ABSTRACT

THE ACCELERATION OF CLIENT PROGRESS IN COUNSELING AND PSYCHOTHERAPY THROUGH INTERPERSONAL PROCESS RECALL (IPR)

By

Paul G. Schauble

The purpose of this study was to investigate the effects of affect simulation films together with stimulated recall on client movement in counseling. A treatment program integrating simulation films and stimulated recall via videotape in order to accelerate client growth in counseling was compared with more traditional counseling methods.

Affect simulation is a technique wherein clients are confronted with films which encourage them to simulate interpersonal relations, and client and film are videotaped while the client watches the film. The videotape is then played back while his counselor helps him examine his reactions to the film. In some cases an actor directs affection or rejection toward the viewer, in others the actor reacts as if he had been rejected or seduced.

Interpersonal Process Recall (IPR) is a technique using stimulated recall of videotape to accelerate client insight and change during therapy. A videotape of a counseling session is replayed to the client and a recall session is conducted by a clinically trained "interrogator" who helps the client examine the underlying dynamics of his interaction with the counselor. In

previous studies, IPR found to accelerate client movement in counseling when the counselor is actively involved in the recall process (Kagan, Krathwohl, et. al., 1967).

In a pilot study conducted in 1967, the simulation and IPR techniques were combined in an attempt to increase the client's ability to recognize and understand his feelings and responses interpersonal encounters. Three treatments were compared: 1) counseling alone (control treatment); 2) counseling using first simulation films, or VRAS (videotape recall of affect simulation) for three sessions, then IPR for three sessions; 3) counseling using IPR first and then VRAS. Judges' ratings of client movement indicated that both treatment groups moved significantly on four in-therapy behavior dimensions, while the control group did not. Examination of vocational placement status at the end of treatment also favored the treatment groups, where 66% had been placed on jobs against 33% for the control group.

In the present study, the treatment program was designed to integrate the VRAS and IPR into a sequential program of treatment. The use of a sequential approach stemmed from the data observed in the pilot study, suggesting the following series of developmental experiences facing the client as he undergoes counseling or therapy: a) the need for the client to become aware of his feelings and reactive behavior in emotional stress situations, b) the need to identify and

examine the feelings he has during the counseling relationship itself, c) the need to experience and deal with these feelings in the immediacy of the counseling relationship itself. The experimental treatment consisted of three integrated phases which were designed to meet these developmental needs.

In the first - or VRAS - phase, the client was videotaped while watching an affect simulation film. The video tape was played back and the client's videotaped behavior served as the focus for the counseling session. As the client examined his reactions to the simulated confrontation, he was able to look at his emotional reactions to others without having to be responsible for their impact and consequences, i.e., he was dealing with interpersonal threat from a position of relative safety. In the second - or IPR - phase, client and counselor were videotaped while conducting a counseling session, the videotape was replayed and a trained recall worker ("interrogator") conducted an IPR session with the client while the counselor observed through a one-way mirror. The recall worker was essential in helping the client to examine his feelings in relating to his counselor, since the client still was not confronting the counselor and thus had a reduced responsiblility for the immediate consequences of his feelings. Afther the recall, client and counselor resumed their counseling session, incorporating the insights gained from the

recall. In the final phase, both client and counselor viewed a replay of the counseling session together, while the interrogator encouraged them to share their feelings as they occurred during the interview. As counselor and client communication about their feelings and reactions during the videotaped interview increased, the interrogator played a progressively less active role. When the interaction between client and counselor moved from a focus on the videotape to the immediacy of the recall(when they had finished talking about the videotape and were again engaged in face-to-face discussion)session the interrogator left the room and counselor and client continued the therapy session.

The control-group treatment consisted of traditional counseling, i.e., no IPR interventions were used. Both the counseling -- with-IPR and the traditional-counseling group treatments were focused on effective client/counselor communication. In the traditional-counseling groups, the therapists concentrated on client/counselor interaction in an attempt to help the client achieve greater self-awareness and understanding of his own dynamics.

The clients in this study were twelve female undergraduate students who had requested personal counseling from the university counseling center, and who also agreed to participate in the research. The two therapists were pre-doctoral interns

at the Counseling Center who had training and experience in IPR techniques as well as in traditional counseling methods.

Each therapist was rated on scales measuring facilitative behavior in therapy. One therapist was found to be functioning at approximately 3.00 across dimensions on a five point scale where a rating of 3.00 is considered the minimal level of counselor performance if client growth is to occur. The second therapist was functioning at an average of approximately 3.40 across dimensions.

Clients were assigned to therapist and treament groups on a random basis. Each interivew was recorded for subsequent rating by independent judges (two Ph.D. counseling psychologists) on four dimensions of client behavior in therapy considered characteristics of client growth: Owning of Feelings (OF), Commitment to Change (CCh), Differentiation of Stimuli (DS), and Depth of Self-exploration (DX). Ratings of the intitial sessions served as the pre-test measure. Analysis of ratings of the initial sessions indicated no significant difference between groups on any of the dimensions, suggesting that neither treatment group had a higher level of functioning which might have affected their post-treatment behavior.

Ratings of the sixth (final) session for each client on the client growth scales served as a post measure of client

functioning. Each client also completed the Tennessee Self Concept Scale and the Wisconsin Relationship Orientation Scale before and after the treatment program. In addition, each client and therapist completed a shortened form of the Therapy Session Report (TSR) following each treatment session.

The anlysis of pre to post changes in client behavior during therapy within each group by means of a D test for change scores on the same sample indicated significant differences (.05 level) on each of the characteristics of client growth for the counseling with IPR group, but not for the traditional-counseling group. That is, after treatment the clients in the treatment group were rated higher on the dimension of OF, CL, DS, and DX. Ratings of clients in the traditional-counseling group showed no differences, pre to post treatment. Analysis of variance of change scores between groups also indicated differences in the hypothesized direction (.05 level) on each of the client growth dimension.

Analysis of pre to post changes in client ratings of counselors on the WROS did not indicate significant change after treatment for either group, but change scores between groups were found to be significant and favored the experimental treatment. Pre to post differences within groups for client perceptions of treatment were found on only two dimensions: client feelings about coming to the session and client feelings about progress made in the session. In both cases, the

differences were found only for the IPR group, with significant between group differences on change score also favoring the IPR group. Change score differences in therapist perception of treatment were found only for the IPR group's pre to post change on the variable of: therapist looking forward to coming to the session. Finally, change score difference on dimension of the Tennessee Self Concept Scale were evenly divided between groups, and there was little indication of any meaningful change in self-concept score due to treatment.

The analysis of date suggests that the IPR treatment had a significant accelerating affect on client movement in therapy, as rated by independent judges. Clients in the IPR group had a greater positive change 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 withing these sessions. Therapists also were found to look forward more positively to the IPR treatment sessions than the traditional treatment sessions.

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Paul G. Schauble

A THESIS

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DEDICATION

To my father and his memory.....may
they both be proud.

ACKNOWLEDGEMENTS

I am grateful to:

.....Norm Kagan, who constantly kindled my motivation and provided direction for my professional development.

.....Dozier Thornton, Sam Plyer, and John Suehr for showing their confidence in my ability by allowing me freedom to go my own way.

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.....Bob Woody, who works harder at being honest than anyone I know, while having less distance to travel....whose faith and friendship have never been in doubt, even though I was.

.....to Dave Erb....who let me know it was acceptable to ask without giving.

.....to Laura, Steve, and Warren and all whom they represent ....whose loneliness I understood.....thereby making mine more tolerable.

.....Mom, who has always been there.

.....Betty, who has shared my child, loved my adult, and constantly validates me.

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CHAPTER I

THE PROBLEM

This study is an evaluation of the effectiveness of a new method to help people who have sought assistance from professional counselors to deal with personality and/or adjustment problems. In this particular study no distinction is made between counseling and psychotherapy. This position is based on the conclusion that ".....There are no essential differences between counseling and psychotherapy 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).

Counselors and therapists have recently been made painfully aware that the effectiveness and justification of their professional activities must be seriously evaluated. Seventeen years ago Eysenck (1952) drew and substantiated the conclusion that psychotherapy was NOT effective in influencing client improvement in adult neurotics. The response of "helping professionals" ranged from an emotional sweeping-under-the-rug (Sanford, 1953) of this "blasphemis" (Teuber and Powers, 1953) charge to a systematic criticism of the design of the Eysenck study (Rozenweig, 1954; DeCharms, Levy, and Werthermer, 1954). After four years of active debate, Levitt (1957) used a similar design and obtained results "markedly similar" to Eysenck's study, i.e., "the results of the

present study fail to support the view that psychotherapy with 'neurotic' children is effective." These results of this second study were not popularly received, but the response of the profession was more constructive.

Bergin (1963) acknowledged the inadequacies in research design of the Eysenck and Levitt accusations, but pointed to their value.

> "These vexations of the scientific spirit appear on the verge of stimulating important breakthroughs in the analysis of psychotherapeutic effects, even though the majority of findings are negative with regard to the global question of the effects of psychotherapy." (p. 254)

Breakthroughs in the analysis of psychotherapeutic effects have indeed occurred. Psychotherapy has been demonstrated to have positive effects on influencing client change, <u>when related to therapist functioning variables</u> and <u>specific interpersonal behavior dimensions</u> (Truax Carkhuff, 1966; Carkhuff and Berenson, 1967). The singularly most important contribution of such breakthroughs has been to acknowledge that counseling and psychotherapy <u>can</u> have a positive effect; that counselors and therapists <u>can</u> be effective, but that the therapeutic encounter can be "for better or for worse." (Berenson and Carkhuff, 1967). This knowledge carries with it a mandate that the counseling profession constantly examine and evaluate its theory and methodology in an

attempt to assure that the therapy situation be a valuable experience for the client.

This study is an effort to accelerate the positive impact of counseling and therapy. Research has recently been conducted to determine the usefulness of a specific method of video technology as an intervention in the counseling process. The method is called Interpersonal Process Recall (IPR), and uses videotape playback of the counseling situation to stimulate recall of the underlying dynamics involved in the interpersonal interaction between client and counselor. (Kagan, Schauble, Resnikoff, Danish, and Krathwohl, 1969). The method has been shown to have potential in accelerating client growth in therapy with prisoners (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, 1965).

One of the outcomes of this research was a theory of client-counselor interaction. This lead to the development of simulated confrontation procedures which are incorporated in a new method for accelerating client growth. The problem of this study is to provide a controlled examination of the value of the new method for accelerating client growth in therapy.

If traditional counseling and psychotherapy "may or may not" influence a client positively, than the development and evaluation of new approaches is sorely needed. Furthermore, there is an intrinsic ethical obligation for counselors to help clients

change quickly as possible. This obligation also has a pragmatic base, in that professionals are vastly outnumbered by the clients they seek to serve. Counseling approaches must be judged, then, by economy of time and effort as well as degree of "success" achieved.

The use of simulation films and stimulated recall in counseling appears to be a promising approach for accelerating the counseling process. While pilot research has tended to support the value of the method, it is important to conduct a controlled application in order to determine if accelerated client growth does indeed occur.

Purpose

The purpose of this study is to investigate the effects of affect simulation films together with stimulated recall on client movement in counseling. A treatment program which integrates the simulation films and stimulated recall via videotape in order to accelerate client growth in counseling is compared with a more traditional counseling program.

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 any interpersonal interaction (e.g.,

the counseling relationship), and then playing-back the videotape to enable either (or both) of the participants to examine the interpersonal dynamics of the original experience.

2. Stimulated Recall Session:

The phase of the IPR process where the videotape of a counseling interview is played back and a clinical "interrogator" helps to stimulate the participant's examination of the underlying dynamics of his interaction during the recorded counseling session.

3. Interrogator:

The designation given to the third person (counselor or therapist) whose function is to facilitate the client's self-analysis of thoughts, feelings, images, and general pattern of interaction with his counselor. Since this person's clinical function is limited to actively probing the immediate past (of the videotape), the name "interrogator" was selected to describe his role.

4. Affect Simulation:

A technique using films which simulate various kinds and intensities of emotional stress. The films are structured to confront clients with various interpersonal stress situations so that his reactions

to such situations can then be studies with his 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.

Hypotheses

1. Clients receiving personal counseling with IPR intervention will make more positive movement within counseling than will clients that receive personal counseling alone.
2. Clients receiving IPR treatment will see their counselors as more accessible and easier to talk with than will clients not receiving IPR treatment.
3. Clients receiving IPR treatment will develop a more improved self concept of themselves than will clients not receiving IPR treatment.
4. Clients who receive IPR treatment will have a greater level of agreement with their counselor about the counseling process than clients not receiving IPR treatment.

Theory

The theory behind the treatment program used in this study grew from observations and inferences about what constitutes positive client movement in counseling. These observations will therefore be reviewed, followed then by a description of theoretical model of treatment.

Client Growth

Recent literature in counseling and psychotherapy indicates that clients typically enter the counseling relationship with little access to many basic emotions. Instead, the clients have frequently compressed his affective experiences, often because he is afraid that they will become overwhelming in all aspects of his life (Kell and Mueller, 1966). This inability to recognize and deal with feelings is generally the crux of the client's problems. The clients is anxious and has difficulty coping because he cannot identify and/or experience his feelings. Since he cannot know and understand his feelings, it is impossible for him to change the behavior they cause: behavior that is dissatisfying -- and which he wishes to change.

It is generally agreed that the purpose of counseling is to change people's behavior (Kell and Mueller, 1966). This is typically accomplished (in insight therapy) by the client's exploration of anxiety-laden areas with the counselor, beginning

at a "surface" or non-threatening level; as counseling progresses, the client is able to handle greater and greater amounts of "depth" exploration, usually of feelings and thought which are frightening to him. This process of moving into "deeper" affective material is often referred to as "getting down to gut level."

Rogers (1958) proposes that this process of changing occurs in seven stages, and the last stage -- the goal of therapy -- is 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 may be defined, then, as the increased capacity of the client to gain access to, communicate, and fully experience his feelings. The principal task of the counselor is to increase client insight and understanding and help the client experience his feelings (Orlinsky and Howard, 1968).

Obstacles to Client Growth

The counselor's task is made difficult by a number of client-based obstacles.

The client's anxiety about the counseling process is often so strong that his defense systems erect a "strong wall" which makes it difficult for him to react spontaneously to his therapist (Brammer and Shostrom, 1960). Moreover, involvement or partici-

pation in an emotional experience makes it extermely difficult for a person to make precise, objective, unbiased observations (Kubie, 1966). By the very nature of his involvement in his emotional experiences, the client cannot easily label what he feels, the precipitating conditions, etc., much less communicate these to the counselor. Hence, the client's attempt to convey prior emotional experience to the counselor may take on an entirely different meaning -- distorted further by the lapse of time, the client's compressive and repressive (or similarly defensive) behaviors, and numerous other factors relating to client, counselor, and relationship variables. These obstacles may be overcome, but their resolution accounts for valuable time in the initial stages of therapy.

Client growth in counseling is further complicated by the fear of psychological closeness with the counselor, observed an an approach-avoidance dynamic. Previous research with the IPR process (Kagan, Krathwohl, et. al., 1967), furnished frequent evidence of this approach-avoidance counselor-client dynamic in which the client seems to both approach and retreat from psychological closeness with the counselor. It was observed that while the client and the counselor were discussing specific activities outside the counseling relationship, they were at the same time experiencing conflicting feelings about the counseling relationship itself. These feelings are typically evidenced in the client's concerns that (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; (4) the client's own affectionate, dependent, or seductive impulses toward the counselor might be expressed or acted out. These four basic elements of client-counselor interactions seemed to be nearly universal (though of varying intensity across different dyads). This fear of closeness makes continued expression and exploration of emotion unlikely in the early stages of the counseling relationships.

Development of Affect Simulation

In an attempt to identify the limitations of the traditional IPR process, it was determined that the potency of the IPR method for client learning and growth hinged at least partly on the quality of the counseling session. If the session contained intense counselor-client interaction over matters of concern to the client, the recall seemed to have more effect than if the counseling session consisted of bland exchanges. Recognition of this limitation lead to the development of a new system. It was reasoned that if the client were exposed to various kinds and degrees of emotional situations, if his reactions to these situations were videotaped, and if after each such exposure he were given the opportunity to view his behavior with a counselor via IPR, the client could be confronted with his own videotaped

reactions to a series of planned threatening behaviors of another person. It seemed that this might serve as a sort of microscope, focused on the type of interpersonal behavior so stimulated. Furthermore, the counselor would be better able to diagnose if he could observe a client's reactions to a standard stimulus situation and compare these reactions with those of other clients to the same situation. It also seemed that a counselor's efficiency in communication would be increased if he and the client could discuss client behavior which they observed together. A variety of intense interpe sonal encounters compressed into a short period of time through simulation could lead to valuable feedback on client behavior for both client and counselor.

In successful IPR counseling experiences, the client usually becomes aware of self-behaviors which reflect both bids for, and responses to, counselor regard. In other words, when clients make positive movement in counseling, they typically become aware of their own conflicting, approach-avoidance behaviors as described above. These behaviors are related to the client's past experience and seem to be typical of most of his present interpersonal relationships with significant others.

The four dimensions of this approach-avoidance dynamic were thus considered an appropriate model from which to develop common stimuli for interpersonal simulation which would be applicable across a wide range of clients. A series of vignettes was created,

which protray interpersonal confrontations. In some cases, the actor directs affection or rejection toward the viewer; in others he reacts as if he was being rejected or seduced (e.g., with fear or anger). Each of the four emotions is contained in several (from four to seven) filmed scenes which can be used as discrete entities -- although they do progress from mild to very intense degrees of feeling for each emotion. The four are hostility, affection, fear of hostility, and fear of affection.

Treatment Program: A Theory of Progressive Approximation

The treatment program developed for this study consists of three phases. In the first phase -- designated Simulation Video Recall (SVR) -- the client is shown a film designed to simulate various interpersonal stress situations, and the client and film are videotaped while the client watches the film. This videotape is played back immediately to provide the client and his counselor with what is assumed to be a sample of the client's reactive behavior in actual emotional stress situations. This videotaped behavior sample serves as the focal point for the ensuing counseling session. In this phase, it is expected that the client becomes increasingly more able to identify and deal with the simulated emotional confrontation, and he becomes more at ease with his own feelings and behavior. He becomes aware that he and the counselor are both capable of dealing with his emotional

stress, and openness and access to feelings are thus clearly defined as desirable and attainable goals of the counseling experience. As he examines his reactions to the simulated person on the screen, it is expected that the client is in the relatively "safe" position of looking at his emotional reactions to others but yet without having to be responsible for their impact or consequences. In a sense, then, the client is dealing with interpersonal threat but from a position of relative safety.

When the client has completed this stage, he is assumed to be ready to begin to look at the feelings he has about the counseling relationship itself. This begins the second phase, or Interpersonal Process Recall (IPR). The counselor and client are videotaped while conducting a counseling session. Immediately after the session is concluded, the counselor leaves the room and a third person, or "interrogator," conducts the recall session, while the counselor observes through a one-way mirror. The third person is instrumental in this phase. Most clients cannot relate in recall certain feelings which they had during the interview (e.g., affection for the counselor) directly to their counselor, since he was (and is still) the object of their feelings. In other words, at this stage many clients tend to avoid in recall (with their counselors) the same areas they avoided during the interview. The use of an "interrogator" tends to help the client overcome this behavior by keeping the client's attention focused on the videotape and in limiting disucssion to what had transpired

in the counseling session. The interrogator avoids establishing another client-counselor relationship by trying to keep the client focused on the feelings or content of the original relationship.[1] In this manner the interrogator seems to help the client move one step closer to achieving the need for concurrent, "here and now" awareness of his affect.

The interaction in the interrogation process, then, is structured to enable the client to become aware of his behavior in relating to the counselor. The client learns how his feelings originate and develop; he learns what he likes and dislikes about himself in the counseling interaction; and he learns to recognize the feelings he has about the counselor and the ways he expects or hopes the counselor will feel and act toward him. The anxiety which normally attends recognizing such feelings is reduced, since the client is still not confronting the counselor and thus still has a minimal responsibility for the consequences of his feelings.

