videotape of themselves as they watched the simulation films. Following this, they were videotaped during their counseling sessions and given an opportunity to review and recall their own behaviors and feelings as they occurred in the client-counselor relationship. Two sessions were spent with only an inquirer (a third person trained to help the client recall and explore

his original thoughts and feelings during the videotape replay of the interaction) and the client present, and another session was spent with the inquirer and both the client and counselor present. A summary of procedures for the IPR group and the comparison treatment group is presented in Table 5.1.

The final sample for this study consisted of undergraduate students who had sought assistance with personal concerns from the staff at the Michigan State University and the University of Wisconsin at Milwaukee Counseling Centers. Therapists used for the study were staff members, doctoral interns, and doctoral level practicum students, all of whom regularly counseled clients at the counseling center offices. A posttest only design was used with therapists and clients randomly assigned to treatments. Clients who received therapy within the IPR/affect simulation model were compared with clients who received a more traditional therapy treatment and who did not use videotape methods. Measures of client in-therapy verbal behaviors (owning of feelings, differentiation of stimuli, commitment to change and self exploration), client reports (a therapy session report and a self concept discrepancy measure) and reports of peers were used as criterion measures. Hypotheses were presented which predicted that the IPR/videotape group would obtain higher in-therapy behavior ratings, satisfaction with therapy ratings and peer

TABLE 5.1.--Summary of Therapy Procedures.

Session	Time	Therapy Method	
		IPR	Traditional
1	1½ hrs.	Introductory Session--traditional therapy	Introductory Session--traditional therapy
2	1½ hrs.	a) 30 minute therapy session b) 40 minute affect simulation session c) 20 minute therapy session	Traditional therapy session
3	1½ hrs.	a) 30 minute therapy session b) 40 minute affect simulation--client videotaped and reviewed c) 20 minute therapy session	Traditional therapy session
4	1½ hrs.	a) 30 minute therapy session--videotaped b) 40 minute client recall c) 20 minute therapy session	Traditional therapy session
5	1½ hrs.	Same as Session 4	Traditional therapy session
6	1½ hrs.	a) 30 minute therapy session--videotaped b) 40 minute mutual recall c) 20 minute therapy session	Traditional therapy session

ratings and lower self concept discrepancy scores than the traditional group.

Following random assignment of names taken from a waiting list of clients, each prospective client was called by telephone for assessment of willingness to participate in the project. Of those called, all who were able to be contacted and who had not arranged some other therapy experience agreed to participate. A sample of 13 clients and 13 therapists was thus gathered (one client was unable to complete the entire project, resulting in a total final sample of twelve clients). Because of different levels of experience and expertise of the therapists, results were analyzed by a multivariate analysis of covariance. Five dependent variables and one covariable were used in the analysis, with rated empathic understanding of therapists constituting the covariable. Significance testing was carried out at the .05 level for each hypothesis.

No significant differences were noted between group A (IPR/videotape treatment) and group B (traditional treatment) on the variables of interest. Hypotheses predicting higher posttreatment scores for group A clients on a composite Characteristics of Client Growth Scales (COGS, Kagan, 1967) rating (consisting of combined scores for client Owning of Feelings, Differentiation of Stimuli and Commitment to Change), a client Depth of Self Exploration rating (DX, Truax and Carkhuff, 1966; Carkhuff and Berenson, 1967), a Therapy Session Report (TSR, Orlinsky and Howard, 1968)

and a Peer Information Questionnaire (PIQ, developed for this study) were not confirmed. Neither was an hypothesis predicting lower scores for group A clients on the Miskimins Self-Goal-Other Discrepancy Scale (MSGO, Miskimins and Braucht, 1971) supported by the data. Correlation coefficients between covariable ratings and the dependent variables were computed, as well as intercorrelations of dependent variables. Covariable to dependent variable correlations ranged from -.888 to +.562; dependent variable intercorrelations ranged from -.579 to +.920. Two independent one-tailed *t* tests were also performed on the PIQ results in an attempt to ascertain whether differences in the frequency of extreme responses existed between the two groups. No significant differences were evident when these tests were applied. Finally, comments of participating clients were gathered and examined.

Conclusions

1. The application of a series of successively approximative therapeutic tasks in which affect simulation films and videotape replay and review through Interpersonal Process Recall (IPR) were used did not result in more accelerated client growth in therapy as measured on in-therapy process variables than did the application of traditional therapeutic methods.

2. The application of affect simulation and Interpersonal Process Recall with videotape to the personal

therapy experience did not result in greater satisfaction with the therapy experience than the application of traditional therapeutic techniques.

3. The application of affect simulation and Interpersonal Process Recall methods in personal therapy did not result in less self concept-related discrepancies than the application of traditional therapeutic methods without affect simulation and IPR.

4. The application of affect simulation and IPR methods to personal therapy did not result in increased reports of positive behavior change for clients by their peers than the application of traditional therapy methods without IPR and affect simulation.

5. The use of affect simulation and Interpersonal Process Recall with videotape is seen by clients as beneficial and conducive to self exploration and exploration of the client-counselor relationship in personal therapy.

Conclusions one through four are derived from examination of data resulting from this study. Conclusion five is not related to formal questions asked in the study and therefore do not stem from analysis of the data. Rather, it is derived from comments made by client-participants after the conclusion of the therapy program.

Discussion

Implications and Observations

The primary observation stemming from the results of the present study is that of the difference in outcome between this study and that of Schauble in 1970. An important implication of the fact that effects of IPR/affect simulation treatment were noted in the Schauble study but not in the present experiment is that those previous results must be looked upon with more skepticism than would be the case were this study not conducted. That is, while the results of either of these projects may be valid, the fact that differences between treatment groups were noted in the original project but not in the present one to some extent weakens the positive implications of results obtained in the Schauble study.

Reference to another recent study (Hartson, 1971) of IPR use in a therapeutic setting is also pertinent here. The general conclusion that IPR use does not result in more therapeutic progress than traditional methods is not shared by Hartson on the basis of his results, since it was found in that study that the use of IPR resulted in significantly more self disclosure and group readiness and higher judgements of communication skills and therapeutic verbal communication. While the use of the IPR methodology for the Hartson study and for this study was dissimilar, and the therapeutic milieu was different in each case, in the differing results lies the implication that the IPR procedure as a therapeutic

methodology appears to be viable, but deserves further investigation.

A third implication comes from comparing the structured IPR/affect simulation therapy experience with the less structured traditional therapy received by the comparison group clients. This comparison raises the issue of the effect of structure imposed by someone other than the primary therapist to the therapy situation. Each experimental treatment session was organized in this project to facilitate measurement as well as progress by clients through the various stages. While the organization of the progressive movement was done on a logical basis, possibly there were negative effects resulting from not using specific techniques at differing points in the therapy process according to individual client needs as determined by each therapist.

There were also great differences in competency among the therapists used for this study; yet, it is important to note that all of the therapists came from a relatively select group. The selection process for staff members, interns and students at the primary university used for the study is rigorous. The implication here is that a more diverse therapist sample, in which therapists from a number of different institutions were used, for example, may have affected client progress in a different way.