At this stage in treatment program, the client has had the opportunity in the recall situation to examine the underlying emotions influencing his behavior within the counseling situation, and he is expected to be more ready to begin to deal with them with his counselor. This is facilitated through the third phase of interaction, designated the "mutual recall". The recall session

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[1] For a detailed description of the role and function of the "interrogator", see Kagan, N., Schauble, P. G., Resnikoff, A., Danish, S. J. and Krathwohl, D. R. Interpersonal process recall, Journal of Nervous and Mental Diseases, 1969, 148, 4.

is begun as usual, but the counselor remains in the room -- albeit in the background. As the client begins to identify affective material in the videotaped session, the interrogator involves the counselor by inviting him to comment on what he thought was going on. As counselor and client communicate about their reactions and feelings during the videotaped interview increases, the interrogator plays a progressively less active role. When the interaction between client and counselor starts to move from the "then and there" of the videotaped session to the "here and now" of the recall session, the interrogator literally withdraws from the session. The client is thus engaged with the counselor in an honest, open relationship in which it is expected he will become aware of his feelings and behavior in the "here and now". He is able to confront the counselor with his feelings, and he is ready to accept responsibility for their consequences. It is expected that at this stage the client is capable of beginning to live and behave more efficiently. He is beginning to experience immediate in-relationship feelings, and has reached the "working-thru stage" (Brammer and Shostrom, 1960) where the greatest gains are about to be made and consolidated.

The progressive approximation of client feelings in the three phases thus proceeds from identification of generic feelings (through SVR), to feelings about a particular relationship in the "there and then" of the videotape recall (IPR), to the immediate communicating of feelings in relationship (through mutual recall).

Following the third phase of the intervention program, counselor and client are expected to be communicating openly and directly about client feelings, providing an optimal therapeutic environment for client growth.

Overview

In this chapter, a statement of purpose, need, and theory for this study were presented. In Chapter II, a review of pertinent literature relating to client movement, simulation, and stimulated recall will be reviewed. Chapter III contains the resezrch design, treatments, and methodology used in collecting and analyzing data. An analysis of data is presented in Chapter IV. A summary of the study, including a discussion of the results and implications for further research, is presented in Chapter V.

CHAPTER II

REVIEW OF LITERATURE

Introduction

In the first chapter, the client growth system which serves as the theoretical background for this study was presented. The review of literature in Chapter II will be focused on the following areas relevant to the study: 1) client movement; 2) acceleration of client movement, including group counseling, psychodrama, multiple counselings and use of videotape in counseling; 3) stimulated recall to accelerate client movement; 4) simulation in counseling; 5) conclusions and implications of the literature; 6) simulation and stimulated recall - a pilot study.

Client Movement

This study is an attempt to accelerate client movement in short-term counseling. Before one can examine the "acceleration" of client movement in counseling, it is necessary to consider if counseling does or can, in fact, bring about positive client movement. Whether or not counseling "works" is a basic issue which has not been entirely resolved. The findings of studies bearing on the matter would distribute themselves along a curve skewed somewhat toward those studies reporting no change in a positive direction. The two most frequently reported obstacles to satisfactory measurement evaluation 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).

There are two types of criteria by which the impact of therapy on client behavior can be evaluated, i.e., client behavior outside the therapy situation - or external criteria, and client behavior within the therapy situation - or internal criteria.

External Criteria

Positive behavior change in the client's behavior patterns in his daily functioning outside of the therapy process is, of course, the prima-facie of the process itself. Criteria relating to such behavior would seem then to be extremely important in measuring the influence of therapy. When one attempts to use such criteria, however, he is beset by a variety of measurement problems. The essence of the problem is that there is not:

> .....the development of criteria 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)

Attempts have been made to observe change in narrow aspects of functioning, and from these developing implications for a

wider range of behavior. An example of such research was that performed by Teuber and Powers (1951). They compared a group of potential juvenile delinquents who had received treatment with a matched control group who had not. The criteria measure was simply the number of court appearances for each group following treatment. While this is obviously a meaningful criteria for therapy with juvenile delinquents, it would have less relevance as a criteria for evaluating therapy with graduate students in psychology, coeds enrolled in undergraduate special education courses, or divinity students. Furthermore, the measurement value of the specific criterion chosen has to be examined. In the Teuber and Powers study, for example, no significant differences in recidivism between groups were found. The questions left in the mind of the reader are whether the treatment, the criterion, or both were ineffective. These same criteria issues are probably even more important when comparing results from one study with another, where different populations, treatments, and designs may have been used.

The assessment of broader areas of functioning has been pretty much restricted to institutional settings, where the subjects' range of behavior is limited. In such settings researchers have used multiple but individually meaningful behaviors as their criteria. These range from the number of times hospitalized psychiatric patients required electronconvulsive maintenance shock, to discharge from the hospital (Cowden, Zax, Hague, and Tinney,

1956); and reports from the prison chaplain, to return to prison as a parole violater (Fox, 1954). It is evident that there is no unifying framework in which to integrate these observations for comparison across different client populations. The consequence is that results are frequently fragmented, i.e., a variety of behavioral changes as a result of therapy are reported, but very few of these appear in any one study, and even fewer are observed in more than one study. Hence, there may be a variety of seemingly "valid" measures of therapy outcome, but each is valid for certain specified purposes and not necessarily valid for others. One must conclude that we do not have a satisfactory criterion, set of criteria, or even conceptual framework with which to adequately evaluate different forms of therapy with different client populations.

Internal Criteria

The use of internal or intratherpeutic criteria based on client behavior within the therapy process stems largely from the client centered approach. Rogers and Dymond (1954) provided data that indicated that the primary changes occurring during the client-centered therapy consisted of changes in self-concept rather than changes in behavior. This raises a potentially sticky point. If the therapy process odes not consistently produce observable behavior changes, can therapy be justified by arguing that at least client self-concept becomes more realistic or self-

satisfying as a result of therapy? In many cases research results indicate that change in self concept does not occur. In the Rogers and Dymond data, for example, no significant differences between behavior before and after therapy for the treatment group were found, when the external criteria of observations and reports by friends of the client were examined. In addition, however, no differences were found in change in self-concept between patients receiving psychotherapy and those that did not! The latter group were patients who, after waiting for psychotherapy, decided that they no longer felt in need of treatment. In one analysis of data on self-concepts (using the Q-adjustment scores), Dymond compared these no-treatment subjects with successful psychotherapy patients. The results showed that the changes in self-concept were equivalent in degree for both groups. Again, the reader is not certain as to what could account for these results. Is it, as Dymond (1955) remarks later, that

> ....although positive adjustment changes appear to take place in maladjusted persons in the absence of psychotherapy, these are not identical with the changes which occur in equally maladjusted persons who complete therapy (p. 107).

Here Dymond implies that no "deep" reorganization takes place - and client (who has not received therapy) improvement is characterized by "a strengthening of neurotic defenses and a denial of the need for help". While this may be, it provides yet another hypothesis that remains unsubstantiated.

Do the Dymond results reflect basic weaknesses in the Q-sort as a criterion instrument? The Q-sort type of instrument has enjoyed wide usage (Butler and Haigh, 1954; Cartwright, 1957; Rosenthal, 1955; Dymond, 1953; Cartwright and Roth, 1957; Butler, 1960; and Lesser, 1961), but it has not provided for a consistent or conclusive evaluation of the therapy process (Truax and Carkhuff, 1966). Other instruments have been developed which, like the Q-sort, were intended to serve as outcome criteria through use of client feedback. These include a Client Post-Therapy Scale (Tucker, 1953), a Therapy Session Report (Orlinsky and Howard, 1968) and self-rating scale (Fiedler, 1949). The client has also provided evaluation of therapeutic progress through use of open-ended follow-up interviews which were recorded and evaluated by three judges as being "successful, progress, or failure cases" (Cowen and Combs, 1950). It would seem, however, that the greater the extent to which such evaluative approaches depend on client feedback, the more evident is the fundamental weakness of this phenomenological approach in obtaining reliable assessments. These writers go on to indicate that when the client enters treatment, he feel bound to justify seeking help so that his problems are generally discussed freely. When terminating counseling, he feels obligated (to himself and the therapist) to prove he has indeed made movement. It is entirely likely that any report or reduction in discomfort or of positive

> 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 (Zax and Klein, 1960, p. 443).

growth would reflect this "hello-goodbye" effect (Hathaway, 1948).

The most promising approach for evaluating change in behavior in counseling and therapy seems to be the rating of behavior (usually verbal) by outside observers. This has been especially true in the measurement of various dimensions of therapist behavior considered essential to effective counseling and therapy. Rating scales have been developed for a variety of therapist process dimensions, especially the "core" conditions of empathy, positive regard, genuiness and concreteness. Substantial research has shown that these variables can be reliably rated and consistenly related to positive change in the client (Truax and Carkhuff, 1967; Carkhuff and Berenson, 1967).

Rating of client behavior in therapy has, for the most part, centered on the concept of self-exploration.

> In successful therapy, both individual and groups, the client spends much of his time in self-exploration - attempting to understand and define his own beliefs, values, motives, and actions, while the therapist, by reason of his training and knowledge, is attempting to facilitate this process (Truax and Carkhuff, 1967, p. 189).

A number of research studies tend to verify the significance for outcome of the concept of self-exploration. Several examinations of the degree of client self-exploration in client-centered therapy 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; Blan, 1953). Wagstaff, Rice and Butler (1960) also reported that patients with successful outcomes in client-centered therapy tended to explore themselves more in the course of therapy than did patients who could be classified as therapeutic failures.

Truax and Carkhuff (1964a) used the Depth of Intrapersonal Exploration Scale with tape recordings of individual psychotherapy sessions with schizophrenics and found that patients high in degree of self-exploration showed significantly greater personality change than patients low in self-exploration. Their overall analysis (including various psychological tests, percentage of time hospitalized and a number of other specific measures) indicated that patients engaging in a high level of self-exploration showed an average improvement of one standard deviation beyond that of patients low in self-exploration. The Depth of Intrapersonal Exploration Scale has been revised (Carkhuff and Berenson, 1967) and has been found to be a reliable and promising research instrument (the scale is described in detail

in Chapter III). However, it remains a somewhat crude measurement and has been criticized on the grounds that it is a global measure of behavior, derived from a single--the client-centered--therapeutic approach and has been used primarily by researchers disposed toward client-centered precepts.

A possible solution to this problem has been proposed by Kagan, et.al. (1967), who devised a set of outcome criteria to be used in the ongoing counseling process. These criteria had the following characteristics:

1. They were not identified with a particular counseling theory.
2. They were operationally definable and thus had research utility.
3. They did not necessarily represent discreet entities, i.e., a client might display two or more of the characteristics at a given moment.
4. They were not intended to describe <u>everything</u> that went on in the counseling relationship.

The intent was to provide criteria for client change which were acceptable to most theoretical positions without defining <u>all</u> client change; the elements chosen represent some of the most obvious tasks a client experiences in successfully moving through the counseling process. They are:

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

These criteria were operationalized in a rating scale (the Characteristics of Client Growth Scale; Kagan, Krathwohl, et.al., 1967) with 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), and has been found to be related to pre- and post-therapy change scores on the MMPI (Pierce and Schauble, 1969; the scale is further described in Chapter III).

Since it is reasonable to assert that the client establishes the same kind of relationship with his therapist that he forms with other people in his environment (in the sense that it contains the same needs, values, etc.), it would follow that observable behavior change in therapy would be a valuable source for evaluating the success of the therapy process. In light of the ambiguity surrounding research findings using external criteria, it would seem that internal or "process measurements" have at least as much value for attempting to evaluate the influence of counseling or therapy on client movement.

Acceleration of Client Movement

Assuming that there are adequate criteria for measuring client movement in counseling, are there ways of accelerating such movement? Since the development of the one-to-one therapy

relationship pioneered by Freud and his associates, attempts have continuously been made to demonstrate that one type of therapy is superior to another. This is most evident in the development of the various theoretical schools-of-thought. Woody (1970) summarized various writings and indicated that each of the major therapy approaches has had roughly a decade when its impact has been prominent. The 1930's are generally seen as the neo-analytic period. The 1940's were most heavily influenced by the trait-and-factor theorists. The "client-centered" approach was prominent in the 50's, the behavioristic approach was most impactful during the 60's and all indications are that the 70's will be the era of the humanistic therapists. One would expect that the existence of different theoretical models would imply observable differences in the therapeutic treatment offered by the advocates of each model. There is little support for this implication in professional literature. Fiedler's (1950, 1951) early research indicated that theoretical orientation was not a determinant of therapist behavior. Instead, experienced therapists of different orientations agreed with each other more closely than they did with beginning therapists from their own orientation. Another study comparing psychiatrists with clinical psychologists and social workers found no differences in the goals set out for treatment related to the discipline from which the therapist came (Micheux and

Lorr, 1961). Other studies indicate that time and situation limits are more likely to influence therapist behavior than is theoretical orientation (Schlein, 1962; Wrenn, 1960).

If there is no clear difference in therapist's behavior across theoretical approaches, one would not expect to find differences in the behavior of their clients. Research evidence using external criteria has not given a clear indication as to superiority among the various approaches (Truax and Carkhuff, 1966), and where internal, or process, criteria have been used to evaluate therapy, the level of functioning of the individual therapist seems to account for client movement--independent of the particular orientation of the therapist (Carkhuff and Berenson, 1967).

In addition to different theoretical constructs, we find a variety of methods or techniques which seem to have as their purpose the intensification of the therapy influence. Included in these are group counseling and therapy, multiple therapy, psychodrama and the use of videotape.

Group Counseling

Group counseling generally refers to the treatment of a number of individuals assembled for therapeutic purposes (Bion, 1961). Proponents of group counseling cit a number of advantages over the individual situation, e.e., the group situation brings

into focus the adequacy of the patients' interpersonal relationships and provides an immediate opportunity for discovering new and more satisfying ways of relating to people (Hobbs, 1958). When the relative value of groups as compared with individual counseling is subjected to research, however, the differences in effectiveness tend not to be clear. The substantial body of research in group counseling is summarized in reviews by Kagan (1966); Wright (1960) and Hoyt and Moore (1960).

Possibly the most concise evaluation of group counseling research to date is Kagan's statement that:

> An increase during the past three years (1963-1966) in the number of methodologically sound studies on group procedures provides considerable evidence for the conclusion that certain as yet unspecified group procedures--at the hands of some counselors, with some clients, in some settings and at certain times--will result in improved client grade point average, attitudes, knowledge and behavior.

In light of research to date, it is not clear that group counseling is superior to the individual counseling situation and its value is apparently as difficult to demonstrate (Shaw and Whorton, 1965).

Psychodrama

An elaborate group therapeutic technique was developed by Moreno (1946) in which the patient is encouraged to dramatize situations spontaneously, and, in the role of actor, to relive

many of his conflicts, wishes, fears and attitudes. Through an acting-out of his problem and giving vent to his feelings and fantasies, the person is said to resolve many of his deeper problems and conflicts. The technique sometimes uses a device called an "auxiliary ego" assumed by a trained worker who mimics the patient and reacts spontaneously by acting out feelings and thoughts he believes the patient may not be able to express. Or, the patient may play the role not only of himself but also of a significant person in his life, such as a parent or sibling. The material elicited during psychodrama can be dealt with in the group format or used in individual sessions with the therapist at a later time. This technique appears to have an emotionally carthartic value for the patient, and it is possible that the patient can gain understanding of his problems as they are revealed in his expressed acts and thoughts as reflected back to him by the "auxiliary-ego". Clinical reports indicate that, with coordinate individual therapy, the technique helps the patient to gain insight into his disturbed behavioral patterns but this is as yet unsubstantiated by controlled research. Anker and Welsh (1961), in a study of the effectiveness of group therapy as opposed to drama group-activity, found that the group engaged in drama activity supposed to serve as a "control" group for purposes of comparison) made consistently <u>greater</u> improvement than the

psychotherapy treatment group. Apparently the "acting-out" of feelings in some sort of role-playing activity can have some (heretofore unqualifiable) benefits for client movement. In fact, many of the devices used in psychodrama are used in other forms of group counseling, as well, e.g., role playing, auxiliary or "alternate" egos, non-verbal communication, etc. (Bradford, Gibb and Benne, 1964), but their value has yet to be conclusively demonstrated through research.

Multiple Therapy

A relatively new technique uses two or more therapists and is called co-therapy or "multiple-therapy". The benefits of this technique, according to Kell and Burow (1970) is that it provides the opportunity for both conflict generation and resolution that is not so available in dyadic therapy. This is due to the multiplicity of possible relationships, e.e., between each therapist and the client (or clients), between each therapist and the client's interaction with the relationship between therapists. One advantage of multiple therapy is that it approximates the family situation (if male and female therapist are used), thus evoking more conflicts related to the developmental problems of the individual. The therapists involved seem to experience a number of advantages, not the least of which is the availability of in-therapy consultation with each other.

> Impasse situations during treatment and problems in the ending of therapy became much less threatening, with the certainty that there was a consultant available to share the responsibility. Similarly, group psychotherapy became a more intense experience for both therapist and patients because we became less afraid of 'transference--non-transference' gains (Warkentin, 1967).

Multiple therapy has become a popular and widely used technique (Nunnally, 1968). Therapists who have participated in multiple therapy groups reported it: Was effective; facilitated expression of feelings regarding conflict with parents; helped in resolving problems in sex role and education and influenced the formation of healthy heterosexual relationships (Rabin, 1967; Mintz, 1963; Minta, 1965; Mullan and Sangliuliano, 1960). These are descriptive data, however, and in those few studies where an empirical evaluation of the technique was attempted, there has been no indication that multiple therapy is any more effective in accomplishing client movement than with one therapist (Nunnally, 1968; Daniels, 1958 and Staples, 1959).

Use of Videotape in Counseling

A variety of techniques using videotape have been developed and applied in counseling and psychotherapy. Most of these studies have been focused on videotape in the training of counselors and therapists but they do provide implications for client movement as well.

Suess (1966) and Schiff and Reivich (1964) using psychiatric supervision models, report the value of videotape in understanding the interview dynamics of counselor and clinet--especially as a record of the non-verbal communication within the interview which is not available to the supervisor through the traditional techniques of process notes or audiotapes. In discussing the influence of videotape on the process of psychotherapy supervision, Gruenberg, Liston and Wayne (1969) state that supervision becomes more complete and honest, providing the necessary feedback with which to determine the progress of the patient and therapist. They cite several important contributions of the videotape. First, before the advent of videotape, the supervisor felt no genuine source of encounter with the patient. He often did not see the patient and his knowledge depended on the subjective reports of the therapist-in-training. Access to the videotaped therapy session provides the supervisor with specific first-hand knowledge of the client. Gruenberg, et.al., claim that the supervisor is able to become a more effective consultant, in effect a "co-therapist" and is better able to help the therapist-trainee arrive at a "therapeutic result". The quality of client treatment logically should improve when the therapist is getting "improved" and personalized supervision. With a greater degree of involvement with the patient via the videotape, the supervisor can protect him against anti-therapeutic maneuvers by the

therapist/trainee. Second, the therapist/trainee does not need to concern himself taking notes, as the videotape provides a record of the therapy for supervision. The authors claim this alleviates therapist concern over completeness of notes, as well as eliminating patient worries that the therapist is more interested in notes than in him. Finally, they cite experience indicating that the use of videotape seems to increase the tempo of therapy.

> The cessation and subsequent resumption of videotaping were clearly related to the effectiveness of therapeutic activity. Succintly 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. (Page 104)

The effect of this focusing and "investment of attention" would seem to have potentially at least as much of an effect on the client as on the therapist, i.e., if the client were aware that his behavior and adequacy as a client participant were to undergo "intensive scrutiny," his "performance" as a client might be improved.

Two separate studies suggested that counselors-in-training gained new insights and greater self awareness as a result of viewing a videotape replay of their counseling behavior (Landsman and Lane, 1963; Walz and Johnston, 1963). There was no evidence as to whether or not these insights were translated into new or effective counseling behaviors but if counselors can gain insight

and self awareness from watching their sessions on videotape, it seems logical to expect clients could enjoy the same gains.

The use of videotapes of one's own behavior in therapy might seem to contain the danger of evoking extreme threat within the client, similar to the "psychic shock" reactions observed by Cornelison and Arsenian (1960) upon confronting hospitalized psychiatric patients with motion pictures and still photographs of themselves. Such increases in the level of anxiety upon viewing a tape of oneself have been noted by Moore, et.al. (1965), with hospitalized psychiatric patients and Gurtsma and Reivich (1965) with a psychiatric out-patient. This does not have to be the case, however, as demonstrated by Poling (1968). Poling investigated the impact of videotaping counseling interviews in three different environments. While the 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 <u>less threatening</u> and <u>more conducive to counseling</u> 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. (Page 352)

While the different environments were not compared with a control environment of no-videotaping in this study, the results tend to confirm Poling's conclusion that when counseling was conducted in a "professional manner," the physical environment had little effect upon the degree of success of the interview. In another continuing research project, little difference has been observed in the behavior or anxiety level of clients in sessions where they are videotaped as opposed to sessions in which they are not (Kagan, Krathwohl, et.al., 1967).

In a few of the studies investigating the value of videotape in the training of counselors, the client has been able to view the videotape immediately after the counseling session (Schmeding, 1962; Pascal, 1967 and Walz and Johnston, 1963). It is unfortunate that the effects or potential of this practice on influencing client behavior were not examined by the writers involved, although Ryan (1969) does report experience that suggests clients are eager to view their videotapes. Ryan also suggests that the client, counselor candidate and supervisor should work together as a team in analyzing the session, but again he does not suggest or evaluate the behavior or roles available in this situation and their potential impact on client behavior.

In a carefully controlled study, Goldberg (1967) did use a structured approach to replaying the client's videotaped interview developed by Kagan, Krathwohl, et.al. (1967). In Goldberg's study

the counselor/trainee was able to observe the client's "stimulated recall" of the completed counseling session through a one-way mirror, thus maximizing the counselor's feedback as to client perceptions of the therapy session. After a later session, the client, counselor and supervisor engaged in a "mutual" recall session where counselor and client shared directly their perceptions of the videotaped counseling session. Goldberg's training program was found to result in significantly improved counselor performance when compared to a control group of trainees receiving intensive traditional supervision. The trainees in both the treatment and the control groups were rated as more affective, understanding, specific, exploratory and effective, but positive behavior change in the videotape treatment group was significantly greater than in the control group.

There have been few studies which examine directly the therapeutic potential of videotape on client movement in therapy. Moore, Chenell and West (1965) report the procedure of having patients see themselves on videotape in order that they might gain a perspective of their own abnormal behavior. In that study, patients who were exposed to interviews made over a period of several weeks made more rapid changes in the "direction of health" than those who were videotaped but did not see themselves. Paul (1965) and Gurtsma and Reivich (1965) provide further descriptions

of the technique of exposing the patient to tapes of previous behavior. These studies lacked adequate controls and did not seem to make optimal use of videotape as a therapeutic tool. In most uses, the videotape of a client's behavior was simply played back for him to view. No attempt was made at helping the client gain in-depth understanding of the dynamics underlying the behavior. In contrast, in a series of studies Kagan, et.al., applied a structured method of stimulating immediate client recall of videotapes made of the client's previous counseling sessions. The results indicated that, with a structured approach to examining the videotape, accelerated client movement in counseling could be obtained (Kagan, Krathwohl, et.al., 1967; Kagan, Krathwohl and Miller, 1963; Resnikoff, Kagan and Schauble, 1970). This approach will be discussed in the next section.

Stimulated Recall to Accelerate Client Movement

The technique of using stimulated recall by videotape as a tool in accelerating client insight and change during counseling is part of the Interpersonal Process Recall (IPR) method developed by Kagan, et.al. (1963, 1967, 1969). The technique was derived from Bloom's (1954) use of stimulated recall as a means of examining the thought processes of students and Nielsen's (1962) investigation of perceptual change through self-confrontation.

A special value of the technique is that it contains a clear formulation of the approach where in the videotape of the client's own in-therapy behavior serves as the stimulus for client investigation of the dynamics underlying that behavior. It is from this method and the outcomes of several studies using IPR that the present research developed.

The initial research with IPR was structured in the following manner:

> A counselor and client were videotaped in a counseling interview (see Figure 1, Appendix A). As soon as the interview was concluded, the counselor left the room; and a second trained clinician--designated an "interrogator"--entered the room, whereupon the playback of the interview was conducted.* Then the "interrogator", with the aid of a remote-control stop-start unit, helped the client probe for the underlying affective components of the client-counselor communication (see Figure 2, Appendix A).
>
> An essential variable of the process was for the counselor to directly observe the recall session. Through the recall, the counselor seemed to gain a great deal of understanding of the nature of the client's problems and of the client's interpersonal relationships by observing the kind of interpersonal relationship the client had established with him. That is, by observing the client's projections, fears and aspirations about him (the counselor), the counselor could more clearly understand the client's interpersonal behavior and some of the more central qualities of the client's presenting-problem. At the same time the client began to understand his own general perceptions and reactions to people by observing the way in which he interacted with the counselor.

In addition to intensive analysis of case studies (Kagan, Krathwohl, Miller, 1963; Woody, Kagan, Krathwohl and Farquhar, 1964; Resnikoff, Kagan and Schauble, 1970) where the potential of IPR for accelerating movement was indicated, controlled studies (Kagan, Krathwohl, et.al., 1967) were conducted which led to the following 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 a study examining the effects of IPR with prison inmates, no differences in client movement in therapy were observed after the intervention of the IPR session, despite the fact that the recall session where the client viewed and discussed his behavior appeared extremely productive. It was later determined that the counselors involved had not viewed the client's recall session, and when they resumed their counseling relationship with the client they were oblivious to and seemed to discourage the client's new found insights and exploratory behavior. In a second study, the same counselors were required

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*The role, function and training of the interrogator in the IPR method is discussed in Kagan, N.; Schauble, P.; Resnikoff, A.; Danish, S. and Krathwohl, D.; Interpersonal Process Recall, Journal of Nervous and Mental Disease, 1969, 148, 4.

to remain with the client and interrogator during the recall session. By remaining in the room and eventually participating in the recall session, the counselor was confronted directly with client feedback. This "mutual recall" resulted in subsequent client growth in therapy.

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 with the mutual 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) benefited more from the regular IPR* than from the mutual IPR. For the lower functioning counselor, these results were reversed. The writers conclude:

> 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 interrogator and his client, and gain less from taking part in the interrogation. The less competent therapists, on the other

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*Unlike the study with prison inmates, in the regular IPR session in this study, the counselor was able to observe directly the recall session through one-way glass.

> 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. (Pages 319, 320)

The writers go on to say that the less competent counselor becomes more effective with his client by participating directly in the recall session, where the presence of the interrogator may serve to reduce the anxiety of the counselor so that he is more comfortable in dealing directly with the interpersonal dynamics and conflicts between his client and himself.

There is support for this conclusion in other areas of research, where it has been found that counselors functioning at low facilitative levels have a negative effect on well motivated clients (Piaget, Berenson and Carkhuff, 1967; Carkhuff and Berenson, 1967) i.e., 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.

In summary, it appears that the use of stimulated recall via videotape can be an effective influence in accelerating client growth in therapy when counselor involvement and functioning level are taken into account.

Simulation in Counseling

For many years simulation techniques have been successfully employed in both the armed services and industry in training to avoid damaging costly equipment or endangering human lives, e.g., astronaut training (Kersh, 1965), but it is only recently that these techniques have been adopted in education and the social sciences. There is no lack of logical rationale for the use of simulation techniques in counseling. Greenalw, Huron, and Rawdon (1962) describe the benefits of simulation in training as including the condensening of time, whereby participants can increase their understanding of the decision-making process and sharpen analytic skills through immediate observation of the results of their decisions. For many clients and counselors, each decision is crucial and loaded with implications for the future. If we assume that a major ingredient of the client's coping difficulty is his lack of ability ot make appropriate decisions and take action on them and/or his lack of confidence in his ability, than a simulated situation where he can make and examine various behavioral responses free from much of the fear of disastrous consequences would seem an invaluable adjunct to the therapy process. Indeed, the counseling situation itself initially represents an unreal or simulated situation for many clients in the sense that they are involving themselves in a relationship and self-analytic behavior heretofore deprived them in the "real world". Despite the available rationale, however,

there has been little research into the development of simulation techniques in counseling. Of the work that has been done, most involves the education and training of counselors, or related personnel.

Simulation research in teacher education has led to programs that prepare 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); to evaluate the impact of individual or innovative approaches on the teaching process (Fattu, 1965). Each of these qualities is readily interchangeable with the aims of counselor educators. This position is adopted by Delaney (1969), who submits a proposal for developing the simulation approach in counselor education. Delaney indicates that research to date justifies the following conclusions:

1. Simulation is effective 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 shown to be feasible and effective (p. 185).

The application of simulation techniques to counselor education has obvious implications but it has not as yet been empirically validated. In one of the few attempts to provide research

evidence, Beaird and Standish (1964) obtained encouraging results. These writers used a simulated environment to train practicum-student counselors to discriminate between cognitive and affective client responses and then to use counselor response leads to facilitate more affective behavior in clients. This study used audio recordings as simulation stimuli within a programmed-learning instructional format. 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 positive results can be obtained using an audio-simulation approach, one wonders what the application of film or video techniques could add. One study (Lougne, Zenner, and Gohman, 1968) did attempt to evaluate the influence of videotape on the job interview situation; but the results were confusing. The writers divided a group of neuropsychiatric in-patients into three experimental groups: programmed materials group, programmed materials with videotape group, and control group. The results did not indicate that the programmed materials or materials with videotape facilitated performance in the job interview situation, in fact there was a noticeable (but non-significant) trend favoring the control group. Among many methodological weaknesses in this study was the fact that each client participated in a single simulated interview, and was able to view himself on videotape

only once. The writers suggest that the self-confronting nature of the videotape produces anxiety, thus the single video session in this study may have done more hard than good.

> In other words, what one may be dealing with in the attempt to increase efficiency by single-practice interview and subsequent group and individual replay is this anxiety effect. Whatever positive features might be gained from the attempted modification of specific bits of behavior is nullified by the self-conscious anxiety which might contribute to less able performance on both the application blank and the later job interview. (p. 438)

There are two distinct notions expressed in this explanation: 1) That increased anxiety may lead to lower performance, and 2) That the self-image is an anxiety producing stimulus. There is little doubt that simulated situations can produce anxiety in clients. "Stressor films" have been used in a laboratory situation to create and study psychological stress and anxiety (Laxurus, Speisman, Mordkitt, and Davison, 1962), but this approach calls only for vicarious involvement on the part of the client. In other words, the subject views a filmed situation which involves him only as a spectator (e.g., a vivid traffic accident). Earlier in this chapter it was noted 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 rarely seems to be the case. It would seem apparent that such self-confrontation <u>can</u> raise client anxiety, but there is

some evidence to suggest that this can be of positive value in terms of stimulating client behavior that relates to his problem area and can thus be dealt with in the therapy situation. Two examples illustrate this point.

Cornelison and Arsenian (1960) took still photographs of psychotic patients and later showed the pictures to the subjects. Initial responses for most patients "conveyed an impression of sudden psychic shock". The writers proceed to describe a variety of intense reactive responses to the photographs, and conclude that stimulating such behavior responses may be a potent "adjunct to psychotherapy with disturbed persons", if the behavioral response are integrated into the therapeutic diagnosis and setting of goals.

Small (1967) recorded on audio-tape the comments of patients who were experiencing delerium tremors. After five or six days, when the patient was oriented again with most of tremulousness gone and with the disappearance of hallucinations and delusions, the tapes were played back to the patient. The tape had such a realistic effect that it reinduced symptoms that he had experienced just a week before when in the midst of his delerium. This was carried out even to the extent where the patient would become very suspicious again, and on occasion re-experience, on a temporary basis, the visual hallucinations which he had previously had. Small postulated that this technique could have therapeutic benefit for chronic alcoholics if such tapes were replayed at

stated intervals - "in a sense recharging their therapeutic batteries and in this way, perhaps, condition them against returning to a chronic drinking pattern". While this idea has not been validated through research, it has intriguing implications for counseling and therapy.

Conclusions and Implications of the Literature

Despite the lack of controlled, definitive research in many of the areas reviewed which relate to the acceleration of client growth, there are a number of implications that can be drawn from the literature.

There do not appear to be appropriate or satisfactory external dimensions of client behavior by which to evaluate techniques designed to accelerate client growth in therapy. A number of internal or "process" dimensions have recently grown out of Roger's work. Of the three potential sources of process data: client, counselor, or independent observer, the most promising seems to be the independent observer (Truax and Carkhuff, 1967; Carkhuff and Berenson, 1967). Several dimensions of "desirable" in-therapy behavior have been developed and operationalized into apparently reliable rating scales, 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); these seem to have some validity and research utility as criteria by which to evaluate client growth.

A variety of approaches have been developed to improve or accelerate the influence of therapy on client growth. While each has a seemingly sound theoretical rationale, however, there simply has not been consistent or conclusive empirical support that the new approach works any better than the usual one-to-one therapy. The innovations that seem to have considerable potential for influencing client growth are videotape and simulation but these have yet to be tried with clients. Most relevant research with these techniques centers on their use in counselor-training. The one method that has found direct application in counseling and therapy has been stimulated recall through IPR (Kagan, Krathwohl, et. al., 1967; Resnikoff, Kagan and Schauble, 1970; Kagan, Krathwohl, and Miller, 1963). This technique clearly formulates an approach to maximize client participation and feedback, and has accomplished positive (if small scale) results in accelerating client growth.

If the IPR method with videotape maximizes feedback to the client about his behavior in the videotaped interaction, and if simulation experiences provide an opportunity for stimulating a variety of emotional reactions in the client (Cornelison and Arsenian, 1960; Small, 1967), the logical question then develops: can simulation techniques be developed which can be combined with IPR methods to formulate a new approach to accelerating observable client movement in therapy.

Simulation and Stimulated Recall: A Pilot Study

During the spring and summer of 1968 a pilot study was conducted to determine if the simulation and IPR techniques could be integrated into a viable treatment program. The nine clients participating in this study were referred by a local community rehabilitation agency for short-term intensive counseling. These clients were referred because they were suffering from personal and adjustment problems which substantially interferred with rehabilitation service or vocational placement. Clients were seen for six sessions of one and one-half hours each. The clients were assigned to one of three treatments: 1) counseling (control treatment); 2) counseling using VRAS (simulation films and videotapes) first, (three sessions) then IPR (interpersonal process recall) (three sessions); 3) counseling using IPR first and then VRAS.

The results indicated that clients receiving counseling which included either combination of the simulation and videotape techniques made more progress on four process measures of client growth (using independent judges) than did control clients, and clients receiving either innovation treatment were also judged as having made more positive movement on variables relating to change in the therapeutic process. In fact, control clients were found to move negatively on the process variables used. This was taken to indicate that positive movement within counseling is not

necessarily concommitant with counseling experience (a finding which is consistent with the findings of Piaget, Carkhuff, and Berenson, 1967; and Carkhuff and Berenson, 1967) and it was tentatively concluded that the IPR intervention did have an "accelerating" influence on growth in counseling. It was also found that five of the six clients receiving counseling with simulation and videotape achieved vocational placement within six weeks from the beginning of their counseling contact, whereas this was true for only one of the three control subjects.

Exposure to IPR and VRAS resulted in positive growth for all clients, and there did not appear to be a measurable difference in movement related to the order of presentation of the techniques. However, it appeared there may be some advantages to beginning the treatment program with the VRAS. When VRAS preceeded IPR there seemed to be a more contigious "building effect". The client seemed to learn the behavior of self-exploration of his videotaped reactions to simulated confrontation, and was then able to apply this exploratory behavior to recalling of confrontation in the counseling session via IPR.

In summary the pilot study led to three tentative conclusions:

1. VRAS and IPR can be integrated in a counseling intervention treatment program.

2. This program can lead to observable client growth in counseling.

3. There seems to be a practical rationale for beginning the intervention program with affect simulation experiences.

These conclusions provided initial support for the hypothesis reported in the following chapters. (A complete description of the pilot study is included in Appendix B).

Summary

There is a paucity of controlled research in the area of evaluation of counseling and psychotherapy. The most imposing problem seems to have been the development of adequate criteria. There does not seem to be an acceptable or satisfactory system for comparison of external evaluation criteria, so that positive results for different therapy situations (in those instances where they are found) after treatment is concluded cannot be compared across studies. Internal or process criteria are more stable and generalizable, but are still in the process of development and have not been used with any consistency to date. The major obstacles in examining client movement within counseling have been lack of definition of processes and goals, and the inability to operationalize such goals as do exist. One potentially valuable approach to this problem has been the development of rating scales for those dimensions of client behavior which seem to be essential to client movement or change. The scales appear to have reliability and some evidence of validity, and include the client behaviors of self-exploration, owning of feelings, committment to change, and differentiation of stimuli. With these scales providing the framework for examining client

progress in counseling, the accelerating effects of a counseling intervention technique will be examined. The technique derives from earlier research in Interpersonal Process Recall (IPR) and affect simulation. Pilot research indicated that such a treatment has potential for accelerating client growth in counseling, and suggested a format for implementing the treatment.

CHAPTER III

DESIGN AND METHODOLOGY

An experimental research design was formulated which would permit the testing of the hypotheses posited in Chapter I, namely, that: a) clients who receive counseling with IPR intervention will make more positive movement within counseling than will clients who receive personal counseling alone, b) clients receiving IPR treatment will perceive their counselors as more accessible and easier to talk with than will clients not receiving IPR treatment, c) clients receiving IPR treatment will develop a more improved self concept than will clients not receiving IPR treatment, and d) clients who receive IPR treatment will evaluate themselves as having made more progress than clients not receiving IPR treatment and counselor judgements will support these client evaluations. In order to answer these questions, the design had to permit comparisons of client interview behavior within experimental groups over time and treatment. A schematic representation of this design is presented in Table 3.1.

A pre-post design was used as the framework for answering the main research questions. Because the clients participating in this study were individuals presenting varying degrees and kinds of personal and emotional problems, it was necessary to have a measure of their initial level of functioning if an assessment of the effectiveness of either type of treatment, counseling with IPR or counseling alone, was to be made. The initial interview provided a measure of base-line functioning for ascertaining

TABLE 3.1

Schematic Representation of the Overall Experimental Design

Groups	Treatments	Analysis
IPR Treatment Groups (N = 6)	O_1 Counseling with IPR Intervention Techniques (6 sessions)	O_2 O_1-O_1 = D_1
	D_1	Analysis Between Treatment
Control Group (N = 6)	O_1 Counseling Without IPR Intervention Techniques (6 sessions)	O_2 O_1-O_2 = D_2

the degree of behavior change resulting from each type of counseling experience.

The pre-training measures also served as an additional check on the power of each of the counseling experiences. It was necessary to determine if the counseling experience afforded the group not receiving IPR intervention changed client behavior, in order to determine the relative effectiveness of the IPR intervention techniques.

Finally, judges' ratings of each client's initial interview behavior afforded a means of investigating the possible differential potential for change at varying levels of functioning.

Description of the Experimental Procedures

Counseling With IPR

The introductory and first treatment sessions were the same for both the counseling with IPR group and the traditional counseling group. The introductory session was necessary in order to insure that each of the participants was fully "informed" as to the research aspects of the treatment, and willing to engage in the various data gathering activities. The first session served primarily to provide a pre-measure of each client's functioning level at the onset of therapy.

As outlined in Table 3.2, the IPR treatment fell into three distinct yet sequential phases. Phase 1, sessions 2 and 3,

combined video-recall and affect simulation filsm (VRAS). In phase 2, sessions 4 and 5, the client went through a stimulated recall session of a videotape of his in-counseling interaction with his therapist (i.e., a traditional IPR session, conducted by a trained interrogator). In phase 3, the therapist remained with his client and a mutual recall was conducted.

Phase 1

During sessions 2 and 3, the first 30 minutes was conducted as a "standard" personal counseling session and audiotaped for subsequent rating by judges. The next 40 minutes centered around the use of the simulation films. Not more than five scenes were shown to a client in any one session and no scene was longer than two minutes in length. As the client watched the film, he and the film were videotaped to produce a split-screen image with the client on one half of the screen and the film on the other half. After the client had been videotaped watching the films, the tape was played back and a recall of client reaction to the films was conducted (VRAS session). The remaining 20 minutes consisted of personal counseling without the use of the simulation films; this was audio taped for subsequent rating by judges. During the VRAS session, the counselor attempted to help the client use the videotaped examples of his reactive behavior to explore the nature of (and feelings about) actual and existing interpresonal relationships. The actual

TABLE 3.2

Summary of the Experimental Procedures

Counseling With IPR	Traditional Counseling (no IPR)
Introduction Session: Thirty minute initial counseling session between each client and the investigator.	
a) The initial contact interview provided the opportunity to orient the participating clients to the special circumstances of the research project. It was explained that they would be involved in a study which was designed to help define what went on in counseling and therapy, from both the client's and the therapist's point of view. To do this, it would be necessary for the client to cooperate by: (1) Completing a paper/pencil self-concept instrument before the first therapy session and after the sixth session. (2) Fill out a questionnaire after each session describing their feelings about that particular session. (3) Permit all sessions to be audio-recorded for subsequent rating by judges and (4) meet for two hours per session, rather than the customary one-hour session.	
b) In addition, the IPR group was told that their sessions would be videotaped and that these videotapes and specially developed films would be used as a part of their treatment during the first six weeks of their counseling.	
Session #1	
a) Ninety minute initial counseling session with each client. This initial interview in the treatment program served as a measure of each client's interpersonal functioning level at the beginning of therapy.	a) Ninety minute initial counseling session with each client. This initial interview in the treatment program served as a measure of each client's interpersonal functioning level at the beginning of therapy.
b) Thirty additional minutes allowed for completion of relationships inventory.	b) Thirty additional minutes allowed for completion of relationships inventory.
Session #2	
a) Thirty minute counseling interview with each client.	a) Ninety minute intial counseling session with each client.