Treatment and Methodological Considerations

A number of factors deserve to be considered in the interpretation of the results of this study. It must be remembered that the length of treatment consisted of only six therapy sessions for a total of nine hours of therapeutic encounter. The issue of whether this amount of time is enough to produce evident change for either group could be raised. That is, six weeks may not have been sufficient for either treatment to realize its full impact, and because of this factor, differences were not apparent. Yet, it must also be remembered that in the 1970 Schauble study, some differences were noted after the same length of treatment. One difference between the two studies that is worthy of note however, is the fact that the physical facility for this study was different than that for the Schauble study. In the present study, the videotape equipment was more visible and contained in the room, while for the previous study the camera and VTR were partially concealed and contained in an adjacent room behind a partition. While clients' self reports do not seem to indicate this, it is possible that the presence of some of the equipment in the counseling room detracted from the experimental clients' ability to concentrate fully on themselves, thus reducing the potency and effectiveness of the method.

Other methodological differences between the Schauble study and the present one deserve consideration. While

clients for the Schauble study were also randomly selected and assigned, the entire sample consisted of female clients, while the sample for the present study was composed of both male and female individuals.

Another difference between the two studies is in the assignment of therapists to treatment groups. While each of the two therapists in the Schauble study used both IPR and traditional methods with different clients, none of the therapists in the present study worked with more than one subject in the study, and consequently used only one of the two treatment methodologies. The effects of sex differences in the client sample or possible therapist bias toward or against a particular treatment approach as a result of one therapist using both treatments may be cause for speculation as to the different results. Similarly, the fact that one inquirer conducted a majority of the recalls should be considered a possible influence in the present study.

A final consideration relates to the affect simulation portion of the experimental treatment. The use of affect simulation has been thought to be particularly effective for counselors in training, especially for assisting them in exploration of their own reactions to affective stimuli. Training of this sort is typically carried out by persons quite experienced in helping counselors-in-training to use the affect simulation films or videotape to best advantage. The counselors used for this study, however, were not all versed in the use of the affect simulation

films prior to their training for the study. Hence, their training may not have been sufficient to help their clients realize the full benefits of the films for self exploration. Yet, reports of experimental group therapists about these sessions would indicate that the films certainly did have some impact on some clients. The specific effects of affect simulation for direct use in therapy with clients would seem to warrant further investigation.

Statistical Analysis

While a different analysis procedure was used for the results of this study than was used for those of the former study (Schauble, 1970), it would not appear that this modification can be used to account for the differing results of the two experiments. The covariate analysis procedure used here essentially equated all Ss on the covariable criterion so that differential growth could be observed. The use of a covariable in this manner accomplishes essentially the same purpose as the use of a pretest, provided the covariable correlates sufficiently high with the dependent variables. It is therefore proper to speak of client growth from beginning to end of the treatment period, rather than only of higher or lower post-treatment scores on the criterion measures. And on the basis of analysis of data, it is evident that significantly more growth in therapy did not occur for experimental clients than for comparison-treatment clients.

The degree of covariance must be considered in the interpretation of these results, however, since the precision of the statistic used corresponds directly to the degree of covariance between the covariate and the dependent variable(s) (Campbell and Stanley, 1963). While correlation coefficients between the empathic understanding covariate and the dependent variables used for this study were generally sufficiently high to use the EU covariate, the use of another, or additional covariates might have increased the precision of the analysis. Correlation coefficients ranging from -.888 (significant at .01 level) to +.562 were noted for the covariable to dependent variable relationships. The additional use of the Degree of Self Exploration Scale as a covariable, for example, may have increased the precision of the covariate analysis statistic.

Limitations

Basic methodological limitations exist in this study. The most obvious, and probably most basic weakness is the size of the N. Although a larger sample size would certainly have been preferable, the availability and willingness of therapists at the time the study was undertaken was prohibitive of obtaining a larger sample. The necessity of controlling for a therapist-treatment interaction or bias was obvious; assignment of each client to a different therapist seemed crucial in order to control for this possible contaminating effect. The number of observations

was thus limited to twelve, and this small sample size would have required sizable differences for statistical significance.

A second limitation of the study is the imprecision of measurement. As discussed in Chapter II, certain problems are inherent in the assessment of inter- and intrapersonal behavior. Attempts were made in this study to circumvent some of these problems but the development of adequate measurement techniques for human behavior remains in initial stages. Research has shown that verbal behavior rating scales can be reliable and valid measures of therapy processes, but these need further refinement and specification. The fact that one of the measures used dealt with clients' behavior in real social situations (clients' peer relationships) rather than only the therapy setting, suggests relevance. Yet the reliability and validity of the Peer Information Questionnaire in particular is certainly questionable. A follow-up reliability study of the PIQ results, in which a Hoyt (1967) two-way analysis of variance technique was used, revealed a coefficient of .123. On the basis of this reliability coefficient it can be concluded that the peers so disagreed in their ratings of their client-peers that the observation of differences between the two treatment groups would have been impossible to observe. Essentially, nothing was measured by the PIQ in this study. Yet, the use of peer-informants seems a logical and relevant way to measure real behavior change

in individuals undergoing therapy. More specific studies of the effectiveness and appropriateness of this means of measuring human behavior are needed and are continuing.

Specifically relevant to the above discussion is the issue of whether any single criterion should be used to assess individual behavior change as a result of therapeutic intervention. In the present study, both internal and external criteria were used; an attempt was made to measure change both in the therapy situation and outside the therapy setting, in the clients' day-to-day relationships with peers. The rationale for the use of these multiple criteria stems from the concept of a directional, progressive sequence of events which may be more valid when considered in one direction but not necessarily when viewed in the opposite sequence. If it is assumed that counselor behavior, if appropriately acted out, will change a client's behavior (therapist empathy, for example, being conducive to self exploration by the client) in the therapy situation, can it automatically be assumed that the clients' behavior will also be changed outside of the therapy setting? Further, can it therefore be assumed that if the clients' behavior outside of therapy is changed, then that change will be observed by others? Not necessarily, it seems, especially when the possibility of change occurring exclusively intraindividually is considered. Rather, a reverse series of assumptions would appear to be more valid: If an individuals' behavior is observed to have changed in

his everyday living and relationships, it probably has, in fact, changed. If it has changed outside of the therapy milieu it has likely changed in therapy also. And the change is likely related in some way to the behaviors of the therapist in his work with the client. In attempts to assess real, observed behavior change in clients, therefore, the use of external criteria seems crucial and relevant.

Another consideration specifically relevant to the use of the Peer Information Questionnaire has to do with the way in which peers were asked to judge the client-peers. Asking peers to review and remember the clients' behavior "over the past six weeks" may be less accurate and more susceptible to inaccuracies and distortions than keeping a daily observation log, for example, or informing the peers prior to the start of the clients' treatment programs that they will be asked to comment about the behavior of their peer.