Counseling With IPR	Traditional Counseling (no IPR)
b) Forty minute session in which affect simulation films were shown to client, videotape of client reactions was made, tape was then played back for counselor and client to use in discussion of client reaction to these stimuli.	b) Thirty additional minutes allowed for completion of relationships inventory.
c) Twenty minutes of counseling interview were conducted without use of videotape or film.	
d) Twenty-Thirty minutes allowed for completion of relationship inventory.	
Session #3	
a) Thirty minute counseling interview with each client.	a) Ninety minute initial counseling session with each client.
b) Forty minute session in which affect simulation films were shown to client, videotape of client reactions was made, tape was then played back for counselor and client to use in exploration of client behavior.	
c) Twenty minutes of counseling interview were conducted without use of IPR.	
d) Twenty-Thirty minutes allowed for completion of relationship inventory.	
Session #4	
a) Thirty minute counseling interview with each client.	
b) Forty minute client recall of videotape made of first 30 minutes.	

Counseling With IPR	Traditional Counseling (no IPR)
c) Twenty minute counseling interview conducted without use of IPR.	
d) Twenty-thirty minutes allowed for completion of relationship inventory.	
Session #5	
a) Thirty minute counseling interview with each client.	a) Ninety minute initial counseling session with each client.
b) Forty minute client recall of videotape made of first 20 minutes.	
c) Twenty minute counseling interview conducted without use of IPR.	
d) Twenty-thirty minutes allowed for completion of relationship inventory.	
Session #6	
a) Thirty minute counseling interview with each client.	a) Ninety minute initial counseling session with each client.
b) Forty minute client and counselor (mutual) recall of videotape made of first 20 minutes.	
c) Twenty minute counseling interview conducted without IPR.	

videotaped sample of client behavior never exceeded ten minutes, since the purpose of VRAS session was to explore the reaction stimulated in the client by the simulation films, i.e., the client's videotaped behavior served as the focus for a personal counseling session.

Phase 2

For the second phase of IPR counseling, sessions 4 and 5, the first 30 minutes was again conducted as a traditional counseling session. In addition to being audiotaped for subsequent judge rating, this 30 minutes was videotaped to produce a split screen image with the client on one half and the counselor on the other. At the end of the 30 minute interview the counselor left the room; another counselor (trained in the recall or "interrogation" technique) entered and conducted a recall of the videotaped session while the counselor observed the recall process through a one-way mirror. After a half-hour recall the interrogator left and the client was rejoined by his counselor for a resumption of the counseling process. The last 20 minutes was audiotaped for subsequent rating by judges. During the recall (or IPR) session, the interrogator attempted to focus the client on an exploration of his own behavior in the counseling relationship. Through direct observation of the recall session, the counselor was able to share the client's awareness of his behavior and incorporate this information into the development of the

counseling relationship.

Phase 3

The final phase of the IPR counseling treatment (session 6) again began with 30 minutes conducted in a standard counseling format which was audiotaped for subsequent rating by judges. This session was also videotaped for playback to the client, except that this time during the recall session, the counselor remained in the room. The interrogator then conducted a "mutual" recall, where the client and counselor were first encouraged to share their thoughts and feelings about the counseling interaction on videotape (the "then-and-there" of the transpired session); this then developed into a more direct communication about their immediate relationship (the "here-and-now" of their counseling relationship). At some point in this process (but always within forty minutes) the interrogator, who had become less and less active in the recall session, left the counselor and client and they continued the counseling session, the last twenty minutes of which were audiotaped for subsequent rating.

Traditional Counseling (Without IPR)

In order to equate client contact time in counseling and to provide the most intensive "control" counseling experience for this group, the clients receiving traditional counseling were seen for six counseling sessions of 1½ hours each. The

goals of counseling for this group were the same as those for the IPR group, i.e., the therapists concentrated 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. These counseling procedures were responsive to each client's needs and as intensive as possible.

A summary of the experimental procedures within the framework of the overall design is presented in Table 3.2.

Physical Environment

Counseling sessions for the IPR treatment groups were held in a specially constructed room equipped with pre-set television cameras, an unconcealed microphone, and a monitor to receive the replay. The cameras were located behind the wall connecting to an adjoining room, and were clearly visible through thermopane windows . The adjacent (control) room was blackened during sessions, however, and while the cameras when visible they were quite unobstrusive. Between the windows for the television cameras was a one-way mirror through which the therapist could view the recall of IPR sessions. (See Figure 3.1)

The videotape facility was not located in the counseling center building, nor was it always available to the traditional counseling group, so to avoid unforseen environment changes, control subjects were seen in the research studio in the counseling center. This facility had the advantage of sophisticated

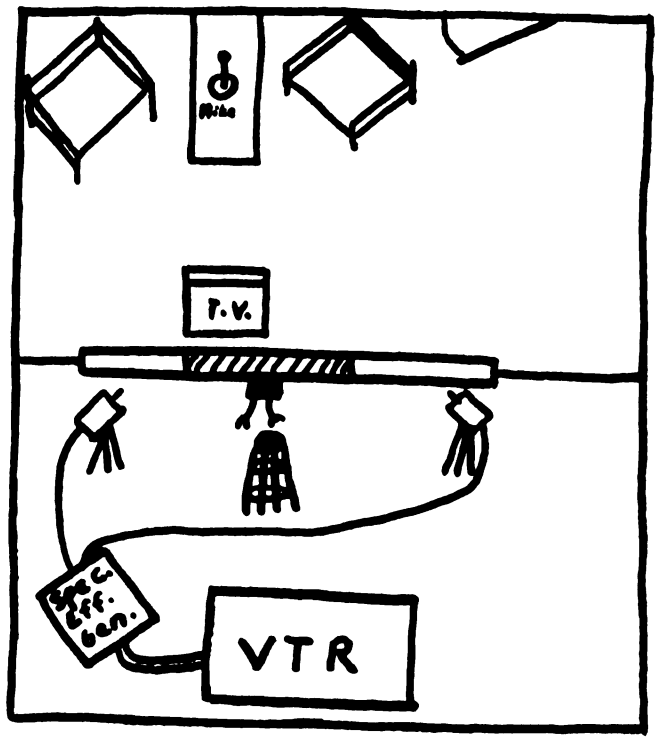

Figure 3.1 Floor plan of IPR suite. Upper half: counseling studio with TV monitor for viewing playback. Lower half: Recording room with videotape recorder (VTR), special effects generator (for accomplishing split-screen recording), cameras aimes through clear thermo-pane windows - separated by one-way mirror through which recall session can be observed.

audio-recording equipment, and although it did not have television cameras, monitors, or a one-way vision mirror, it was obviously a research or "special" interview area. As such, the noverty or "Hawthorne" effect which might have an influence were clients in the control group to meet in the counselor's office (as opposed to the "special" nature of the videotape facility) was minimized.

Sample

Therapists

Counseling of all clients in this study was conducted by two Counseling Center Interns who had completed all requirements but dissertation for the Ph.D. degree in Counseling Psychology. While both therapists had received the bulk of their training in the "traditional form of counseling and therapy, they were also trained and had experience in the use of IPR procedures in counseling. These therapists knew the research hypotheses, and because of the obvious differences in counseling procedures, knew the experimental group to which clients were assigned. Nevertheless, random assignment to these therapists of clients in both treatment groups and reliance on their professional attitudes seemed more advisable than using different counselors for each treatment. The procedure also provided the advantage of assuring a common frame of reference within therapists across treatment

groups. In this way, equality of therapist skill, background and training was assured across treatments (neither therapist was used as a judge for rating outcomes.

Clients

The clients participating in this study were students who were referred to the investigator by counselors on screening duty at the MSU Counseling Center. When a student initially requests counseling service from the counseling center, he/she is seen immediately by a screening counselor, who attempts to assay the client's needs and determine how the center's services can be used to the best advantage in meeting the client's needs. For purposes of this study, screening counselors were informed of the existence and nature of the research, and were requested to ask all clients seen in screening interviews over a three-week period if they would be willing to participate (See Form for Instruction of Screening Counselors, Appendix C). The only restrictions posed by the investigator were that clients not be requested to participate if they were potential suicide or "cricis" cases, if they had primarily educational/vocational concerns, or if they had been seen in therapy at the center at a previous date. It happened that the clients making initial contact during this period of time (Spring term, 1969) were predominantly female. In order to reduce the possibility of either a treatment or therapist interaction effect with the sex variable,

12 clients were selected from the first 13 female screening referrals, and then randomly assigned to both treatment and therapist. They were then contacted by the investigator for a 30 minute interview in which the nature of the research project was described to them, and they were asked if they were willing to participate.

While the use of a volunteer sample might limit generalizability of results, it should be noted that only one of the subjects asked if they were interested in participating in the research declined to do so; when this individual was assigned to a counselor through regular screening channels she failed to keep scheduled appointments and was eventually terminated with no further contact. It thus seems that in this study, the fact that subjects had agreed to participate in no way differentiated them from the other clients requesting and following through on counseling services at that particular time.

The IPR counseling group and traditional counseling group were compared on variables which might have influenced the outcome of counseling, namely: 1) age, 2) grade point average (G.P.A.), and 3) class standing. Summaries of this data are presented in Table 3.3.

Instrumentation

Five measures were used as criteria in this study: 1) The Characteristics of Client Growth Scales (COGS, Kagan, Krathwohl,

et. al., 1967; Schauble and Pierce, 1969), 2) The Degree of Self-Exploration Scales (D.X. Truax and Carkhuff, 1966; Carkhuff and Berenson, 1967), 3) The Wisconsin Relationship Orientation Scale (WROS, Steph, 1963), 4) The Therapy Session Report (Orlinsky and Howard, 1966, and 5) The Tennessee Self-Concept Scale (Fitts, 1965).

TABLE 3.3

Comparison of Treatment Groups According To Mean Age, Mean G.P.A., and Class Standing

	IPR Counseling Group	Traditional Counseling Group
MEAN AGE	20 years, 6 months	20 years, 3 months
MEAN GPA	2.74	2.97
MEAN CLASS STANDING	10 terms*	13 terms

*Term refers to one quarter of academic year.

The Characteristics of Client Growth Scales

The COGS consists of three separate scales which character-

ize productive client behavior in counseling.[1] The client owns his own feelings. Some clients in therapy are aware of their inappropriate behaviors and discomfort, but others have only vague feelings - not tied to specific problems or interactions yet pervading much of their outlook on life. Progress in therapy occurs when the client admits and "owns" his feelings as coming from himself. The second characteristic is the client commits himself to change. The client decides he wants to change, and is willing to deal with his problems and face the consequences of changing as evidenced by increased cooperation with his therapist. The third characteristic is the client differentiates stimuli. Clients who progress in counseling typically learn to perceive more of the stimuli in their environment and to react to these stimuli as discrete rather than stereotyped factors. They are then better able to identify and differentiate their emotions and reactions to these stimuli.

Each of these characteristics of client growth is operationalized into a five-point continuous scale with 1.0 the lowest possible rating and 5.0 the highest rating. A rating of 3.0 is defined as the minimal level at which constructive change can take place.

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[1] See Appendix D.

At level 1 of the owning of feelings scale the client seems to avoid accepting any feelings. He may remain silent or deny he feels anything. In sum, he seems to believe he is not part of the world of feelings. At level 2 he may express feelings but does so in a vague manner and they seem intellectualized and distant. At level 3 the client identifies his feelings and can usually tie them to their source but he does this in an intellectual manner. At level 4 the client almost always acknowledges his feelings and expresses them with emotional proximity but at times has difficulty in connecting the feelings to their source. At level 5 the client clearly expresses his feelings with emotional proximity and at the same time demonstrates awareness that they are tied to specific behavior of his own and others.

At level 1 of the committment to change scale the client shows no motivation for change, and is resistive to the counselor's attempts to accomplish change. This may take the form of complete passivity or defensive hostile behavior. At level 2 the client may express the desire to change but his committment is noticeably questionable. He may be somewhat passive, evasive or seem more interested in rationalizing his behavior than in changing it. At level 3 the client vacillates between an overt desire to change and the desire to resist change. He may deal with feelings which are centrally involved with his problem but has some tendency to rationalize or move from topic to topic. In sum, he varies in his maintainence of motivation to change. At level 4, the client

expresses a desire to change, and while he may be reluctant at times to experience painful feelings almost always actively cooperates with the change process. At level 5 the first person actively cooperates in the counseling process and continually engages in confronting his problems and feelings directly.

At level 1 of the differentiation of stimuli scale the first person seems unable to differentiate his problems, feelings, or concerns and is unwilling or unable to move in this direction. He tends to lump broad groups of differentiable stimuli into stereotyped categories, e.g., all adults, all young girls, all bosses, etc. At level 2 the first person may talk about different feelings and problems but he does so in an intellectualized manner as if he had little grasp of any real differences among them and their effect on him as an individual. At level 3 the first person vacillates between discussing different stimuli and their effect on him as a unique person, responding in a general, unclear fashion. In other words he may start out making clear differentiations but is unable to persist for very long, and often lapses back into hazy generalizations. At level 4 the first person 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. At level 5 the first person seems always to perceive the different stimuli in his world and reacts to them in a variety of differential ways. 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 importance of client self exploratory behavior was discussed in Chapter II. The DX Scale in its most recent form consists of five levels, where a rating of one is the lowest possible score and a rating of five the highest score. The scale incorporates several dimensions of client behavior including intrapersonal probing of matters of personal relevance, accompanied by the immediate (or spontaneous) expression of feelings.

At level 1 the client's behavior provides no evidence of self exploration. At level 2 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 3 the client may introduce personally relevant material but does so without any spontaneity or inward probing to discover new feelings and experiences. At level 4 the client introduces personally relevant discussions with spontaneity and emotional proximity, but without a distinct tendency toward inward probing to newly discover feelings and experiences. At level 5 the client is fully and actively focusing upon himself and exploring himself and his world (The complete DX Scale is included in Appendix E).

The Wisconsin Relationship Orientation Scale

The client's perception of the counselor is generally considered

a critical component of successful counseling. The Wisconsin Relationship Orientation Scale (WROS; Steph, 1963) has been used to determine the nature of the relationship existing between counselor and client, as perceived by the latter. The client indicates on a five-point scale how he feels about the counselor, ranging from total avoidance to feeling free to discuss almost anything with the counselor. Goldberg (1967) found that the clients of counselors receiving IPR supervision rated their counselors as being easier to talk with than did clients in the traditional supervision group, and Resnikoff (1968) notes significant differences on the WROS between counselors rated high and low on a counselor behavior scale. Ratings of counselors on the WROS by clients in experimental and control groups will be compared (The WROS is included in Appendix F).

The Therapy Session Report (BP)

An often neglected source of information in examining counseling or psychotherapy outcomes has been feedback from the participants in the therapy experience: How do clients and counselors feel during their sessions? What are their goals in counseling? How do they evaluate the counseling process?

The Psychotherapy Session Project (Orlinsky and Howard, 1968) devised two parallel questionnaires, one for patients and one for therapists, to survey various aspects of the therapy experience. The questionnaires are completed independently by each patient

and therapist, and consist of simple descriptions and evaluations covering various dimensions of experience. These behavior reports have resulted in a useful structure with which to examine the therapy relationship. Modifications of these instruments were used in this study in an attempt to evaluate the influence of IPR treatment as seen by the counselor and client, on a session-to-session basis. The 12 client and therapist perceptions and feelings about the completed session: client motivation, progress made, therapist attitudes and behavior, and anticipation of subsequent sessions (See Appendix G for copies of items selected from TSR).

The Tennessee Self Concept Scale

The notion of the "self-concept" has become a popular reference for studying and understanding human behavior. 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. Accordingly, a positive change in self-concept should be an index of movement in adjustment. Fitts (1965) has developed the Tennessee Self Concept Scale (TSCS), which has been used for a variety of purposes - counseling, clinical assessment, research in behavioral science, etc. The Scale consists of 100 self-descriptive statements which the subject

uses to portray his own picture of himself. Test-retest reliability coefficients of all major scores range from .60 to .92. The test has been shown to differentiate between and within various diagnostic groups, and seems to correlate well with such instruments as the Minnesota Multiphasic Personality Inventory (MMPI).

Since the sample used in this population was small, a quantitative analysis was not feasible. Instead, a descriptive comparison of treatment and control group on the sub-scales of the TSCS was performed.

Reliability of Rating Scales: The Characteristics of Client Growth Scales (COGS)

The COGS have been used in earlier research to measure client change both within and between counseling sessions. When the immediate effect of treatment on client behavior was to be evaluated, the COGS was used to rate two segments of the same interview. In one study (Kagan, Krathwohl, et. al., 1967) each client met with his counselor for one half-hour. This session was immediately followed by one half-hour of one of the experimental treatments, and the client then met with his counselor for a final half-hour session. The half-hour counseling sessions were videotaped and presented in pairs (1st half-hour and 2nd half-hour with no indication of interviewing treatment) randomly to judges. The judges watched the last 20 minutes of each of the

videotaped counseling session pairs, and rated differences in client behavior on the COGS - using the first half-hour tape as the "before" of client functioning. Each of the COGS was rated on a four point differential (much, some, little, none). Two groups of five judges were used in this study in order to provide replication for determining the reliability of the COGS. Reliability measures were obtained through use of Ebel's intra-class correlation, as reported in Table 3.4.

TABLE 3.4

Reliability Of Client Movement Scales
By Two Groups Of Judges

Client Growth Scale	Raters Group I (N = 5)	Raters Group II (N = 5)
The client owns discomfort	.87	.88
The client commits himself to change	.82	.90
The client differentiates stimuli	.83	.93

When it was desirable to examine change in client behavior over a period of time and/or treatment, a similar approach was used. In the pilot study (See Appendix B), video tapes of the 1st and 6th sessions (in between which experimental procedures in counseling were being compared) were presented for rating to three independent judges. The rating scales had been modified

for this study so that each of the COGS was rated over nine points ranging from very markedly lessened to very markedly improved. Interjudge reliability for the COGS as determined by the Spearman-Brown is presented in Table 3.5. The COGS scales had been expanded in this study, since the original four-point scale did not permit scoring of the lessening of a behavior dimension, i.e., negative movement. The revision of the scale did appear to provide a more satisfactory measurement of client behavior, but at the price of reduced interjudge reliability.

TABLE 3.5

Interjudge Reliability Of Client Movement Scales
On Pilot Study Data

Client Growth Scale	Judges (N = 3)
Owning discomfort	.75
Committment to change	.69
Differentiation of stimuli	.69

For purposes of the present study, the COGS were revised again. The two principle goals of the revision were (1) To provide a more clearly defined scale for each behavior dimension - which would allow for more efficient and consistent evaluations of client behavior across judges; (2) To provide a scale measuring current functioning level for each client, rather than a change

score. Obviously, the importance (if not the degree) of client behavior change from one point to another in therapy will depend to some degree on his original level of functioning, i.e., the base-level of client coping behavior must be considered if change in that behavior is to have relevance. The present form of the COGS (as described earlier in this chapter) appears to combine the previous scales' value as a change measure with the quality of determining base levels of in-therapy behavior.

Rating Of Tapes

Two independent and experienced Ph.D. therapists served as judges for this study. Both judges were experienced in the use of counselor-behavior scales, and their ratings were known to correlate well with one another. In addition, both judges had themselves been rated as functioning at high levels (above 3.0) of facilitative counselor behavior. Training sessions were conducted with both judges and the investigator, and consisted of 3 hours (approximately one hour for each of the COGS) of listening to a variety of therapy tapes borrowed from the counseling center research library. During the training sessions, the tapes were stopped at various points and the ratings of the judges were compared and discussed. By the end of the three hour training session, there appeared to be good agreement among the judges. Judges were not aware of the differences in experimental procedure between groups, nor were they aware of group

assignment.

The tape ratings used in the present study were obtained in the following manner: Each of the six sessions for the twelve clients (in both groups) was audio recorded. From each of the 72 tapes obtained, four five-minute excerpts were presented to the judges for rating. The excerpts were taken from the first and last 20 minutes of each session - in order that the tapes for the two groups could be compared on client behavior in counseling when the IPR techniques were not being used. Each 20 minute segment was broken down into four five-minute units. The second (6-10 minutes) and fourth (16-20) units were selected for purpose of rating. Thus two excerpts for rating were obtained from the beginning, and two from the end of each session. The four excerpts for each session were then presented to the judges, who were unaware of which clients were receiving IPR treatment, or of which of the client's six sessions they were rating.

In order to obtain the interjudge reliability for this investigation, Ebel's intraclass correlation technique was used. This technique offers the reliability of each judge's rating as well as the average ratings for judges across tapes and individual segments.

Since the average of the four ratings for each tape was used as the unit of analysis for evaluating client-movement, the across-tape (interview) reliability rather than the reliability of individual segments was calculated. The reliability sample con-

sisted of the ratings of the 12 initial interview (pre-test) tapes for the 12 clients in this study is presented in Table 3.10.

TABLE 3.6

Intraclass Correlation Reliabilities Of Average Ratings Calculated For Judge's Ratings Of Clients Across Tapes On Each Dimension Of The COGS and DX

		Intraclass Correlation Dimension			
Tapes	N	Owning Discomfort	Committment To Change	Differention Of Stimuli	Degree of Self Exploration
Averaged Ratings, Pre-Tapes	12	.94	.93	.91	.88

The Depth Of Self Exploration Scale

The DX Scale has been found to have interjudge reliability ranging from .59 to .91 (Truax and Carkhuff, 1967). The training of raters on the DX Scale and the rating procedure were identical to the procedures followed for the COGS scales. The interjudge reliability for DX in this study is also contained in Table 3.10. The reliabilities reported in Table 3.10 range from .88 to .94, indicating that the ratings are sufficiently reliable for further analysis.

Analysis of Data

The following statistical analyses were performed on the data obtained in this study:

1. Client Growth Variables

   Ratings on the COGS and DX were gathered on each session for all clients. In order to test differences in change scores within groups a D test of change score differences for the same group was used. A 2 X 2 analysis of variance (with equal frequency in each cell) of change scores (pre to post sessions) on each scale was used to test differences between groups. Patterns of movement on each of the COGS and DX scales were traced chronologically through the course of therapy by graphically representing ratings of each session.

2. The WROS and TSR

   The same analysis procedure was followed for these variables as was followed for analysis 1 above. The analysis of variance with equal frequency in each cell statistic is the most powerful parametric test (Siegel, 1956), and was appropriate for this study since there was no evidence to indicate that the assumptions associated with the statistical model had been violated. Since the hypotheses related to analyses #1 and #2 are directional, a one-tailed test of significance at the .05 level was used in all cases.

3. Tennessee Self Concept Scale

A descriptive analysis of within group change scores on various subscales was attempted.

Hypotheses

The specific hypotheses of this study are presented in research form.

H_1: The treatment receiving personal counseling with IPR intervention will make more movement within counseling than will a control group that receives personal counseling alone.

H_2: Clients receiving IPR treatment in counseling will be more satisfied with the counseling relationship and process than will clients not receiving IPR treatment.

H_3: Clients receiving IPR treatment will see their counselors as more accessible and easier to talk with than will clients not receiving IPR treatment.

H_4: Clients receiving IPR treatment will develop a more improved concept of themselves than will clients not receiving IPR treatment.

Summary

Twelve female clients were randomly assigned to two treatments: 1) counseling using IPR intervention techniques and 2) traditional personal-social counseling. A randomized block

design incorporating change scores pre to post treatment was used to measure the differences in change within and between groups on: 1) Four dimensions of client growth in counseling (Characteristics of Client Growth Scales, or COGS and Depth of Self Exploration, or DX), 2) The Wisconsin Relationship Orientation Scale, 3) The Therapy Sessions Report and 4) The Tennessee Self Concept Scale (TSCS). Ratings on the client-growth scales were made by two independent professional judges trained in the use of the scales. Each client completed the TSR and WROS and each therapist completed the TSR, after each session.

Interjudge reliability on the client movement scales was found to range between .88 and .94, warranting their use as reliable criteria instruments. Analyses were made of the mean change score differences pre to post treatment for both groups on all criteria. In addition, patterns of client behavior were descriptively analyzed session by session on the client movement dimensions and the TSR.

CHAPTER IV

ANALYSIS OF THE DATA

In Chapter IV, an analysis of the data is presented based upon the methodology and statistical treatment outlined in Chapter III. Professional judges rated four five-minute excerpts from each counseling session using the Characteristics of Client Growth Scale (COGS) and the Degree of Self-Exploration Scale (DX). Each client and counselor completed the Therapy Session Report (TSR) after each session, and clients completed the Wisconsin Relationship Orientation Scale (WROS) after each session in addition to taking the Tennessee Self-Concept Scale (TSCS) before and after the treatment period. Results of the analysis of this data are reported in the following sequence:

1. (a) D tests of pre-treatment to post-treatment change in ratings on each dimension of the COGS and DX are compared for both the Counseling-With-IPR groups and the Traditionally-Counseled groups to determine the within group effect of each treatment on observable behavior change.

   (b) An analysis of variance of change score differences between groups is presented for each of the COGS and DX dimensions to determine change differences between the two treatments.

2. (a) Pre-treatment to post-treatment change scores on the WROS and the TSR are compared for both treatment groups to determine the within group effect

of each treatment on counselor and client perceptions of treatment.

(b) An analysis of variance of change score differences between groups on the WROS and TSR is presented to compare differences in change of counselor and client perceptions of treatment.

3. (a) Graphical representations of ratings of client movement on the COGS and DX by time (from session to session) are presented to indicate differences in patterns of change between the two groups.

(b) A descriptive analysis of pre-treatment to post-treatment change scores on the TSCS is presented.

Pre-Treatment To Post-Treatment Differences In Client Movement Within and Between Groups

The null hypotheses tested for the four dimensions of client movement were:

Ho 1: There is no difference in ratings of client Owning of Feelings for the Counseling-With-IPR group between the pre-treatment and the post-treatment measures.

Ho 2: There is no difference in ratings of client Owning of Feelings for the Traditional-Counseling group between the pre-treatment and post-treatment measures.

Ho 3: There is no difference in pre- to post-treatment change in client Owning of Feelings between the Counseling-With-IPR group and the Traditional-Counseling group.

Ho 4: There is no difference in ratings of client Committment to Change for the Counseling-With-IPR group between the pre-treatment and the post-treatment measures.

Ho 5: There is no difference in ratings of client Committment to Change for the Traditional-Counseling group between the pre-treatment and post-treatment measures.

Ho 6: There is no difference in pre- to post-treatment change in client Committment to Change between the Counseling-With-IPR group and the Traditional-Counseling group.

Ho 7: There is no difference in ratings of client Differentiation of Stimuli for the Counseling-With-IPR group between the pre-treatment and the post-treatment measures.

Ho 8: There is no differences in ratings of client Differentiation of Stimuli for the Traditional-Counseling group between the pre-treatment and post-treatment measures.

Ho 9: There is no difference in pre- to post-treatment change in client Differentiation of Stimuli between

the Counseling-With-IPR group and the Traditional-Counseling group.

Ho 10: There is no difference in ratings of client Degree of Self-Exploration for the Counseling-With-IPR group between the pre-treatment and post-treatment measures.

Ho 11: There is no difference in ratings of client Degree of Self-Exploration for the Traditional-Counseling group between the pre-treatment and post-treatment measures.

Ho 12: There is no difference in pre- to post-treatment change in client Degree of Self-Exploration between the Counseling-With-IPR group and the Traditional-Counseling group.

A D test for change scores on the same sample was computed for each of the above hypotheses testing differences in means pre to post for both the Counseling-With-IPR group and the Traditional-Counseling group. In order to test differences in change scores between groups, a 2 X 2 analysis of variance with equal frequency in each cell was used. The results of these analyses are presented in Tables 4.1 through 4.4.

A D value of 2.01 for a one-tailed test of significance with 5 degrees of freedom in necessary before chance differences within treatment groups can be rejected at the .05 level of confidence. Inspection of Tables 4.1a, 4.2a, 4.3a and 4.4a indicate

TABLE 4.1 A

D Tests Of Pre To Post Treatment Differences In Client Owning Of Feelings (OF) Between The Counseling-With-IPR Group And The Traditional Counseling Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\bar{D}$
Couns. $\bar{c}$ IPR	6	2.28	3.21	0.94	1.13	2.04*
Trad. Couns.	6	2.54	2.31	-0.22	0.64	-0.85
Therapist 1	6	2.45	2.46	0.01	0.85	.03
Therapist 2	6	2.36	3.06	0.70	0.98	1.75

* Significant at .05 level

TABLE 4.1 B

Analysis Of Variance Of Change Score Differences In Client OF Between Groups

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	4.10	1	4.10	10.60*
Therapist	1.45	1	1.45	3.75
Interaction	0.03	1	0.03	0.08
Error	3.09	8	0.39	
Totals	8.665	11		

*Significant at .05 level

TABLE 4.2 A

D Tests Of Pre To Post Treatment Differences
In Client Committment To Change (CCH)
Between The Counseling-With-IPR Group And
The Traditional Counseling Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\bar{D}$
Couns. $\bar{c}$ IPR	6	2.01	3.15	1.14	1.21	2.33*
Trad. Couns.	6	2.23	2.19	-0.04	0.38	-0.25
Therapist 1	6	2.18	2.53	0.35	0.82	1.06
Therapist 2	6	2.06	2.80	0.74	0.97	1.85

*Significant at .05 level

TABLE 4.2 B

Analysis Of Variance Of Change Score Differences
In CCH Between Groups

Source of Variance	Sum of Square	df	Mean Square	F
Treatment	4.18	1	4.18	22.06*
Therapist	0.45	1	0.45	2.37
Interaction	0.01	1	0.01	0.05
Error	1.52	8	0.19	
Totals	6.149	11		

*Significant at .05 level

TABLE 4.3 A

D Tests Of Pre To Post Treatment Differences In Client Differentiation Of Stimuli (DS) Between The Counseling-With-IPR Group And The Traditional Counseling Group

Variable	N	Pre Mean	Post Mean	Change	σ	$\bar{D}$
Couns. $\bar{c}$ IPR	6	2.05	3.38	1.33	0.45	7.39*
Trad. Couns.	6	2.40	2.34	-0.06	-0.29	-0.50
Therapist 1	6	2.25	2.61	0.35	0.76	1.13
Therapist 2	6	2.20	3.12	0.92	1.25	1.80

*Significant at .05 level

TABLE 4.3 B

ANOVA Of Change Score Differences In DS Between Groups

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	5.81	1	5.81	40.97**
Therapist	0.95	1	0.95	6.67*
Interaction	0.21	1	0.21	
Error	1.13	8	0.14	
Totals	8.10	11		

**Significant at .05 level

*Significant at .0005 level

TABLE 4.4 A

D Tests Of Pre To Post Treatment Differences In Client Depth Of Self-Exploration (DX) Between The Counseling-With-IPR Group And The Traditional Counseling Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\bar{D}$
Couns. $\bar{c}$ IPR	6	2.05	3.11	1.06	1.28	2.04*
Trad. Couns.	6	2.21	2.27	0.06	0.45	-0.33
Therapist 1	6	2.23	2.43	0.20	0.56	0.87
Therapist 2	6	2.03	2.95	0.82	1.21	1.67

*Significant at .05 level

TABLE 4.4 B

Analysis Of Variance Of Change Score Differences In DX Between Groups

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	3.56	1	3.56	12.35**
Therapist	1.17	1	1.17	4.04
Interaction	0.60	1	0.60	2.07
Error	2.31	8	0.29	
Totals	7.64	11		

**Significant at .008 level

D values greater than 2.01 on each dimension of client movement for the Counseling-With-IPR group. Thus the null hypotheses 1, 4, 7, and 10 were rejected. No D values have 2.02 were found for the Traditional-Counseling group for any of the client movement dimensions. Thus we fail to reject hypotheses 2, 5, 8, and 11.

An F value of 4.84 for a one-tailed test of significance with 11 degrees of freedom is necessary before chance differences of mean change between treatment groups can be rejected at the .05 level of confidence. The F statistic reported in Tables 4.1b, 4.2b, 4.3b, and 4.4b indicate significant differences exist between the Counseling-With-IPR group and the Traditional-Counseling group on each of the client growth dimensions. Null hypotheses 3, 6, 9, and 12 are thus rejected, since the Counseling-With-IPR treatment was effective in bringing about significantly greater positive client growth than was the Traditional-Counseling treatment.

While there is no evidence of any treatment-therapist interaction, in Table 4.3b, the F statistic for change differences by therapist was found to be significant. The importance of therapist functioning level on client movement was discussed in earlier chapters. An assumption made in this study was that both therapists were functioning at high, and approximately the same, level of functioning in terms of providing "facilitative conditions" for client growth. In order to determine if the

client behavior changes observed were influenced by differences in therapist functioning level, the four tape segments from the fourth therapy interview which had been rated previously for client movement were submitted to the same independent judges, who then rated therapist functioning on scales of facilitative Empathy, Regard, Genuineness, and Concreteness. Validity and reliability of these scales is reported in Truax and Carkhuff (1967) and Carkhuff and Berenson (1967). These ratings and the Pearson r for inter-rater correlation are presented in Table 4.5.

TABLE 4.5

Mean Levels Of Functioning Of Therapists On Facilitative Conditions By Counseling-With IPR And Traditional-Counseling

Treatment		Facilitative Conditions				
		N	Empathy	Regard	Genuiness	Concreteness
Therapist #1	IPR Counseling	3	3.08	2.95	2.94	2.83
	Traditional Counseling	3	3.03	2.91	2.97	2.79
Therapist #2	IPR Counseling	3	3.41	3.29	3.31	3.44
	Traditional Counseling	3	3.40	3.53	3.39	3.31
Interjudge Reliability (Pearson r)		12	.92	.89	.92	.93

Inspection of these ratings indicates that therapist #1 was functioning consistently at (or slightly below) level 3.0, which is considered the minimum level of functioning for facilitating growth (Carkhuff and Berenson, 1967). Therapist #2 consistently was functioning at well above the minimal 3.00 level. In each case there were negligible differences in therapist functioning level between treatments. The results thus indicated there was a difference in functioning level between therapist #1 and therapist #2, yet this difference was only indicated as a significant factor in client movement by therapist (in both treatments) on one dimension of the COGS -- Differentiation of Stimuli. Because of the very small n for each treatment group (3 ss) by therapist, no statistical procedure seemed appropriate for further examination of possible therapist influence. However, inspection of pre to post differences for positive, negative, or no client movement (Table 4.6) provides additional information on changed client behavior by therapist and treatment group. All clients receiving Counseling-With-IPR made positive progress on the client movement dimensions. Only one of the three clients receiving Traditional-Counseling with therapist #1 made positive movement. The remaining two clients were rated as moving in a negative direction on the dimensions. Two clients receiving Traditional-Counseling from therapist #2 made positive movement, while the remaining client was seen as not moving positively or negatively.

TABLE 4.6

Direction Of Pre To Post Treatment Behavior Change On The Dimensions Of Client Movement By Therapist And Treatment Group

		Owning Feelings			Committment To Change			Differentiation Of Stimuli			Depth Self-Exploration		
		Pos	Neg	None	Pos	Neg	None	Pos	Neg	None	Pos	Neg	None
Therapist #1	IPR Coun (N=3)	3			3			3			3		
	Trad Coun (N=3)	1	2		1	2		1	2		1	2	
Therapist #2	IPR Coun (N=3)	3			3			3			3		
	Trad Coun (N=3)	3			2		1	2		1	2		1

Pre-Treatment to Post-Treatment Differences In Client And Therapist Perceptions Within and Between Groups

The null hypotheses tested for client and therapist perception were:

Ho 13: There is no difference in pre- to post-treatment change in scores on the WROS for clients who receive Counseling-With-IPR.

Ho 14: There is no difference in pre- to post-treatment change in scores on the WROS for clients who receive Traditional-Counseling.

Ho 15: There is no difference in pre- to post-treatment change in scores on the WROS between the Counseling-With-IPR group and the Traditional-Counseling group.

Twelve different items from the TSR were chosen to measure client and therapist change in perception of the treatment process. Since this would amount to 36 additional hypotheses if stated individually, in the interest of sparing the reader, one hypothesis is stated for within group change for each treatment group, and one is stated for between group change in therapy perceptions. Each of the perceptions measured is then listed individually.

Ho 16: There is no difference in pre- to post-treatment change scores on the dimensions of client and counselor perception of treatment within the Counseling-With-IPR group.

Ho 17: There is no difference in pre- to post-treatment change scores on the dimensions of client and counselor perception of treatment within the Traditional-Counseling group.

Ho 18: There is no difference in pre- to post-treatment change in perception of treatment between the Counseling-With IPR group and Traditional-Counseling

group.

The dimensions of client perception of treatment measured were:

1. Client's feelings about the session just completed.
2. Client's feelings about coming to the session.
3. Client's feelings about the progress made in the session.
4. Client's feelings about how he is currently coping ("getting along").
5. Client's perception of therapist understanding.
6. Client's perception of therapist helpfulness.

The dimensions of therapist perception of treatment measured were:

1. Therapist's feelings about session completed.
2. Therapist's perception of client motivation.
3. Therapist's perception of progress made.
4. Therapist's perception of client's coping behavior ("getting along").
5. Therapist's anticipation of ("looking forward to") the session just completed.
6. Therapist's perception of his understanding of client feelings.

A D test for change scores on the same sample was computed for each of the above hypotheses testing differences in means pre to post for both the Counseling-With-IPR group and the Traditional-Counseling group. In order to test differences in change scores between groups, a 2 X 2 analysis of variance with equal frequency in each cell was used. The results of these analyses are presented in Tables 4.7 through 4.20.

TABLE 4.7 A

D Tests Of Pre To Post Treatment Differences In The Wisconsin Relationship Orientation Scale (WROS) Between The Counseling-With-IPR Group And The Traditional Counseling Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\bar{D}$
Couns. $\bar{c}$ IPR	6	3.17	4.50	1.33	1.73	1.87
Trad. Couns.	6	3.17	3.17	0.00	0.57	0.00
Therapist 1	6	3.33	4.00	0.67	1.29	1.26
Therapist 2	6	3.00	3.67	0.67	1.29	1.26

TABLE 4.7 B

ANOVA Of Change Score Differences In WROS Between Groups

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	5.33	1	5.33	5.33*
Therapist	0.00	1	0.00	0.00
Interaction	1.33	1	1.33	1.33
Error	8.00	8	1.00	
Totals	14.67	11		

*Significant at .05 level

TABLE 4.8 A

D Tests Of Pre To Post Treatment Differences In Client Feelings About Session Completed Between The Counseling-With-IPR Group And The Traditional Counseling Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\bar{D}$
Couns $\bar{c}$ IPR	6	5.00	5.50	0.50	1.22	1.00
Trad. Couns.	6	4.83	4.67	-0.17	.71	-0.58
Therapist 1	6	5.17	5.67	0.50	.91	1.35
Therapist 2	6	4.67	4.50	-0.17	1.08	-0.39

TABLE 4.8 B

Analysis Of Variance Of Change Score Differences In Client Feelings About Session Completed Between The Counseling-With-IPR Group And The Traditional Counseling Group

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	1.33	1	1.33	1.23
Therapist	1.33	1	1.33	1.23
Interaction	.33	1	.33	0.30
Error	8.67	8	1.08	
Totals	11.67	11		

TABLE 4.9 A

D Tests Of Pre To Post Treatment Differences In Client Feelings About Coming To The Treatment Sessions Between The Counseling-With-IPR Group And The Traditional Counseling Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\bar{D}$
Couns. $\bar{c}$ IPR	6	2.17	4.50	2.33	2.71	2.10*
Trad. Couns.	6	3.83	3.83	0.00	1.00	0.00
Therapist 1	6	2.67	4.50	1.83	2.67	1.67
Therapist 2	6	3.33	3.83	0.50	1.08	1.14

*Significant at .05 level

TABLE 4.9 B

D Tests Of Pre To Post Treatment Differences In Client Feelings About Coming To The Treatment Sessions Between The Counseling-With-IPR Group And The Traditional Counseling Group

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	16.33	1	16.33	12.25**
Therapist	5.33	1	5.33	4.00
Interaction	1.33	1	1.33	1.00
Error	10.67	8	1.33	
Totals	33.67	11		

**Significant at .008 level

TABLE 4.10 A

D Tests Of Pre To Post Treatment Differences In Client Feelings About Progress Made In Session Between The Counseling-With-IPR Group And The Traditional Counseling Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\bar{D}$
Couns. $\bar{c}$ IPR	6	3.00	4.67	1.67	1.91	2.14*
Trad. Couns.	6	4.00	4.17	0.17	1.08	0.38
Therapist 1	6	3.83	5.00	1.17	1.78	1.60
Therapist 2	6	3.17	3.83	0.67	1.29	1.26

*Significant at .05 level

TABLE 4.10 B

ANOVA Of Change Score Differences In Client Feelings About Progress Made In Session Between Groups

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	6.75	1	6.75	5.79*
Therapist	0.75	1	0.75	0.64
Interaction	2.08	1	2.08	1.79
Error	9.33	8	1.17	
Totals	18.92	11		

*Significant at .05 level

TABLE 4.11 A

D Tests Of Pre To Post Treatment Differences In Client Feelings-About-Coping-Behavior Between The Counseling-With-IPR Group And The Traditional Counseling Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\bar{D}$
Couns. $\bar{c}$ IPR	6	3.67	4.17	0.50	0.71	1.72
Trad. Couns.	6	3.50	4.33	0.83	1.35	1.51
Therapist 1	6	3.67	4.33	0.83	1.35	1.51
Therapist 2	6	3.50	4.17	0.50	0.71	1.72

TABLE 4.11 B

ANOVA Of Change Score Differences In Client Feelings-About-Coping-Behavior Between Groups.