While the other instruments may also be criticized for their general lack of sensitivity, an additional factor may have compounded or accentuated the insensitivity of two of these instruments. Composite scores were used for the Characteristics of Client Growth Scales in that the summed total of ratings on Owning of Feelings, Differentiation of Stimuli and Commitment to Change for each client was used. Similarly, only the Total scale of the Miskimins Self-Goal-Other Discrepancy Scale, which incorporates all factors into one score, was used as a criterion. The

decision to use the composite COGS score and only the MSGO Total scale score may have resulted in less sensitivity to subtle differences across clients or groups of clients.

Implications for Further Research

1. Because contradictory results have been obtained from the two in-depth studies conducted to date on the effectiveness of the affect simulation/IPR therapy program, further investigation of the viability of the model for therapeutic use is indicated. Further research concentrating on investigation of the differences between the previous (Schauble, 1970) and the present study may reveal factors which are important in determining the potency of the affect simulation/IPR method in counseling and psychotherapy.

2. The necessity versus economy of videotape equipment as an integral part of the therapy experience should be carefully considered and evaluated. While clients report that they benefitted from the videotape experience, objective assessment does not support the conclusions that therapeutic benefits occur to clients with whom it is used.

3. Studies which investigate the effects of the treatment model used here over longer periods of time should be initiated. Attention should be focused on the impact of a similar successively approximative treatment program on client behavior over a longer period of time. Possibly a more extended therapy program would allow for the impact of the films and/or videotape to be more fully realized.

4. The use of specific parts of the IPR/affect simulation therapy model remains a possibility which requires further investigation. Research in which various stages (e.g., Video Recall of Affect Simulation, Client Recall) of the model are applied individually would be appropriate for determining the individual potency of each stage for specific purposes in therapy.

5. In addition to evaluation of individual stages as therapeutic tools, an assessment of various combinations of stages in various sequences is necessary. That is, the content and sequence of the therapy model should be further scrutinized. It may be found that some parts of the model should be enhanced or lengthened in order for the treatment to have its maximum effect. The mutual recall stage, for example, seems to be a particularly helpful stage for clients, according to their reports, and may be particularly suited to extension or emphasis in a therapy program of the sort examined in this study.

6. The imposition of structure, particularly time limits of the type imposed in this study, on clients and therapists seems to deserve further investigation. Study of the effects of moving to a new task or stage on a scheduled basis rather than on a basis considerate of individual differences and needs is required. Implications for training therapists to use simulation and videotape independently and without supervision or structure may also be found in this type of investigation. With appropriate

training in the use and appropriateness of videotape and simulation methodologies (the forty-hour training program currently being given many counselors and paraprofessionals, for example), therapists could use those which are most capable of assisting their clients learn and grow.

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APPENDICES

APPENDIX A

SUBJECT CONSENT FORM

SUBJECT CONSENT FORM

MICHIGAN STATE UNIVERSITY East Lansing, Michigan 48823

Counseling Center Student Services Building

CONSENT FORM

I, _____, student number _____, agree that the information obtained during the course of my counseling and testing sessions may be used for scientific purposes. This permission covers the use of test results, counselor reports, video and/or sound recordings, and behavior ratings given by the individuals I have identified for that purpose. This permission is given with the understanding that all information will be treated in a professional manner and that adequate safeguards will be taken to insure anonymity.

Signed _____

Date _____

Witness _____

APPENDIX B

STANDARD LETTERS OF EXPLANATION

TO STUDENT CLIENTS

STANDARD LETTERS OF EXPLANATION

TO STUDENT CLIENTS

MICHIGAN STATE UNIVERSITY East Lansing, Michigan 48823

Counseling Center

(1) April 10, 1972

Dear Student:

We at the Counseling Center believe that one of the ways we have of becoming increasingly helpful to students like yourself is through careful study of your concerns and of our effectiveness in helping you with them. We are presently in the process of evaluating the use of videotape in counseling with students as a possible means of facilitating "growth" in counseling. We would like you to consider participating in this project.

As a participant, you will be assigned to a counselor whose primary concern is helping you. You will be asked to make a commitment to meeting for six weeks with your counselor, for 1½ hours per week (instead of one hour per session). Portions of your counseling sessions would be recorded on videotape and the additional time is needed to allow you to view a playback of the videotape. You would also be asked to complete some brief inventories after your sixth session and provide us with the names of two individuals whom you know and who are in a position to observe your behavior over Spring Term. After you have had six sessions with your counselor the two individuals you named will be asked to respond to a brief checklist in which they will indicate their perceptions of your behavior.

The research period will be for the next six weeks of Spring Term. After this period you may continue on a regular basis with your counselor if you both agree it is appropriate.

In summary, your participation consists of: (1) making a commitment to see your counselor 1½ hours a week for at least six weeks, (2) supplying the names of two people we may contact in regard to your behavior which they may have observed, and (3) completing two brief (about ½ hour) inventories after your sixth session.

We want to emphasize that your willingness to participate in no way affects your seeing a counselor at the Center and that all information will be used for scientific purposes only, with adequate safeguards to insure anonymity. Our most important consideration is to assist you with the resolution of the concerns that stimulated you to seek our help. We do want you to know, however, that through the participation of students like yourself we are able to improve our effectiveness.

Sincerely,

Robert Van Noord
Counseling Intern

Dr. Ralph Kron
Assistant Director for
Research

MICHIGAN STATE UNIVERSITY East Lansing, Michigan 48823

Counseling Center

(2) April 10, 1972

Dear Student:

We at the Counseling Center believe that one of the ways we have of becoming increasingly helpful to students like yourself is through careful study of your concerns and our effectiveness in helping you with them. We are presently in the process of evaluating the use of a different approach consisting of longer contact sessions with students as a possible means of facilitating "growth" in counseling. We would like you to consider participating.

As a participant, you will be assigned to a counselor whose primary concern is helping you. You will be asked to make a commitment to meeting for six weeks with your counselor, for 1½ hours per week (instead of one hour per session). Your counseling sessions would be recorded on audiotape and you will be asked to complete some brief inventories after your first six sessions. We will also ask you for the names and addresses of two individuals whom you know and who are in a position to observe your behavior over Spring Term. After you have had six sessions with your counselor the two individuals you named will be asked to respond to a brief checklist on which they will indicate their perceptions of your behavior.

The research period will be for the next six weeks of Spring Term. After this period you may continue on a regular basis with your counselor if you both agree it is appropriate.

In summary, your participation consists of: (1) making a commitment to see your counselor 1½ hours a week for at least six weeks, (2) supplying the names and addresses of two people we may contact in regard to your behavior which they have observed, and (3) completing two brief (about ½ hour) inventories after your sixth session.

We want to emphasize that your willingness to participate in no way affects your seeing a counselor at the Center and that all information is used for scientific purposes only, with adequate safeguards to insure anonymith. Our most important consideration is to assist you with the resolution of the concerns that stimulated you to seek our help. We do want you to know however, that through the participation of students like yourself we are able to improve our effectiveness.

Sincerely,

Robert W. Van Noord
Counseling Intern

Dr. Ralph Kron
Assistant Director for
Research

APPENDIX C

MEMOS TO COUNSELORS REGARDING PARTICIPATION

MEMOS TO COUNSELORS REGARDING PARTICIPATION

To: Senior Staff and Interns

From: Bob Van Noord

Subj: Participation in Research Project

Date: March 27, 1972

I'm planning to run some dissertation research during Spring term, preferably here at the Student Services Branch, but possibly at the Fee Branch Center as well.