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	0.33	1	0.33	0.33
Therapist	0.33	1	0.33	0.33
Interaction	0.00	1	0.00	0.00
Error	8.00	8	1.00	
Totals	8.67	11		

TABLE 4.12 A

D Tests Of Pre To Post Treatment Differences In Client Perception-Of-Therapist-Understanding Between The Counseling-With-IPR Group And The Traditional Counseling Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\bar{D}$
Couns. $\bar{c}$ IPR	6	3.83	3.83	0.00	0.57	0.00
Trad. Couns.	6	3.67	4.00	0.33	0.82	0.52
Therapist 1	6	4.00	4.00	0.00	0.57	0.00
Therapist 2	6	3.50	3.83	0.33	0.82	0.52

TABLE 4.12 B

ANOVA Of Change Score Differences In Client Perception-Of-Therapist-Understanding Between Groups

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	0.33	1	0.33	0.57
Therapist	0.33	1	0.33	0.57
Interaction	0.33	1	0.33	0.57
Error	4.67	8	0.58	
Totals	5.67	11		

TABLE 4.13 A

D Tests Of Pre To Post Treatment Differences In Client Perception Of Therapist Helpfulness For The Counseling-With-IPR Group And The Traditional Treatment Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\bar{D}$
Couns. $\bar{c}$ IPR	6	3.83	4.67	0.83	1.58	1.30
Trad. Couns.	6	4.50	4.50	0.00	1.00	0.00
Therapist 1	6	4.33	5.00	0.67	1.41	1.16
Therapist 2	6	4.00	4.17	0.17	1.22	0.34

TABLE 4.13 B

ANOVA Of Change Score Differences In Client Perception-Of-Therapist-Helpfulness Between Groups

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	2.08	1	2.08	1.39
Therapist	0.75	1	0.75	0.50
Interaction	4.08	1	4.08	2.72
Error	12.00	8	1.50	
Totals	18.92	11		

TABLE 4.14 A

$\bar{D}$ Tests Of Pre To Post Differences In Therapist Feelings About Session Completed For The Counseling-With-IPR Group And The Traditional Counseling Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\bar{D}$
Couns. $\bar{c}$ IPR	6	4.33	4.17	-0.17	0.91	-0.46
Trad. Couns.	6	4.00	4.33	0.33	0.82	1.00
Therapist 1	6	4.33	4.50	0.17	0.71	0.59
Therapist 2	6	4.00	4.00	0.00	1.00	0.00

TABLE 4.14 B

ANOVA Of Change Score Differences In Therapist Feelings About Session Completed Between Groups

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	0.75	1	0.75	1.00
Therapist	0.08	1	0.08	0.11
Interaction	2.08	1	2.08	2.78
Error	6.00	8	0.75	
Totals	8.92	11		

TABLE 4.15 A

$\bar{D}$ Tests Of Pre To Post Treatment Differences In Therapist Perception Of Client Motivation For The Counseling-With-IPR Group And The Traditional Treatment Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\bar{D}$
Couns. $\bar{c}$ IPR	6	2.17	3.67	1.50	2.27	1.61
Trad. Couns.	6	2.82	3.33	0.50	0.71	1.72
Therapist 1	6	2.33	3.50	1.17	1.87	1.54
Therapist 2	6	2.67	3.50	0.83	1.47	1.38

TABLE 4.15 B

ANOVA Of Change Score Differences In Therapist Perception Of Client Motivation Between Treatment Groups

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	3.00	1	3.00	1.80
Therapist	0.33	1	0.33	0.20
Interaction	5.33	1	5.33	3.20
Error	13.33	8	1.67	
Totals	22.00	11		

TABLE 4.16 A

$\overline{D}$ Tests Of Pre To Post Treatment Differences In Therapist Perception Of Progress Made For The Counseling-With-IPR Group And The Traditional Treatment Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\overline{D}$
Couns. $\overline{c}$ IPR	6	3.50	4.50	1.00	1.53	1.61
Trad. Couns.	6	3.33	3.67	0.33	0.57	1.43
Therapist 1	6	3.67	4.33	0.67	1.15	1.42
Therapist 2	6	3.17	3.83	0.67	1.15	1.42

TABLE 4.16 B

ANOVA Of Change Score Differences In Therapist Perception Of Progress Made Between Treatment Group

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	1.33	1	1.33	1.33
Therapist	0.00	1	0.00	0.00
Interaction	1.33	1	1.33	1.33
Error	8.00	8	1.00	
Totals	10.67	11		

TABLE 4.17 A

$\bar{D}$ Tests Of Pre To Post Treatment Differences In Therapist Perception Of Client Coping Behavior For The Counseling-With-IPR Group And The Traditional Treatment Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\bar{D}$
Couns. $\bar{c}$ IPR	6	3.50	3.67	0.17	0.41	1.00
Trad. Couns.	6	3.67	3.83	0.17	0.41	1.00
Therapist 1	6	3.50	3.83	0.17	0.41	1.00
Therapist 2	6	3.50	3.67	0.17	0.41	1.00

TABLE 4.17 B

ANOVA Of Change Score Differences In Therapist Perception Of Client Coping Behavior Between Treatment Groups

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	0.00	1	0.00	0.00
Therapist	0.00	1	0.00	0.00
Interaction	0.33	1	0.33	2.00
Error	1.33	8	0.17	
Totals	1.67	11		

TABLE 4.18 A

$\bar{D}$ Tests Of Pre To Post Treatment Differences In Therapist Looking-Forward-To Session For The Counseling-With-IPR Group And The Treatment Group

Variable	N	Pre Mean	Post Mean	Mean Change	σ	$\bar{D}$
Couns. $\bar{c}$ IPR	6	2.67	3.33	0.67	0.82	2.03*
Trad. Couns.	6	3.00	3.50	0.50	1.08	1.14
Therapist 1	6	3.33	3.83	0.50	0.91	1.35
Therapist 2	6	2.33	3.00	0.67	1.00	1.63

*Significant at the .05 level

TABLE 4.18 B

ANOVA Of Change Score Differences In Therapist Looking-Forward-To-Session Between Treatment Groups

Source of Variance	Sum of Squares	df	Mean Square	F
Treatment	0.08	1	0.08	0.14
Therapist	0.08	1	0.08	0.14
Interaction	2.08	1	2.08	3.57
Error	4.67	8	0.58	
Totals	6.92	11		

TABLE 4.19

Levels Of Client Behavior On The Dimensions Of Client Growth Over Six Weeks For Clients Receiving Counseling-With-IPR Or Traditional Counseling

Session Number	Discomfort Mean		Committment Mean		Differentiation Mean		DX Mean	
	IPR	Trad	IPR	Trad	IPR	Trad	IPR	Trad
I	2.28	2.54	2.01	2.23	2.05	2.40	2.05	2.21
II	2.55	2.62	2.13	2.28	2.48	2.53	2.47	2.32
III	2.71	2.10	2.28	2.19	2.68	2.32	2.63	2.27
IV	3.10	2.23	2.58	2.11	2.80	2.30	2.90	2.29
V	3.31	2.60	3.20	2.16	3.20	2.35	3.05	2.35
VI	3.21	2.31	3.15	2.19	3.38	2.34	3.11	2.27

TABLE 4.20

Mean Pre To Post Treatment Change Score On The TSCS

Variable	Mean Change IPR Treatment	Mean Change Traditional Treatment
	5.33	-1.00
SC		
T/F		
Net Conflict		
Total Conflict		
Total Positive	-7.67	-3.16
Row 1 - Identity	-4.67	-1.50
2 - Self Satisfaction	0.83	2.67
3 - Behavior	-3.83	-4.33
Col. A - Physical Self	0.00	1.83
B - Moral-Ethical	-3.17	-0.33
C - Personal Self	-4.17	0.17
D - Family Self	-0.17	-1.17
E - Social Self	-0.17	-2.50
Total V	-0.50	-1.50
Col. Total V	-1.17	0.83
Row Total V	0.67	-2.33
Distribution	-5.33	-5.17
DP	-3.50	2.00
GM	-0.33	-2.00
PSY	-1.33	2.17
PD	-7.83	-0.50
N	-2.17	0.17
PI	-0.17	1.33

WROS. A D value of 2.01 for a one-tailed test of significance with 5 degrees of freedom is necessary before chance differences within treatment groups can be rejected at the .05 level of confidence. Inspection of Table 4.7a does not indicate differences sufficient to reject the null hypothesis of no change on the WROS for either treatment group. Inspection of Table 4.7b, however, indicates that there is a difference in change score between treatments which is significant. The difference favors the Counseling-With-IPR treatment group which had a mean change of 1.33, while the Traditional-Counseling group score remained the same.

Client Perception of Treatment. A D value of 2.01 for a one-tailed test of significance with 5 degrees of freedom is necessary before chance differences within treatment groups can be rejected at the .05 level of confidence. Examination of the change measures on the TSR indicates that significant change within groups for client perception of treatment were found only for client feelings about coming to session (Table 4.9a) and client feelings about progress made in the session (Table 4.10a). Since an F value of 4.84 for a one-tailed test of significance with 11 degrees of freedom is necessary before chance differences can be rejected at the .05 level, these were also the only dimensions where significant between group differences were obtained (Tables 4.9b and 4.10b). At the same time, positive change in measures of client perception were observed for five of the six

dimensions for the Counseling-With-IPR group, and on three of the six for the Traditional-Counseling group.

Therapist Perception of Treatment. Inspection of Tables 4.14 through 4.19 indicates that significant change without groups in therapist perception of treatment occurred on only one dimension, that being the pre- to post-mean change for the Counseling-With-IPR group on therapist anticipation of (looking forward to) the session just completed (Table 4.18a). This finding should be viewed with caution since there was no difference between change scores for the two treatment groups. This could be due, in part, to the positive change score observed for the Traditional-Counseling group, but since this was the only one of six therapist perception dimensions to reach significance for pre-post change differences, it is possible the result is a chance finding.

Client Movement On The COGS and DX By Time

The treatments provided in this study to both groups of clients consisted of more than a pre- and post-session. Each of the six sessions for all clients were recorded and rated on the dimensions of client movement in the same manner as the pre- and post measures. Due to the fact that the N involved in this study is quite small, statistical procedures did not seem appropriate to describe session-by-session movement. However, inspection of the mean rating scores by session on each of the

Client movement dimensions provides useful information for comparison of movement trends between treatment groups (Table 4.19).

Both treatment groups showed positive change scores from session I to session II on all dimensions of client movement. The clients assigned to the Traditional-Counseling group appear to be functioning higher on the pre-measure than clients assigned to the Counseling-With-IPR group, but these differences were not significant. The second session was the beginning of the experimental treatment, starting with the simulation films. Ratings of the second session showed that the Counseling-With-IPR group had a greater increment of change than did the Traditional-Counseling group, and in fact was rated higher on self-exploratory behavior (DX) than the Traditional-Counseling group. From session II to session III the IPR group continued a steady gain on all client movement dimensions, while the Traditional-Counseling group showed negative movement (to varying degrees) on all dimensions. At the end of the third session, neither group was functioning at level 3.0 on any of the dimensions.

Between session III and session IV the IPR group again showed positive gain on all client growth dimensions, and for the first time was observed to be functioning above 3.0 on one dimension: Owning of Feelings. The Traditional-Counseling group showed a slight gain on Owning of Feelings and DX, but showed virtually no change on either Committment to Change or Differentiation.

Between sessions IV and V clients in the IPR group showed their best degree of positive gain on all dimensions, and for the first time their mean functioning was above level 3.0 on all dimensions. The Traditional-Counseling group also continued positive gain on all dimensions and approached (Committment and Differentiation) or surpassed (Owning and DX) their original level of functioning as observed in session I.

Between session V and session VI both groups seemed to slip, with the IPR group showing slight negative movement on all dimensions except Differentiation, which went from 3.20 to 3.38. The Traditional group showed a marked drop in Owning of Feelings and no change or slight negative movement on the other dimensions. Since both groups lost momentum at the sixth session, there is the possibility that, because it was the final session of the treatment, clients became more cautious and hesitant to examine their feelings and behavior. Verbal reports indicated that both therapists were influenced by the knowledge that this would be the last session for most clients (at least for the summer recess period), and they were reluctant to move into new areas of client concern for which there would be insufficient time to work with.

The movement in client behavior across dimensions can be seen in Figure 4.1 for the Counseling-With-IPR group and Figure 4.2 for the Traditional-Counseling Group. In Figure 4.3 the average growth on all dimensions over time is illustrated for

FIGURE 4.1

Ratings Of Client Behavior Over Time On
The Dimensions Of Client Growth
For The Counseling-With-IPR Group

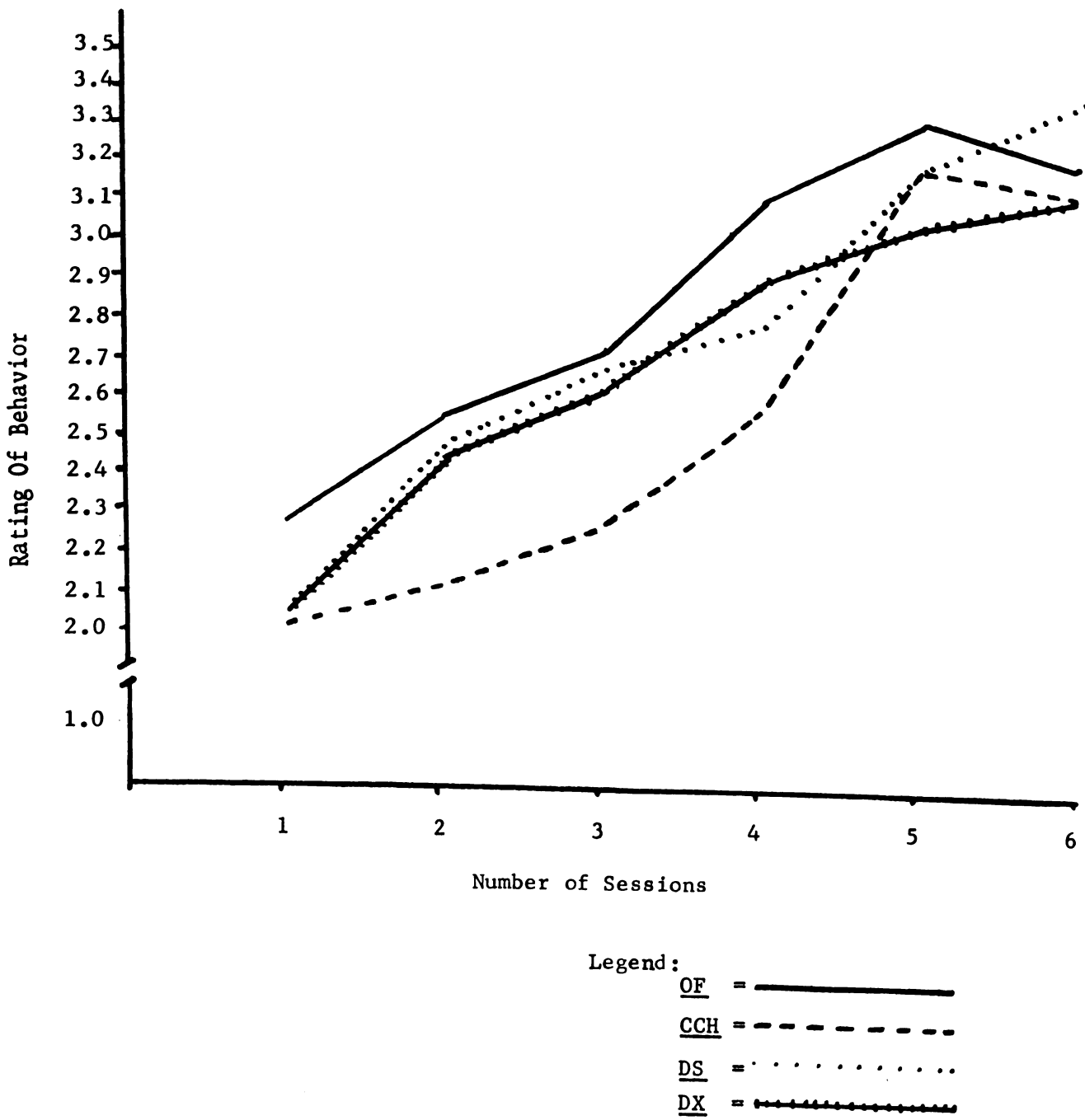
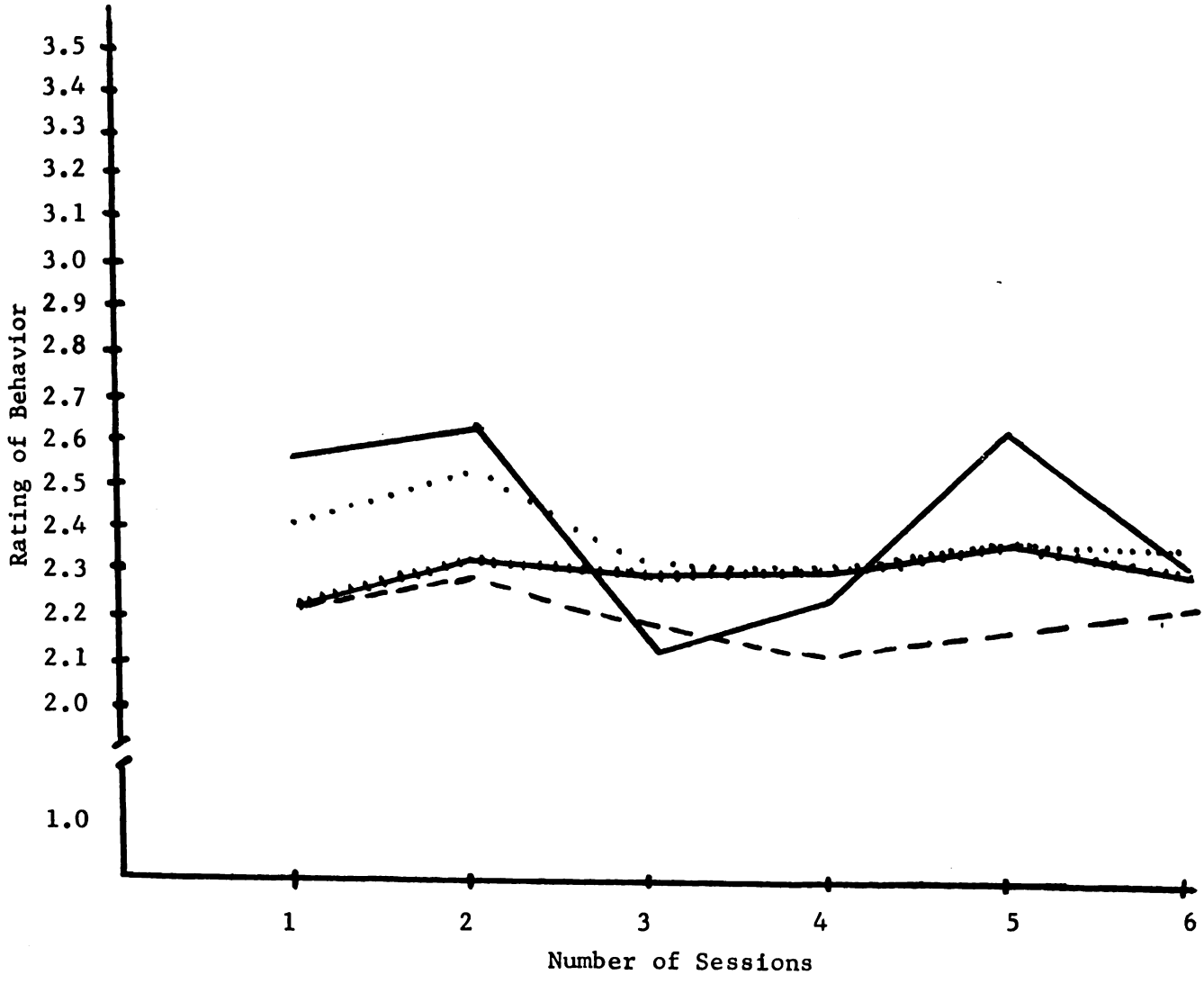


FIGURE 4.2

Ratings Of Client Behavior Over Time On
The Dimensions Of Client Growth
For The Traditional Counseling Group



Legend:

OF =

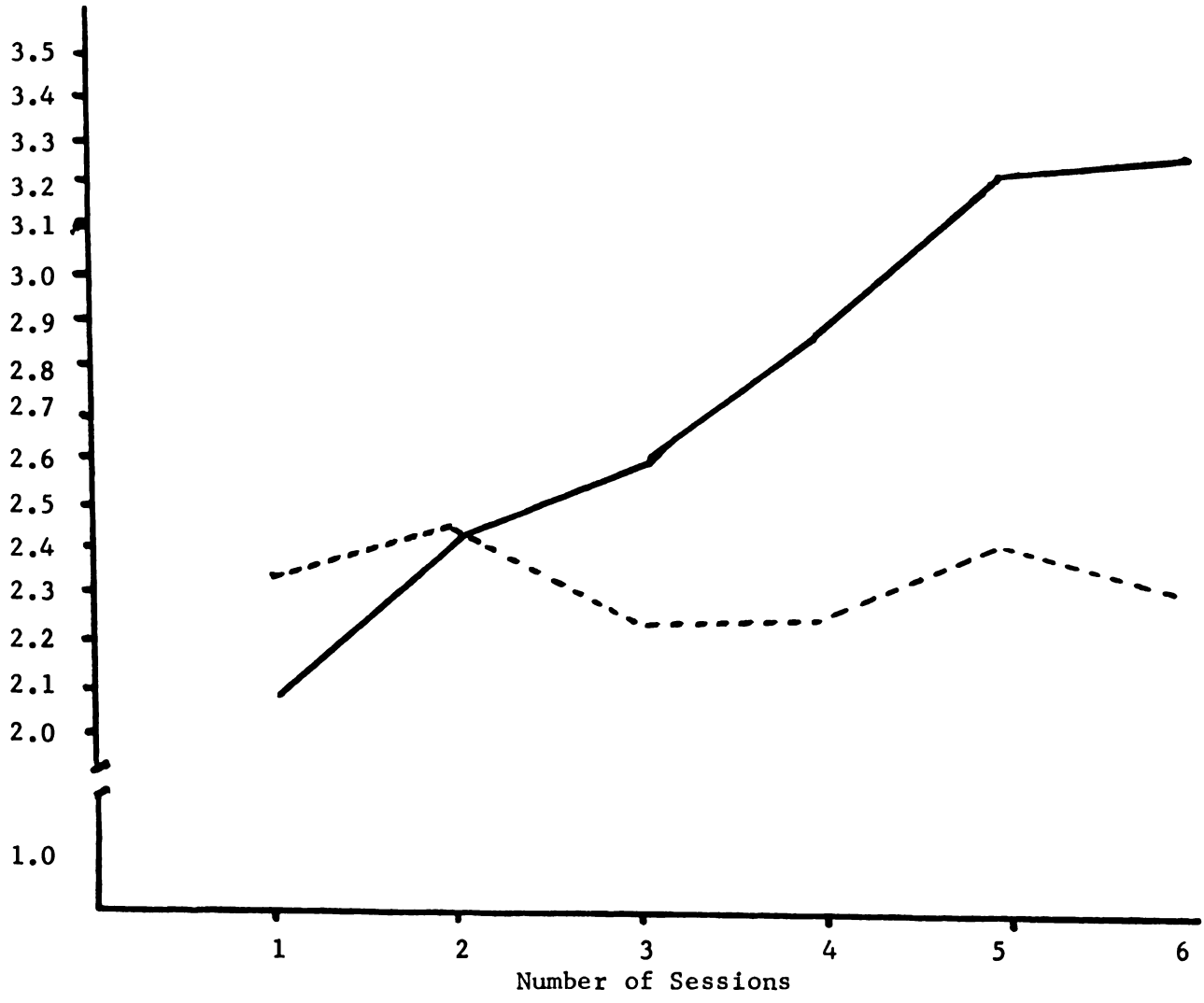
CCH =

DS =

DX =

FIGURE 4.3

Combined Ratings Of Client Behavior Over Time
For The Counseling-With-IPR Group And
The Traditional Counseling Group



both groups. It appears that a crucial point in the eventual post measurement differences in client movement came between sessions II and III, where the IPR group made positive gain while the Traditional group showed negative movement.

TSCS - Descriptive Analysis. In the foregoing sections, statistical evidence was presented to demonstrate the effects of each treatment on client movement or perceptions in therapy. A further question is: to what extent did the treatments effect client self-concept? The TSCS was employed to measure possible changes in self-concept, but it proved to be a confusing instrument to relate to the present study. Statistical examination of the twenty subscales of the instrument revealed only one significant change, this being on the self-criticism subscale. Since there is a probability that two to three of twenty such measures will be significant on a chance basis, this finding must be viewed with extreme caution.

In the interests of sparing the reader additional bulk, the various statistical tests are not presented. Instead, the mean change scores for both groups on the sub-scales of the TSCS are presented in Table 4.20. In nine of the twenty sub-scales recorded, the direction of change differences favored the IPR treatment group. Two of the larger change score means were found for the SC (self-criticism) and DP (defensive positive) variables. Higher scores on SC "generally indicate a normal,

healthy openness and capacity for self-criticism." The SC score is considered an obvious defensiveness score, whereas DP is a subtle defensiveness score, i.e. a decrease in DP score could be seen as a greater awareness of negative self-concepts, thus having an inverse correlation with SC.

Summary

The hypotheses for client movement pre to post-treatment were tested using a D test for change scores on the same sample. Differences in change score between groups was tested using a 2 X 2 analysis of variance. The IPR-treatment-group changed significantly on all dimensions of client movement, but significant change was not found for the group receiving traditional counseling. Change score differences between groups were found to be significant and favoring the IPR treatment group. Thus, clients in the Counseling-With-IPR group were rated as changing significantly in owning their own discomfort, committment to change, differentiation of stimuli, and degree of self-exploration. No therapist-treatment interaction was observed, but one therapist was found to be functioning at (or slightly below) a minimal facilitative level, while the second therapist functioned considerably above the minimal level for facilitating growth. All clients receiving IPR treatment made positive movement on the dimensions of client growth; only three of the clients receiving traditional counseling made positive movement.

The second series of hypotheses related to differences in client and therapist perception of treatment. There was no pre- to post-treatment difference within groups observed on client ratings of their counselors using the Wisconsin Relationship Orientation Scale, but a significant difference in change scores between groups was found favoring the IPR treatment group. Pre- to post-treatment differences for the IPR treatment group were observed for two of the Therapy Session Report variables relating to client perceptions: client feelings about coming to the session and client feelings about progress made in the session. Significant differences were also observed in change score comparison between groups on these two variables, indicating clients felt more positive about coming to IPR treatment sessions and saw themselves as making more progress within those sessions than did clients receiving traditional counseling. A significant pre- to post-treatment change difference was found for therapist anticipation of (or looking forward to) IPR treatment sessions, but change difference was not significant between groups. The results did not support any other differences in the way therapists viewed either treatment.

A descriptive comparison of client growth behavior for each session was also undertaken. Both treatment groups showed positive movement between the first and second therapy sessions. From that point on, the IPR treatment group continued positive growth through the fifth session, tapering off slightly at the sixth

and final treatment session. The Traditional-Couseling group showed negative change between the second and third sessions, then seemed to recover and show gradual positive growth through the fifth session. This group also dropped slightly between the fifth and sixth sessions.

Finally, a description of change in self-concept scores on the Tennessee Self Concept scale was presented. There was no conclusive evidence that either treatment accomplished meaningful change in dimensions of self concept.

CHAPTER V

SUMMARY, DISCUSSION, AND IMPLICATIONS

Summary

The purpose of this study was to investigate the effects of affect simulation films together with stimulated recall on client movement in counseling. A treatment program integrating simulation films and stimulated recall via videotape in order to accelerate client growth in counseling was compared with more traditional counseling methods.

Interpersonal Process Recall (IPR) is a technique using stimulated recall of videotape to accelerate client insight and change during therapy. A videotape of a counseling session is replayed to the client and a recall session is conducted by a clinically trained "interrogator" who helps the client examine the underlying dynamics of his interaction with the counselor. In previous studies, IPR was found to accelerate client movement in counseling when the counselor is actively involved in the recall process (Kagan, Krathwohl, et. al., 1967). The IPR process was observed to be most valuable when the counseling or therapy session being replayed dealt with intensive or immediate experience of emotion, such as when counselor and client were speaking about intensive feelings the client had toward the counselor or when these feelings were existent although avoided by either (or both) party during the therapy session. This observation led to the development of the technique of affect

simulation. Clients are confronted with films which encourage them to simulate interpersonal relations, and client and film are videotaped while the client watches the film. The video tape is then played back while his counselor helps him examine his reactions to the film. In some cases an actor directs affection or rejection toward the viewer, in others the actor reacts as if he had been rejected or seduced.

In a pilot study conducted in 1967 the simulation and IPR techniques were combined in an attempt to increase the client's ability to recognize and understand his feelings and responses to interpersonal encounters. Three treatments were compared: 1) counseling alone (control treatment); 2) counseling using first simulation films, or VRAS (videotape recall of affect simulation) for three sessions, then IPR for three sessions; 3) counseling using IPR first and then VRAS. Judges' ratings of client movement indicated that both treatment groups moved significantly on four in-therapy behavior dimensions, while the control group did not. Examination of vocational placement status at the end of treatment also favored the treatment groups, where 66% had been placed on jobs against 33% for the control group. The pilot study indicated that there might be some clinical advantage for beginning the treatment program with the VRAS. When VRAS preceded IPR there seemed to be a contigious "building effect", where the client first learned the behavior of self-exploration of his videotaped reactions to simulated confrontation

and was then able to apply this exploratory behavior to recalling emotions in later counseling sessions via IPR.

In the present study, the treatment program was designed to integrate the VRAS and IPR into a sequential program of treatment. The use of a sequential approach stemmed from the data observed in the pilot study, suggesting the following series of developmental experiences facing the client as he undergoes counseling or therapy: a) the need for the client to become aware of his feelings and reactive behavior in emotional stress situations, b) the need to identify and examine the feelings he has during the counseling relationship itself, c) the need to experience and deal with these feelings in the immediacy of the counseling relationship itself. The experimental treatment consisted of three integrated phases which were designed to meet these developmental needs.

In the first - or VRAS - phase, the client was videotaped while watching an affect simulation film. The video tape was played back and the client's videotaped behavior served as the focus for the counseling session. As the client examined his reactions to the simulated confrontation, he was able to look at his emotional reactions to others without having to be responsible for their impact and consequences, i.e., he was dealing with interpersonal threat from a position of relative safety. In the second - or IPR - phase, client and counselor were videotaped while conducting a counseling session, the videotape was

replayed and a trained recall worker ("interrogator") conducted an IPR session with the client while the counselor observed through a one-way mirror. The recall worker was essential in helping the client to examine his feelings in relating to his counselor, since the client still was not confronting the counselor and thus had a reduced responsibility for the immediate consequences of his feelings. After the recall, client and counselor resumed their counseling session, incorporating the insights gained from the recall. In the final phase, both client and counselor viewed a replay of the counseling session together, while the interrogator encouraged them to share their feelings as they occurred during the interview. As counselor and client communication about their feelings and reactions during the videotaped interview increased, the interrogator played a progressively less active role. When the interaction between client and counselor moved from a focus on the videotape to the immediacy of the recall (when they had finished talking about the videotape and were again engaged in face-to-face discussion) session the interrogator left the room and counselor and client continued the therapy session.

The control-group treatment consisted of traditional counseling, i.e., no IPR interventions were used. Both the counseling - with - IPR and the traditional - counseling group treatments were focused on effective client/counselor communication. In the 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. The traditional counseling procedures were as responsive to each client's needs and as intensive as possible, and equal amounts of client contact were given to each group.

The clients in this study were twelve female undergraduate students who had requested personal counseling from the university counseling center, and who also agreed to participate in the research. The two therapists were pre-doctoral interns at the Counseling Center who had training and experience in IPR techniques as well as in traditional counseling methods. Since there is evidence that therapist functioning level has an influence on client progress in therapy, each therapist was rated on scales measuring facilitative behavior in therapy. One therapist was found to be functioning at approximately 3.00 across dimensions on a five point scale where a rating of 3.00 is considered the minimal level of counselor performance if client growth is to occur. The second therapist was functioning at an average of approximately 3.40 across dimensions.

For the purposes of testing the research hypotheses a pre-post design was used. Clients were assigned to therapist and treatment groups on a random basis. Each interview was recorded for subsequent rating by independent judges (two Ph.D. counseling psychologists) on four dimensions of client behavior in therapy considered characteristics of client growth: Owning of Feelings (OF),

Committment to Change (CCH), Differentiation of Stimuli (DS), and Depth of Self-exploration (DX). Ratings of the initial sessions served as the pre-test measure. Analysis of ratings of the initial sessions indicated no significant difference between groups on any of the dimensions, suggesting that neither treatment group had a higher level of functioning which might have affected their post-treatment behavior.

Ratings of the sixth (final) session for each client on the client growth scales served as a post measure of client functioning. Each client also completed the Tennessee Self Concept Scale and the Wisconsin Relationship Orientation Scale before and after the treatment program. In addition, each client and therapist completed a shortened form of the Therapy Session Report (TSR) following each treatment session.

The basic hypotheses of this study were:

Hypothesis I: Clients receiving personal counseling with IPR intervention will make more positive movement within counseling than will clients who receive personal counseling alone.

Hypothesis II: Clients receiving IPR treatment will see their counselors as more accessible and easier to talk with than will clients not receiving IPR treatment.

Hypothesis III: Clients who receive IPR treatment and their therapists will report more positive perceptions of their counseling than clients and

their therapists not receiving IPR.

Hypothesis IV: Clients receiving IPR treatment will develop a more improved self concept of themselves than will clients not receiving IPR treatment.

The analysis of pre to post changes in client behavior during therapy within each group by means of a D test for change scores on the same sample indicated significant differences (.05 level) on each of the characteristics of client growth for the counseling - with IPR group, but not for the traditional - counseling group. That is, after treatment the clients in the treatment group were rated higher on the dimensions of OF, CL, DS, and DX. Ratings of clients in the traditional - counseling group showed no differences, pre to post treatment. Analysis of change scores between groups also indicated differences in the hypothesized direction (.05 level) on each of the client growth dimensions.

Analysis of pre to post changes in client ratings of counselors on the WROS did not indicate significant change after treatment for either group, but change scores between groups were found to be significant and favored the experimental treatment. Pre to post differences within groups for client perceptions of treatment were found on only two dimensions: client feelings about coming to the session and client feelings about progress made in the session. In both cases, the differences were

found only for the IPR group, with significant between group differences on change score also favoring the IPR group. Change score differences in therapist perception of treatment were found only for the IPR group's pre to post change on the variable of: therapist looking forward to coming to the session. Finally, change score difference on dimensions of the Tennessee Self Concept Scale were evenly divided between groups, and there was little indication of any meaningful change in self-concept score due to treatment.

In essence, the IPR treatment had a significant accelerating affect on client movement in therapy, as rated by independent judges. Clients in the IPR group had a greater positive change 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.

Discussion

Before conclusions can be drawn from the data in this study, the critical question of therapist bias must be considered. The traditional counseling treatment did not influence significant change on any of the criteria examined, and in face there was a

slight negative (though non-significant) pre to post treatment change observed on several dimensions (OF, CCH, DS) which may have contributed to the finding of significant differences in change scores between treatments. Could the differences that were found between treatments be a function of therapist, rather than treatment effect? It is true that the pre to post change scores in behaviors of clients in the IPR group were significantly different from those of the traditional counseling group, but in order to assure equal therapist competency in each treatment, the same therapists had been used for both groups. The fact that the participating therapists knew the research hypotheses and the group (IPR or traditional) to which the client had been assigned must be considered in the interpretation of the results. While the possibility of a bias effect cannot be discounted, there are aspects of the data which tend to minimize the likelihood of such therapist control. First, the time period chosen for comparison of treatment effects (six weeks) is strikingly brief in that short-term psychotherapy is rarely seen as less than six months to a year in duration. The time period was made short in order to examine the possible accelerating effects of IPR in the initial stages of treatment. Any significant change in client behavior in this period of time is noteworthy, since the absence of such change is less the exception than the rule. In a recent study examining forty different individual therapy cases, positive change in client growth behavior before the 10th

session was observed in only seven cases - or less than 20 per cent (Pierce and Schauble, 1970). Yet such growth was observed in only six sessions for clients receiving IPR treatment.

If the therapists in this study were capable of accomplishing such results without the use of IPR, one would have to assume that they were most unusual therapists, capable of influencing significant gains in some clients, but not in others. It seems likely that such differences in therapist behavior would have been readily observable when tapes of the sessions were compared, and certainly would be evident in much higher scores when the behavior of the therapists was rated on the "facilitative conditions" scales. The judges rating tapes for client movement reported no such extraordinary counselor behaviors, and it was found that when therapist behavior was rated on the facilitative conditions (Table 4.5) there were no differences in therapist functioning level between treatments. When the direction of client movement was examined (Table 4.6), it was observed that three of the six clients receiving traditional counseling did make positive movement on the growth dimensions. If the possibility of therapist bias is accepted, one would also have to assume that the therapists involved exerted sufficient control to accomplish some degree of change with the traditional counseling group, but significantly more with the IPR group. In light of our current state of knowledge about the therapy process, it seems unlikely that the therapists involved could so control

their clients' behavior - even if they overtly or covertly were motivated to do so.

There exists the possibility that the therapist's enthusiasm or preference for the IPR treatment was conveyed to the clients, thereby affecting their motivation. However, the records of client participation show no evidence of greater interest and/or motivation between groups. Clients regularly kept appointments, and half of the clients in each group continued therapy contact after termination of the treatment period. There is further written feedback evidence that the clients in the traditional counseling group perceived their experiences as being positive and "observed" noticeable changes in their coping behavior. These self-reports are admittedly subject to a halo effect, yet they suggest that the therapists communicated concern and interest to clients regardless of the type of treatment involved. It is also useful to note that many of the experiences which serve as the core for the IPR treatment (e.g., examination of immediacy of feelings of client toward therapist and vice versa) may have increased therapist competency and hence were probably integrated by the therapists into their counseling behavior with clients in the traditional counseling group as well. It was not uncommon for either therapist to ask traditional-treatment these clients, "How do you think I feel about that"..... and "What did you want me to think or feel". In essence, the therapist adopted those aspects of the "interrogators" role that

were appropriate in the traditional counseling setting as well. (This has been a common observation in the research done with IPR, where the skills learned in becoming an effective interrogator are carried over into the therapy role - usually leading to a more appropriate and effective behavior on the part of the therapist (Kagan, Krathwohl, et. al., 1967). In fact, the acquisition of the "concrete" behaviors of the interrogator may be one of the most potent influences in the successful application of the IPR for training counselors /Goldberg, 1967/). Finally, it should be noted that both therapists had received much more extensive training in the traditional approaches to therapy than in the IPR techniques. Both therapists described themselves as eclectic in identification, and both used a variety of techniques to augment the "relationship - therapy" approach, e.g. visual imagery and learning theory techniques. In fact, a criticiam of the IPR treatment suggested by both therapists was that the step by step program delimited their freedom to respond to their clients' individual needs. In other words, the research dictated a rigid schedule of IPR experiences which did not take into account the unique growth rate of each client; that is, in the interest of uniform treatment <u>within</u> groups the therapist was allowed no flexibility in varying the approach to meet client needs. This criticism usually applied to cases where the therapist felt his client moved <u>more rapidly</u> than expected, hence a particular stage might have been eliminated (e.g., the second VRAS

session) to more effeciently capitalize on the client's gains. This criticism might suggest more dissatisfaction with the IPR treatment than with the traditional treatment, and yet the TSR results indicate that the therapists became more positive about their IPR sessions than their traditional treatment sessions.