I'd be interested in knowing if any of you who will be picking up new P-S clients early Spring Term from the waiting list would be willing to spend an extra half-hour per week with one new client, at least audiotaping your sessions, and possibly videotaping them and using some Interpersonal Process Recall techniques in them, within the context of the concern that a particular client has presented.

That is, I'm asking for a half-hour of your time per week for six weeks during Spring Term, in addition to the usual hour that is typically spent in a continuation of your regular session with the client or in examination of some of the dynamics of the relationship between you and your client.

If you think you might be able to spring loose some time for this, and would be interested, would you please check the appropriate places below and return this to my box by the end of the week? As an after thought, please check the appropriate place(s) and return in either case. Thanks.

_____ I will be picking up one or more new clients.

_____ I'm willing to participate

_____ I'm unwilling or unable to participate.

Name _____

Note: If this isn't clear or if you have some questions, please feel free to stop by and ask.

To: Practicum Students

From: Bob Van Noord

Subj: Participation in Research Project

Date: March 27, 1972

I'm planning to run some dissertation research during Spring term here at the Student Services Branch of the Center.

I'd be interested in knowing if any of you who will be picking up new P-S clients early Spring Term would be willing to spend an extra half-hour per week with one new client, at least audiotaping your sessions and possibly videotaping them and using some Interpersonal Process Recall techniques in them, within the context of the concern that a particular client has presented.

That is, I'm asking for a half-hour of your time per week for six weeks during Spring Term, in addition to the usual hour that is typically spent per week with most clients. The additional half-hour will be spent in a continuation of your regular session with the client or in examination of some of the dynamics of the relationship between you and your client.

If you think you might be able to spring loose some time for this, and would be interested, would you please check the appropriate places below and return this to Nancy Bossenbroek? As an afterthought, please check the appropriate place(s) and return it to her in either case. Thanks.

_____ I will be picking up one or more new clients.

_____ I'm willing to participate.

_____ I'm unwilling or unable to participate.

Name _____

Note: If this isn't clear or if you have some questions, please feel free to stop by and ask.

APPENDIX D

THERAPY SESSION REPORT ITEMS

THERAPY SESSION REPORT ITEMS*

This booklet contains four questions about the therapy sessions which you have just completed. These questions have been designed to make the description of your experiences in the session simple and quick.

The questions have a series of numbered statements under them. You should read each of these statements and select the one which comes closest to describing your answer to that question. Then circle the number in front of your answer.

BE SURE TO ANSWER EACH QUESTION

Client Code _____

Date _____

*These items were selected from the Therapy Session Report,

Therapy Session Report Items

1. In general, how do you feel about the previous six sessions which you have just completed?
   1. Very poor
   2. Pretty poor
   3. Fair
   4. Pretty good
   5. Very good
   6. Excellent
   7. Perfect

2. How much progress do you feel you made in dealing with your problems over these six sessions?
   1. In some ways my problems seem to have gotten worse.
   2. Didn't get anywhere over the period of the six sessions.
   3. Some progress.
   4. Moderate progress.
   5. Considerable progress.
   6. A great deal of progress.

3. How well did your therapist seem to understand what you were feeling and thinking during your session?

   1. Misunderstood how I thought and felt.
   2. Didn't understand too well how I thought and felt.
   3. Understood pretty well, but there were some things he (she) didn't seem to grasp.
   4. Understood very well how I thought and felt.
   5. Understood exactly how I thought and felt.

4. How helpful do you feel your therapist was to you during your sessions?

   1. Not at all helpful.
   2. Slightly helpful.
   3. Somewhat helpful.
   4. Pretty helpful.
   5. Very helpful.
   6. Completely helpful.

APPENDIX E

PEER DATA FORM

PEER DATA FORM

Names of people whom we may contact in about six weeks:

Name _____

Address _____

Telephone _____

Name _____

Address _____

Telephone _____

*Name _____

Address _____

Telephone _____

*If you are doubtful as to the availability or willingness of one of the above, please give us an alternate. It is important to receive responses from two individuals.

Again, we thank you for your cooperation!

APPENDIX F

SAMPLE QUESTIONS FOR USE WITH AFFECT SIMULATION FILMS

SAMPLE QUESTIONS FOR USE WITH AFFECT

SIMULATION FILMS

1. Focus on what the actor/actress is communicating.

   A. What was he/she saying?
   B. What was he thinking?
   C. What was he feeling?
   D. Can you separate the content of what he was saying (the actual words) from the meaning (intent or feeling) behind what he was saying?

2. Focus on how the client reacted.

   A. What kind of reaction did you have?
   B. What were you thinking?
   C. If there was more than one feeling or emotion aroused in you can you sort them out, i.e., recognize, identify, and label the feeling?
   D. Can you tell where the feeling was coming from, i.e., identify the source?
   E. How would you respond to that person?

The first session in which affect simulation is used will probably make use more of the types of questions found under 1 above. The second session in which affect simulation is used (i.e., Session 3) should be spent more in getting into the client's reactions to the films; consequently, the type of questions found under 2 above would be in reviewing the videotape of the client as he was watching the films.

APPENDIX G

WEEK-BY-WEEK MEMOS REGARDING PROCEDURES FOR GROUP A COUNSELORS

WEEK-BY-WEEK MEMOS REGARDING PROCEDURES

FOR GROUP A COUNSELORS

To: Group A Counselors

From: Bob Van Noord

Subj: Procedures

Date: April 14, 1972

The following is an outline of the sequence of events for the next six weeks as you're seeing your client within my research project. You will be meeting your client for six weeks, for 1½ hours a session. I'd like you to audiotape your first and last sessions and I'll provide the materials for this.

Session 1 (Week 1)
A 90 minute session with the client which is audiotaped

Session 2 (Week 2)
a) a 30 minute counseling session with the client
b) a 40 minute session in which simulation vignettes will be shown to the client and counselor will use films as focal point for discussion of client reactions to the filmed stimuli.
c) a 20 minute counseling interview conducted without the use of film or videotape.

Session 3 (Week 3)
a) a 30 minute counseling session with the client
b) a 40 minute session in which affect simulation films will be shown to the client, videotape of client will be made as he watches and tape replayed for client and counselor to use in discussion of client reactions to the filmed vignettes. In this session, the counselor focueses more on assisting the client in exploration of his own behavior.
c) a 20 minute session conducted without the use of films or videotape.

Session 4 (Week 4)
a) a 30 minute counseling interview which is videotaped
b) 40 minutes for a client recall of the videotape of the first 30 minute session. A trained "inquirer" will assist the client in this process while the counselor listens and observes through a one way mirror.

c) a 20 minute counseling interview conducted without videotaping.

Session 5 (Week 5)

a) a 30 minute counseling interview which is videotaped (same as week 4)
b) a 40 minute client recall of videotape made of first 30 minutes (same as week 4)
c) a 20 minute counseling interview conducted without videotape.

Session 6 (Week 6)

a) a 30 minute counseling session with the client which will be videotaped.
b) a 40 minute client and counselor recall (review of videotape of the first 30 minutes). A trained "inquirer" will enter and assist in this process.
c) a 20 minute counseling interview conducted without the use of videotape or IPR.

Your clients will be taking two inventories following their 6th session in the testing office. Your work with them after this 6th session, if you continue, would be on a regular basis.

This is intended only to provide an overview for you. I'll be getting more details to you week by week. Thanks!

Session 2

Hopefully, in Session 1 you have had a chance to establish a beginning relationship with your client and in some ways define the parameters of his concern. Possibly you have already formulated some notions about how you would like to proceed with that client--what his needs, desires, defenses might be and how you would like to consider these.

The essential purpose of the use of affect simulation films in Session 2 is to assist the client in getting more in touch with his affective domain--how he perceives interpersonal threat, for example, how he hears it, and how he reacts to it. While your client may already have some realization of what is "fair game" to talk about with you, and some awareness that talking about feelings and emotions is all right and appropriate, the films are intended to help him experience these feelings. In a sense, the films legitimize, stimulate and define your willingness to deal with affect in depth as well. They are also an initial step in a successively approximative process of bringing the client from a position of relative threat, from his perception, namely, dealing face-to-face with you and himself about his immediate, in-therapy reactions and emotions, to a point where he is able to do this without perceiving it as a major threat to himself.

Over the course of the six sessions, using the films and videotape as aids, the client will be brought through a gradual process of approaching and dealing with himself and you--the result being an ability to deal immediately and honestly with oneself and others. The use of affect simulation films is one of the initial steps in this process.

This may all be clearer if it is pointed out that in the process of viewing the films and reacting and talking about his reactions to them, the client has begun the process of self-exploration and examination, but is doing so from a position of relative interpersonal safety. While he has been asked to imagine himself in a situation with the person on film, the client still knows that the filmed other is on film, and is not a real person. Out of this position, he can begin to look at his feelings and reactions without having to be responsible for their impact or consequences. Session 3 will also assist in this process and will include the use of videotape in the client's examination of himself. Session 2, however, will not make use of videotape replay.

In Session 2, please use the first 30 minutes to conduct a regular session with your client. After 30 minutes, move into using the films for the next 40 minutes with the client. You may want to view a vignette, then stop and talk about your client's reactions to the stimulus situation, using the type of questions found on the attached sheet entitled "Sample Question for Use with Affect Simulation Films." Please take your time in using the films. Try not to rush through the vignettes and do not hurry the process of discussing reactions to them. Typically, only a few vignettes stimulate as much or more than an hour of reactive discussion. Allow the client to tell you about his reactions and internal experiences in his own words.

After spending 40 minutes with the films and examination of client reactions to them, return to your regular counseling session for the last 20 minutes.

Session 3

Session 3 will be conducted in essentially the same way as was Session 2, except that the use of videotape will be added. The intent of both sessions is the same: to provide an entry into the client's examination of himself, particularly his affective domain.

The first 30 minutes of your 1 and ½ hour session will be spent as a regular counseling interview, without the use of films or videotape. After these 30 minutes, please move into using the films once again with the client. Have the client view 5 vignettes in sequence, with no interruptions for discussion between them. At this point, the use of the stimulus films is over, except for the discussion and examination of client reactions. The resulting videotape will then be used as the focal point for the remainder of the 40 minute time segment allotted to this. The videotape which you will be viewing with your client will contain an image of him or her accompanied by the audio of the stimulus vignette.

As the client views himself on the videotape, he will be able to recall the feelings and reactions he was having at the time of his watching the actor on film. Assist him in exploring these feelings by using the type of questioning contained on the attached sheet entitled "Sample Questions for Use with Affect Simulation Films." Allow the client to tell you about his experience in his own words. At times you may want to help him get clearer about what he is saying to you--go ahead. Feel free to probe deeper, when appropriate, if you have some hunch or lead you may want to follow up on, doing so within the perspective of the client as the chief explorer. The overall intent is to allow the client to self-discover, to arrive at his own insights about himself, with you and the videotape as helpers to him.

It is very possible that you will not have time to review the entire videotape made of the client as he was watching the film because of the time taken in discussion and exploration. No problem. Please don't rush through the review of client reactions to the vignettes. If you only cover his reactions to one vignette, fine. If more, that's fine too.

After these 40 minutes have elapsed, please return to a regular counseling session for the remaining 20 minutes.

Session 4

The fourth session with the client whom you are seeing as part of this project will make use of a third person, called an "inquirer" who will assist your client in a review of videotape in your counseling session while you observe from another room via a television monitor. The 90 minute session will be spent as follows: For the first 30 minutes, you and the client will conduct a counseling session which will be videotaped. At the conclusion of this 30 minute session, you will leave the room, the inquirer will enter and after explaining the reasoning behind this process and instructing the client, will conduct a recall session with the client for the next 40 minutes. During this time, the inquirer will assist the client in exploring and examining himself and his reactions and feelings as they operated and occurred in the just completed counseling session. You will be able to see and hear this process in the adjoining room on a television monitor.

This next step is intended to assist the client in looking closer at himself as his relationship with you. While he will be aware that you are observing and hearing what he is saying, he is not yet dealing with your relationship face-to-face with you. In a sense, this brings him a step closer to dealing with his feelings in an immediate way, but he does not have to explain them or account for thim to you as yet.

Following the 40 minute recall, you will rejoint your client and continue for another 20 minutes without being videotaped.

To summarize, the 90 minute session, then, will be carried out as follows:

1. A 30 minute counseling session which is videotaped.
2. A 40 minute client recall by a third-person inquirer.
3. A 20 minute counseling session without the use of videotape.

To: Group A Counselors

From: Bob Van Noord

Subj: Procedures for Session 5

Date: May 22, 1972

Session 5 will be conducted in the same way as was Session 4 last week.

You will meet with your client for an initial 30 minute counseling session which will be videotaped. Following this 30 minute session, an inquirer will enter and conduct a 40 minute recall session with the client, which you will observe and hear via a TV monitor in the adjoining room. After the recall session, you will again enter the counseling room and continue with the client for another 20 minutes without being recorded. The sequence, then, for the 90 minute period:

a. 30 minute counseling session--videotaped

b. 40 minute client recall

c. 20 minute counseling session

To: Group A Counselors

From: Bob Van Noord

Subj: Procedures for Session 6

Date: May 22, 1972

Session 6 will make use of a mutual recall process, wherein both you and your client will review the videotape of your counseling session with the help of a trained Inquirer. The outline for the 90 minutes is as follows.

You and your client will meet together for a 30 minute counseling session which will be videotaped. Following this session, an Inquirer will join the two of you and conduct a mutual recall, assisting both of you in recalling the events, thoughts and feelings occurring during the previously recorded interaction. After 40 minutes of recall (possibly less), the Inquirer will leave the two of you to continue a dyadic interaction. The sequence for the 90 minute session:

a. 30 minute counseling session--videotaped

b. 40 minute mutual recall

c. 20 minute counseling interaction

When Session 6 is finished, I'd like you to have your client go to the Testing Office for a brief (½ hour) battery of inventories. If they are not able to take these immediately after Session 6, please have them come in within the next few days following for this. It is only necessary that they give their name to the person in the office. The girls there know which inventories the clients will be taking. When this is completed, the research aspects of your meetings with your client are finished. Further meetings, if arranged by the two of you would be on a regular basis, unless you've made other arrangements.

Thanks much for your cooperation and assistance!

APPENDIX H

PROCEDURAL MEMOS FOR GROUP B CLIENTS

PROCEDURAL MEMOS FOR GROUP B CLIENTS

To: Group B Counselors

From: Bob Van Noord

Subj: Procedures for Research Client

Date: April 14, 1972

This is to clarify the procedures regarding your work with the client that you're seeing as part of my research project this term. I'd like you to meet with that client for an hour and a half weekly, rather than an hour session, and audiotape your first and sixth session with that client.

After the sixth session, the client will go to the testing office and take a couple of inventories which should require no more than about a half-hour.

It's important that your first and sixth sessions be audiotaped. I'll get 1800 foot tapes to you before your sessions--they should go for 1½ hours and 3 3/4 IPS. Again, Thanks!

To: Group B Counselors

From: Bob Van Noord

Subj: Procedures for Session 6

Date: May 22, 1972

I will get an audiotape to you prior to your sixth meeting with the client whom you're seeing as part of my research project. Please record this sixth session on the side of the tape which is indicated for Session 6 on the leader of the tape (ready to use as you get it), and return the tape to me as soon as possible.

Following your sixth session, your client will take a brief (about one-half hour) battery of inventories. If the client has time to take these right after your session, please escort him/her to the testing office for this. If not, he/she should take them within a few days after your sixth session--at least before any subsequent sessions if you are continuing to meet.

Any further meetings between the two of you, if planned, will be on the regular basis, unless the two of you have made other arrangements.

Thanks very much for your assistance and cooperation!

APPENDIX I

CHARACTERISTICS OF CLIENT GROWTH SCALES

CHARACTERISTICS OF CLIENT GROWTH SCALES

Owning of Feelings in Interpersonal Processes: A Scale for Measurement

Level 1

The client avoids accepting any of his feelings. When feelings are expressed, they are always seen as belonging to others, or entirely situational and outside of himself.

Example: The client avoids identifying or admitting to any feelings by either remaining silent or denying he feels anything at all.

In summary, the client seems to believe he is not a part of the world of feelings.

Level 2

The client may express feelings vaguely, but they are not really accepted as coming from within. Feelings are not tied to himself or to specific interactions but seem to pervade his life. In general he shows little involvement with his feelings.

Example: The client discusses or intellectualizes about feeling in a detached, abstract manner and gives little evidence of knowing the origin of his feeling.

In summary, any expression of feeling appears intellectualized, distant and vague.

Level 3

The client can usually identify his specific feelings and their source but tends to express what he feels in an intellectualized manner.

Example: The client seems to have an intellectual grasp of his feelings and their origin but has little emotional proximity to them.

In summary, the client usually ties down and owns his feelings in an intellectual manner. Level 3 constitutes the minimum level for gain.

Level 4

The client almost always acknowledges his feelings and can express them with emotional proximity but at times he has difficulty in connecting the feelings to their source.

Example: The client shows immediate and free access to his feelings but has some difficulty in understanding these feelings or their connection to people or concerns in his life.

In summary, the client owns his feelings fully but seems to have some difficulty in linking them to specific things in his life.

Level 5

The client clearly embraces his feelings with emotional proximity, and at the same time shows awareness that his feelings are tied to specific behaviors of his own and others.

Example: The client is completely in tune with his feelings, expresses them in a genuine way, and is able to identify their origin.

In summary, the client clearly owns his feelings and accurately specifies their source.

Commitment to Change in Interpersonal Processes: A Scale for Measurement

Level 1

The client shows no motivation for change. He is resistive to attempts by the second person to accomplish change or explore the desirability of change. This may take either the form of complete passivity or defensive hostile behavior.

Example: The client may question the efficacy of the helping process and the helpfulness of the second person to an inappropriate degree, i.e., he seems to be attacking the change process, or he is totally unreceptive and uncooperative to the efforts of the second person.

In summary, the client gives no verbal or behavioral evidence of a desire to change.

Level 2

While the client expresses the desire to change, his commitment is noticeably questionable. The client seems to resist the impact of the helping process, and is passive or evasive in his interaction with the second person.

Example: The client seems more involved in rationalizing or defending his behavior than he is in working on changing it. He may communicate the importance or necessity of change, but there is little behavioral evidence of cooperation or real commitment to the change process.

In summary, there is some verbal commitment to change but no behavioral evidence of that commitment.

Level 3

The client vacillates between an overt desire and/or commitment to change, and the desire to resist or evade change in order to avoid pain. He may express the desire to change and attempt to confront his feelings but varies in his maintenance of motivation to change.

Example: The first person deals with the feelings which are centrally involved with his problem, but there is some tendency to rationalize his behavior or move from topic to topic.

In summary, the client expresses the desire to change, but vacillates his commitment to change and cooperation with the second person. Level 3 is the minimal level for change to take place.

Level 4

The client expresses a desire to change, and while at times is reluctant to experience painful feelings involved in exploring his behavior, actively tries to cooperate with rather than resist the second person's efforts.

Example: The client continually returns to the task of understanding his behavior and his role in it, although he experiences (and may overtly express) hesitancy in dealing with his painful feelings.

In summary, the client wants to change, and he cooperates with the change process in a verbal and behavioral manner.

Level 5

The client expresses a clear desire to change. He actively cooperates with the second person in the counseling process, even to the point of accepting painful feelings accompanying the exploration of his problem. The client is deeply involved in confronting his problems directly, and makes no attempt to evade or resist the experiencing of feelings and behaviors.

Example: The client pursues the exploration of his feelings and behavior, attempting to gain a better understanding of his behavior in order to change. He faces his problem directly rather than avoiding it or changing the subject.

In summary, the client clearly expresses verbally and behaviorally a desire and commitment to change his behavior.

Differentiation of Stimuli in Interpersonal Processes: A Scale for Measurement

Level 1

The client seems unable to identify or differentiate his problems, feelings, or concerns and is unwilling or unable to move in this direction.

Example: The client may show either no grasp of his feelings or problems or he seems to respond to everything in very much the same way.

In summary, the client seems totally unable or unwilling to make discriminations between his feelings or the people and events in his life.

Level 2

The client may talk about different feelings and problems but he shows little grasp of real differences among them or of their effect on him as an individual.

Example: The client may respond in a rehearsed manner to people and events as if his reactions were pre-determined by stereotyped expectations.

In summary, the client seems to differentiate between his feelings, people, or events at only a superficial level.

Level 3

The client vacillates between discussing different stimuli and their effect on him (as a unique person) and responding in a general unclear fashion.

Example: The client may initially make clear differentiations about his world, but he is unable to productively maintain this behavior and lapses into hazy generalizations which do not seem to have immediate meaning to him.

In summary, the client clearly differentiates between discrete stimuli, but is unable to develop his perceptions or use them effectively. Level 3 constitutes the minimal level of differentiation for growth.

Level 4

The client is almost always aware of the differences between stimuli in his world, and he responds to them in a

differential manner. He actively attempts to become more aware of his various emotions and their sources.

Example: The first person may show a strong desire to understand himself as a unique and complex person and he attempts to differentiate and identify the distinct people and events in his world.

In summary, the first person is actively involved in a successive differentiation of his feelings and events in his world.

Level 5

The client always perceives the different stimuli in his world and reacts to them in a variety of differential ways. He is fully aware of his own unique effect on the discrete stimuli around him.

Example: The client may clearly differentiate among his characteristics and those of others. He shows immediate awareness of his own unique characteristics, and the reactions he stimulates in others.

In summary, the first person recognizes individuality in himself and in others, and responds in an appropriate manner.

APPENDIX J

DEGREE OF SELF EXPLORATION SCALE

DEGREE OF SELF EXPLORATION SCALE

Helpee Self-Exploration in Interpersonal Processes: A Scale for Measurement[1]

Level 1

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

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

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

Level 2

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

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

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

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[1]This scale is derived in part from "The Measurement of Depth of Intrapersonal Exploration" (Truax & Carkhuff, 1967), which has been validated in extensive process and outcome research on counseling and psychotherapy (Carkhuff, 1963; Carkhuff & Berenson, 1967; Truax & Carkhuff, 1967, 1963, 1964, 1965). In addition, similar measures of similar constructs have received extensive support in the literature of counseling and therapy. The present scale represents a systematic attempt to reduce ambiguity and increase relability. In the process, many important delineations and additions have been made. For comparative,

Level 3

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

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

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

Level 4

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

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

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

Level 5

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

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

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

---

purposes, level 1 of the present scale is approximately equal to stage 1 of the earlier scale. The remaining levels are approximately correspondent: level 2 and stages 2 and 3; level 3 and stages 4 and 5; level 4 and stage 6; level 5 and stages 7, 8, and 9.

APPENDIX K

MISKIMINS SELF-GOAL-OTHER DISCREPANCY SCALE

HAND SCORING SUMMARY SHEET AND

PROFILE SUMMARY

EXAMINER USE ONLY

MSGO DISCREPANCY SCALE
HAND SCORING SUMMARY SHEET
Cards I, II, III

Examiner_____

Name_____ (1-6) Date_____

Age (yrs.) (7-8) R (9) Sex (10) 1 M 2 F Mar. St. (11) 1 S 2 M 3 Sep. 4 D 5 W Education (yrs.) (12-13)

Occupation_____ (14-19) (20-24) (25-28) (29-32)

RAW SCORES

SC																					SC
GSC																					GSC
PRO																					PRO
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
	G					S					E					P					

DISCREPANCIES

SC-GSC																					SC-GSC
SC-PRO																					SC-PRO
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
	G					S					E					P					

TOTAL DISCREPANCIES

Card I

SC-GSC			Card II SC-PRO
33-34		GM	33-34
35-36		GP	35-36
37-38		GT	37-38
39-40		SM	39-40
41-42		SP	41-42
43-44		ST	43-44
45-46		EM	45-46
47-48		EP	47-48
49-50		ET	49-50
51-53		TM (15)	51-53
54-56		TP (15)	54-56
57-59		* T (15) *	57-59
60-61		PM	60-61
62-63		PP	62-63
64-65		PT	64-65
66-68		TM (20)	66-68
69-71		TP (20)	69-71
72-74		* T (20) *	72-74
75-77		(15) GRT (20)	75-77

Card ID No.

80 [1] [2] 80

TOTAL RAW SCORES

Card III

	SC	GSC	PRO
G	33-34	47-48	61-62
S	35-36	49-50	63-64
E	37-38	51-52	65-66
T (15)	39-41	53-55	67-69
P	42-43	56-57	70-71
T (20)	44-46	58-60	72-74

Card ID No. [3]

PERSONAL CONSTRUCT DIMENSIONS

1.

2.

3.

4.

5.

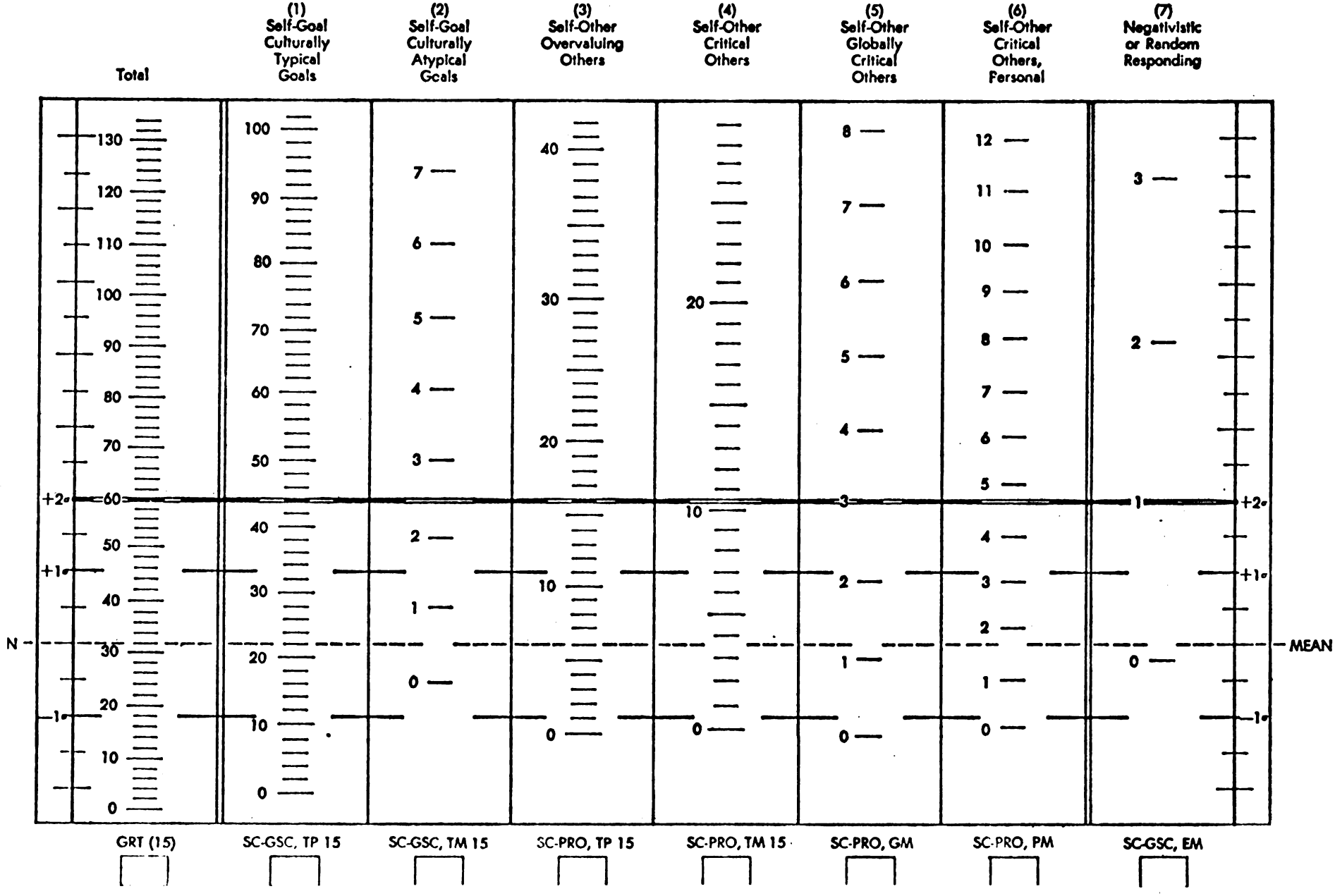
Card III (75-79)

MSGO-HSSS-3

MISKIMINS SELF-GOAL-OTHER DISCREPANCY SCALE PROFILE SUMMARY

no._____ Sex ☐ M ☐ F Age._____ Educ._____ Mar. St. ☐ S ☐ M ☐ Sep ☐ D ☐ W

e._____ Occup._____ Examiner._____ Admin. ☐ I ☐ G



APPENDIX L

COVER LETTER TO PEER-INFORMANTS

COVER LETTER TO PEER-INFORMANTS

Room 207
Student Services Building
Michigan State University

Dear

Your name was given to us several weeks ago by who has been a participant this past term in a social science research project on campus. believed you would be willing to cooperate by responding to the items on the enclosed form. The form is being sent to you by mail so that you have a chance to look it over. A person will be calling you by telephone sometime in the next week in order to obtain your responses. We will be making every effort to get in touch with you; however, in the event that for some reason we are unable to reach you, we would like to ask that you contact us before you leave the area for the summer. Someone can be reached at 355-0722 (on campus) or 351-9428 (off campus).

Your responses will be kept confidential and used for research purposes only. will not see your responses nor will he/she know how you marked them unless you choose to discuss it with him/her.

Quite frankly, the number of subjects in this project is relatively few, which makes every response vital to its success. We will be in touch with you by telephone shortly. Thank you for your cooperation!

Sincerely,

Robert W. Van Noord

and

Dr. Bill L. Kell,
Research Sponsor

APPENDIX M

RESPONSE SHEET FOR PEER INFORMATION QUESTIONNAIRE

RESPONSE SHEET FOR PEER INFORMATION

QUESTIONNAIRE

Client Code _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

16. _____

APPENDIX N

THE PEER INFORMATION QUESTIONNAIRE

THE PEER INFORMATION QUESTIONNAIRE

On the attached form are a number of statements that can describe a person's behavior. Many of them focus on how a person may act or feel toward others, some may not directly involve others.

Consider the changes in the behavior of over the past six weeks. Your best reference of course is his/her behavior in relation to you, but this need not be your only consideration. When you are contacted by telephone, you will be asked to respond to each statement using the scale 1-6 as indicated.

When you are called, please indicate your response by using the number which best represents your response to each statement.

1. I strongly feel that it is not true.

2. I feel that it is not true.

3. I feel that it is probably not true, or more untrue than true.

4. I feel that it is probably true, or more true than untrue.

5. I feel that it is true.

6. I strongly feel that it is true.

It is important that your responses to these items be obtained before you leave for the summer. If you do not hear from us because we haven't been able to reach you, would you please call as indicated in the enclosed letter?

355-0722 (on campus)
351-9428 (off campus)

Again, thanks very much for your cooperation!

1. Strongly feel it is not true.
2. Feel it is not true.
3. Probably not true, or more untrue than true.
4. Probably true, or more true than untrue.
5. Feel it is true.
6. Strongly feel it is true.

1. I believe he/she has feelings he/she does not tell me about, that are causing difficulty in our relationship.

2. He/she willing to express his/her feelings about himself/herself to me.

3. He/she is willing to express his/her feelings about me to me.

4. He/she seems to be in the process of changing or trying to change.

5. He/she gets along better with members of the opposite sex lately.

6. He/she gets along better with members of the same sex lately.

7. He/she worries less now than he/she used to.

8. He/she perceives the different stimuli in his/her experiences and reacts to them in different ways.

9. He/she engages in more introspection and self exploration.

10. When he's/she's working (e.g., schoolwork), he/she is more involved.

11. When he's/she's at play (e.g., sports, leisure time activities), he/she is more involved.

12. I like him/her better than I used to.

13. I respect him/her more.

14. He/she respects himself/herself more.

15. I think the directions in which he/she is changing, or trying to change, are for the better <u>for him/her</u>.

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16. I consider myself in as good a position to make the above responses as most of his/her other acquaintances.

APPENDIX O

CLIENT WRITTEN COMMENTS SHEET

CLIENT WRITTEN COMMENTS SHEET

Comments

Sometimes multiple-choice inventories don't provide an opportunity to express opinions or comments in exactly the way that a person would like to express them. Please feel free to use this space to indicate any impressions, reactions, or opinions you may have had to the six week project which you have completed. Your comments are welcome.

Any further meetings with your counselor, if planned by the two of you, will be on the one hour per week basis, unless other arrangements have been made between you and your counselor.

Your cooperation and participation in this project is very much appreciated. Thank you!

APPENDIX P

THE EMPATHIC UNDERSTANDING SCALE

THE EMPATHIC UNDERSTANDING SCALE

Scale 1

Empathic Understanding in Interpersonal Processes. II

A Scale for Measurement[1]

Robert R. Carkhuff

Level 1

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

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

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

---

[1]The present scale "Empathic understanding in interpersonal processes" has been derived in part from "A Scale for the measurement of accurate empathy" by C. B. Truax which has been validated in extensive process and outcome research on counseling and psychotherapy (summarized in Truax and Carkhuff, 1967) and in part from an earlier version which has been validated in extensive process and outcome research on counseling and psychotherapy (summarized in Carkhuff and Berenson, 1967). In addition, similar measures of similar constructs have received extensive support in the literature of counseling and therapy and education. The present scale was written to apply to all interpersonal processes and represent a systematic attempt to reduce the ambiguity and increase

Level 2

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

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

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

Level 3

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

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

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

---

the reliability of the scale. In the process many important delineations and additions have been made, including in particular the change to a systematic focus upon the additive, subtractive or interchangeable aspects of the levels of communication of understanding. For comparative purposes. Level 1 of the present scale is approximately equal to Stage 1 of the Truax scale. The remaining levels are approximately correspondent: Level 2 and Stages 2 and 3 of the earlier version; Level 3 and Stages 4 and 5; Level 4 and Stages 6 and 7; Level 5 and Stages 8 and 9. The levels of the present scale are approximately equal to the levels of the earlier version of this scale.

Level 4

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

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

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

Level 5

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

Examples: The facilitator responds with accuracy to all of the person's deeper as well as surface feelings. He is "together" with the second person or "tuned in" on his wavelength. The facilitator and the other person might proceed together to explore previously unexplored areas of human existence.

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