Another possible bias effect might be increase in client motivation due to the novelty of the treatment. An attempt was made in the design of the study to minimize the halo effect by arranging for clients in the traditional treatment group to be seen in a specially designed research studio, and while they were informed that they were part of a "research study", they were not aware of the IPR treatment group. There was thus no observable reaction of "feeling cheated", and the clients in both groups who continued treatment after the six weeks appeared to maintain their initial level of involvement for the duration of their contacts.

A final consideration relating to client motivation concerns the voluntary participation of the sample. Should these clients be considered somewhat different from the general population in terms of interest and motivation because they agreed to participate in the research project? While this would not affect the observed differences between groups, it might suggest that this particular sample of clients were more receptive to either of the treatment experiences, in essence that they were more "willing to change". Of the clients who sought help at the Counseling

Center, only one of thirteen clients contacted and invited to participate declined to do so, and she did not persist in her later assignment to conventional therapy. There may well have been some "clinical screening" occurring in the referral process from the Counseling Center screening counselors, whereby only the lowest-risk clients were referred for consideration. However, the only selection criteria suggested to screening counselors were that the client not have concerns of a "crisis" nature, or problems relating solely to educational/vocational areas (see Appendix C). Furthermore, if these clients were in fact more motivated, it should be evident in the pre-treatment ratings of their committment to change. Previous research has in fact indicated that clients who are successful in therapy begin the therapy process at higher levels of the characteristics of client growth than do non-successful clients (Pierce and Schauble, 1970). A comparison of pre-treatment mean CCH scores for each group (Table 4.19) with the means reported in this earlier study indicate that the pre-treatment CCH scores reported for the present research sample (combined mean = 2.12) more closely approximate the mean scores of non-successful clients (mean = 1.91) than successful clients (means = 2.42). Regardless, it seems safe to assume that there were no initial motivational differences between groups which would contribute to the observed behavioral differences existing between groups after treatment. Thus while caution should be exercised in generalizing from a volunteer

university sample to the general population, it seems likely that the conclusions about the superiority of one technique over the other would apply to other samples as well. Naturally, this assertion needs to be tested.

In summary, then, the differences observed in the behaviors of clients in the two treatment groups, the client ratings of their perceptions of change in the therapeutic relationship, and change in client and therapist feelings about participation in the treatment sessions strongly indicate that the sequential treatment of VRAS and IPR experiences used in this study is a viable and effective means of accelerating client movement in counseling and psychotherapy.

Observations and Implications

In discussing the conclusions deriving from the results of this study, it is appropriate to discuss some of the clinical observations gleaned from a review of the therapy tapes and recall sessions as well. These clinical observations may help answer the question of why the IPR treatment was successful in accelerating client progress in therapy.

I. The Progressive IPR Treatment Program Is An Effective Means Of Accelerating Client Progress In Therapy

When a client initiates therapy, he has generally arrived at a state of dissatisfaction with his existing interpersonal

behaviors. It may be that he no longer feels able to cope with his life situation without professional intervention, or he has reached the point where he feels the need for assistance to become a more effective person. Before the helping process can result in new and appropriate behaviors the client must be motivated to change, including recognition on his part of his responsibility for his own condition. After he has "owned his feelings", the client must then decide that he is willing to accept the consequences for change at this point in time, in effect he must committ himself to the therapy - or change - process. This process necessarily entails the differentiation, exploration and experiencing of feelings - however painful - in the immediacy of the therapy relationship. Clients entering therapy will differ in the degree to which they display the behavior so described, but there is theoretical and research evidence to suggest that until client behavior is characterized by high levels of OF, CCH, DS, and DX, behavior change is improbable.

For those clients in the IPR treatment group, the VRAS sessions where the client examined his reactions to the affect simulation films were a concrete introduction to the goals of therapy. Since the client was confronted with a simulated or "unreal" situation, she was able to explore her emotional reactions without having to be responsible for the consequences of her reactions on others. While the VRAS tended to provide the direction for self exploration within a context of relative

emotional "safety", it did not necessarily lessen the anxiety associated with this delimited self-exploration. One client had presented a very passive, inactive picture during her initial interview, and in fact seemed deliberately hostile to any attempts at communication from her counselor. During the first VRAS session she remained inactive and appeared impervious to the affect simulation films (in this particular session, The Aggression I series was employed). When the videotape replay was begun and she was confronted with he own image and behavior so that denial of the impact of the "other" wasn't possible, she burst into tears and asked that the replay be terminated. As she and her therapist discussed her startling reaction to the videotape, it became apparent that this client was so well defended against recognizing her feelings that she had not been aware of experiencing any emotion in the actual moment of watching the films. When the videotape was replayed, however, she was able to identify and acutely experience the feelings she had suppressed while watching the films. In other words, this client had no access or awareness of her feelings until she was once removed from the confrontation situation and enabled to observe herself, at which point her feelings were so intense as to be overwhelming. There is no way of estimating the time it might have taken to uncover this insight through traditional therapy - if indeed it would have been reached at all. This client had come from an intensely fundamental religious background, and had been taught not to

recognize or own her feelings. The VRAS experience made her aware, for the first time, of the degree to which she had isolated herself from her emotions. It was also an invaluable aid for her therapist in attempting to understand the dynamics of this client. In a sense, the VRAS phase of treatment typically helped the client to become increasingly more able to identify and deal with her feelings and behavior, "preparing" her for new learning in the actual therapy experience.

The IPR sessions helped the client bridge the gap between the indentification of feelings in the non-real interpersonal simulation session between client and film to the identification of her feelings during the real interaction in the therapy session. During the videotape replay of the counseling session between client and counselor, the interrogator helped the client identify feelings she had had toward her therapist during the interview but which had not been expressed. As has been found in previous research, the interrogator's function was instrumental in client identification of direct hostile or affectionate feelings toward the therapist. The anxiety which prevented the expression of these feelings in therapy was reduced, since the client was not confronting her therapist but rather telling a third person (the interrogator), and thus had less responsibility for the consequences of her feelings. This appeared to be true despite the fact that the client was aware of the fact that her therapist was watching the recall from behind a one-way mirror and would

momentarily rejoin her for a continuation of the counseling session. Two observations illustrate this point. In one instance, the client frequently giggled during the therapy session when personally relevant material was being discussed. During the recall session it was learned that at each point on the tape where she giggled and seemed to move away from the discussion, the client was actually experiencing a great deal of hurt. When the inappropriateness of her laughter was pointed out, the client was able to verbalize that she was afraid to talk about painful things with her therapist: "I'm supposed to be getting better, aren't I? If I don't let him know how much he's helping me, he won't want me to come back." When the therapy session was resumed subsequent to the recall, the client ventilated considerable hostility toward the counselor for "placing such pressure" on her to perform. This was the first <u>direct</u> expression of feeling made by this client to her therapist, and led to extensive exploration of her feelings of of being exploited by <u>all</u> the significant people in her life. An excert from a different client illustrates the potential of IPR for changing perceptions of feelings:

Interrogator:	"Right here Mary, what were you feeling?"
Client:	"I don't remember, I was just talking."
Interrogator:	"What about?"
Client:	"I don't know...you know, I really don't know! I was just talking and talking and ...you know he just sat there and listened ....."

Interrogator:	"Uh-huh. And what was he feeling then?"
Client:	"He just listened. I was running all over everywhere and he just listened and waited for me to come back. Oh I am an ass! And I didn't even think I could trust him..... and he knew all along."
Interrogator:	"So he was waiting...because he cares for you?"
Client:	"He has to...to sit there...and listen... I never thought...I am an ass!"

In both instances cited the client knew the therapist was observing the recall, but the fact that he was not physically present made it easier to begin to examine the dynamics of the relationship. This early investigation of underlying feelings apparently helped the client identify her feelings toward the therapist early in the therapy process. It also seems likely that the overt expression of these feelings without having to confront the therapist made it easier for the client to deal with them, thus leading eventually to a more open and honest therapy communication.

During the final phase of treatment, the mutual recall, the interrogator, therapist and client viewed the replay of the counseling session together. This phase provided the client with an opportunity to put what she had learned together in the here-and-now of her experience. The session began by recalling and sharing feelings related to the video taped counseling session, and ended with a more open, honest relationship in which the common goal was to become aware of feelings and behavior in the immediacy of the therapy encounter.

The progressive treatment program thus proceded from the identification of generic feelings (through VRAS) to feelings about the therapy relationship in the "there-and-then" of the videotape recall (IPR), culminating in the immediate communicating of feelings in relationship (mutual recall).

II. The IPR Intervention Is Most Useful In The Initial Stages Of Therapy

Previous research with IPR has indicated that the technique has value in various stages of counseling and therapy (Kagan, Krathwohl, and Miller, 1963; Woody, Kagan, Krathwohl and Farquhar, 1965, Resnikoff, Kagan, and Schauble, 1970), but the insights and information gained from the approach (as described above) seem especially appropriate for beginning the therapy process. When used in the early stages of therapy, IPR made the client aware that exploration of feelings and self is the task of counseling, and through the program of progressive approximation the client developed confidence in her ability to survive such exploration with the therapist.

In the pilot study it was observed that clients in the traditional counseling group were found to show negative movement on pre - post ratings of behavior change in therapy. The present study showed similar results, in that slight negative change pre to post was observed on three of the four behavior measures. Comparing session to session movement on the behavior scales provided

additional insight into the pattern of client growth in therapy. The averaged growth curves for both treatment groups over time are represented in Figure 4.3. Both groups showed positive movement between sessions I and II, but there was marked negative movement between sessions II and III for the traditional counseling group. How can such negative movement be explained?

Brammer and Shostram (1960) suggest that "...psychotherapy is analogous to the experience of going deeply into a pit. The vertical dimension represents depth of involvement in the process. The hori ontal dimension represents temporal stages in the process." The authors go on to state that there are "critical points" that must be dealt with at various points in the therapy experience. Critical point number one occurs after the client states his problem and begins to feel comfortable in the relationship:

> "This is the point where he (client) plunges into more detailed exploration of feelings which may not be a pleasant experience. At this point he feels insecure, uncomfortable, and doubtful whether the results will merit the psychic pain which he is beginning to experience. This point is labelled a "critical point" because many clients drop out here. Experienced therapists view critical Point Number One as the place where the client seems to get better." (p. 99) (Emphasis my own)

This statement seems especially relevant to the data observed in

the current study. Positive movement was observed in the initial stages of therapy (between sessions I and II). This might be directly related to the experience for these clients to freely and openly express the feelings they had regarding their "problems" - perhaps for the first time. Following this "cartharsis" the client had to confront the fact that her problems were not suddenly resolved....and that she must begin the painful process of attempting to differentiate anc change behavior. As this realization sank home, the client felt the the pain and doubt referred to by Brammer and Shostrom which was reflected in her getting "worse before she gets better", as observed between sessions II and III.[1]

In contrast, the IPR treatment group showed continued positive movement from session II to session III. It appeared that the use of the VRAS had two facilitating effects on client movement.

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[1] Brammer and Shostrom suggest a slightly different explanation for the negative effects which may follow an initial therapeutic catharsis:

> "If allowed to 'ventilate' excessively, the client may feel so good afterward that he will feel it is unnecessary to go on to the causes of his difficulties and the steps necessary to change his attitudes and acts". (p. 96)

While this explanation would also explain the decrease in positive client behavior in therapy, clinical data suggested that, at least in this study, clients seemed disillusioned by the persistence of their problems beyond initial catharsis, and they were ambivalent about experiencing more pain in further self-exploration.

First, it clearly indicated to the client that there was further areas which she needed to explore, as well as providing her with the stimulus of her own behavior (via videotape). Second, by focusing on client feelings in reaction to the simulation situations, the client became aware that she and her therapist were capable of dealing with her emotional stress. By providing both client and therapist with an example of client affect, the VRAS led to a sharing of the client's experience of feeling, making continuing exploration much more comfortable. White (1956) writes of the importance of the therapists' support in client self-exploration:

> "To the extent that the patient is dominated by anxieties, he may be likened to a frightened child. Alone he cannot face the threats but in the company of the analyst he dares to peek at them and finally approach them. The patient becomes a little more daring because he is not alone in the enterprise. This increase of daring is at the heart of his corrective emotional experience (p. 333)."

The "increase of daring" would seem to be a reflection of the characteristics of client growth. In the VRAS, the client was not "peeking at" she was confronted with the anxiety producing situation, during which she was very much aware of the therapists' sharing of the experience with her in its immediacy. Thus the "corrective emotional experience" that is therapy would seem to be accelerated.

Figure 4.3 indicated that the traditional treatment group began to make positive movement between session IV and V, and in fact achieved a slightly higher level of functioning than their pre-test measure. The IPR treatment group continued its positive growth through session V. Both treatment groups lost momentum between sessions V and VI, but this may well be more a function of the research design than actual treatment effects. All parties knew that the sixth session was to be the last in the treatment program (while clients did have - and in six cases followed through on - the option of continuing in therapy, there was an academic term break of three weeks at this point), and written feedback indicated that there was a marked reluctance for both clients and therapists to begin new exploration or involvement into areas for which there might not be sufficient time to work through problems. This was especially evident in the mutual recall of the IPR treatment, where counselor and client communicated openly and honestly and in several cases verbalized their hesitancy about pushing further with limited time. In retrospect, it is quite unfortunate that the treatment program was so brief, for the IPR treatment clients had only begun to function at productive levels on the characteristics of client growth scale i.e., above the level of 3.0 defined as the minimal level of client behavior necessary before gain

in interpersonal functioning can occur.* Thus they were at the stage where their progress within therapy could just begin to result in new methods of behaving. The fact remains that they did reach this stage in only six therapy sessions, and that the drop in positive growth observed for the traditional treatment group after the second session was not observed for the IPR treatment group.

III. The IPR Treatment Program Has Varying Effects On Different Individuals

This conclusion has several implications for the application of IPR to accelerate client progress in therapy. Just as there are individual rates for speed of learning, clients vary in the level of functioning with which they enter therapy and in the rate with which they can progress. Earlier it was noted that both therapists voiced some reservations about the necessary inflexability of the treatment schedule, suggesting that some clients might become ready for a later stage in the progression before it was in - fact scheduled. This conclusion had also been

* Research on the dimensions of facilitative therapist behavior indicates that level 3.0 is the minimal therapist functioning level necessary for client growth to occur (Carkhuff and Berenson, 1967). The client growth dimensions used in this study were conceptualized so that each of the levels of client behavior would coincide with the different levels of therapist behavior. Level 3.0 is conceived as the minimal level of client in-therapy behavior necessary before behavior change can result.

suggested in the pilot study, where it appeared that clients varied in their developmental ability to directly cope with their feelings. At the same time, there are some decided advantages to adhering to the treatment schedule, becuase there seems to be value in the developmental schedule to both client and therapist for suggesting a direction in which to proceed with in-therapy activity. This would appear to be especially true for the less effective therapist functioning at lower then minimal levels of facilitative behavior. In this study, the therapist who was rated as functioning at minimal levels on the facilitative conditions was able to facilitate positive growth with only one of the three clients he met in a traditional treatment program, whereas the three clients he saw in IPR treatment all made positive movement in therapy (Table 4.6). All clients involved in IPR treatment with the second therapist (who was functioning well above minimal levels) made positive movement, but so did two of his three traditional treatment clients (also note that the third client either made positive movement or remained at the same levels, she did not show negative movement). This data is consistent with previous research on IPR discussed in Chapter II where it was observed that the more competent therapist is able to use IPR profitably but is not dependent on the technique, while the less competent therapist needs the IPR structure to aid in facilitating (or even to avoid retarding) client growth. When one considers the indications that many

professionals are in fact functioning at lower than minimally facilitative levels (Carkhuff and Berenson, 1967), this becomes a very critical point.

In essence, it seems evident that the IPR technique has different effects on both client and counselor. While it is conceivable that variations in the format of the intervention program might be appropriate for particular situations, such variations should be made with careful consideration of the therapists' level of functioning as well as that of the client and any new format should be evaluated in a controlled study.

Implications For Counseling And Therapy

In light of the changes observed in client behavior in therapy as a result of the IPR intervention and the significant differences between the behavior of clients in the IPR treatment and the traditional treatment group, it is assumed that the IPR procedures are a potentially potent tool for use in accelerating client progress in therapy. Even in light of the limitations of the small N sample in this study, the fact that significant differences were found in two separate studies in only six sessions seems too meaningful to ignore.

Most theoretical schools in counseling and psychotherapy agree that client behaviors which reflect owning of feelings or discomfort (awareness of need for help), motivation and committment to change, deliniation and clarification of problem areas,

and self exploration are essential ingredients to client progress in the therapy relationship. There are, of course, other dimensions of the therapy process, but these seem to be basic. Since these are identified as positive, "healthy", and necessary dimensions, it would seem logical that not only are these reliable indices of client functioning in therapy, but they are also desirable goals of the therapy interaction. If these behavior dimensions measure the "good" client, then perhaps we should "teach" clients appropriate behaviors as an integral part of the therapy process. Clients request counseling or therapy because they are dissatisfied with their current level of interpersonal behavior, i.e., they are not effective. It is unlikely that the client can suddenly become any more effective in dealing with his problems in therapy than he has been in dealing with them in his past, unless he is taught what these effective behaviors are. There is an abundance of evidence that validates the concept that students in counselor training programs achieve effective behaviors much more rapidly and successfully when they are made aware of the behavioral correlates of effective practice (Goldberg, 1967; Ivey, et. al., 1968; Carkhuff and Berenson, 1967). There is every reason to believe that the same is true for clients. The IPR treatment program may well owe a substantial part of its success in accelerating client movement to the fact that it is sequentially designed to help the client become aware of (and develop successful behavior in)

the characteristics of client growth.

Implications For Further Research

While the results of this study tend to indicate the effectiveness of IPR as a means of accelerating client progress in therapy, a number of questions were raised which should be the subject of further investigation.

1. Because of the need to control experimental procedure for each group while controlling for therapist impact, it was necessary to use a very small N. 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.
2. While client progress in therapy apparently was accelerated by the IPR treatment, there is little evidence of whether such progress results in either shorter therapy contracts or significantly different behavior outside therapy. Longitudinal studies examining such criteria could also provide data on the long range effectiveness of more traditional treatment approaches.
3. Observations regarding the relationship of therapist level of functioning and IPR indicate that the greatest potential for the technique is with less effective therapists. This hypothesis could be examined by setting

up two groups of therapists - effective and non-effective and comparing the impact of both groups with both IPR and traditional treatments.

4. An attempt should be made to identify client functioning level when he first initiates therapy, and examine the impact of the different phases of treatment on clients on varying levels of functioning. This would necessitate a substantial N, but might result in a "readiness index" wherein an individual treatment program could be designed more scientifically, appropriately, and efficiently for each client.

5. Thus far the choice of sequence for the affect simulation films has been made on the basis of clinical intuition. Future research might compare the sequential programming of simulation experience to determine if there is a common pattern of exposure which might be more efficient.

6. If the observations about the sequential series of IPR experiences are correct, it is important to determine the effects of each phase of the treatment procedure on client behavior. By rating each treatment session over a longer period of contact, the trends in movement pattern observed in this study could be better evaluated, and the particular impact of each phase of the program could be determined.

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APPENDICES

APPENDIX A:

Figures depicting VRAS and IPR

FIGURE 1:

Video recording client and affect simulation films.

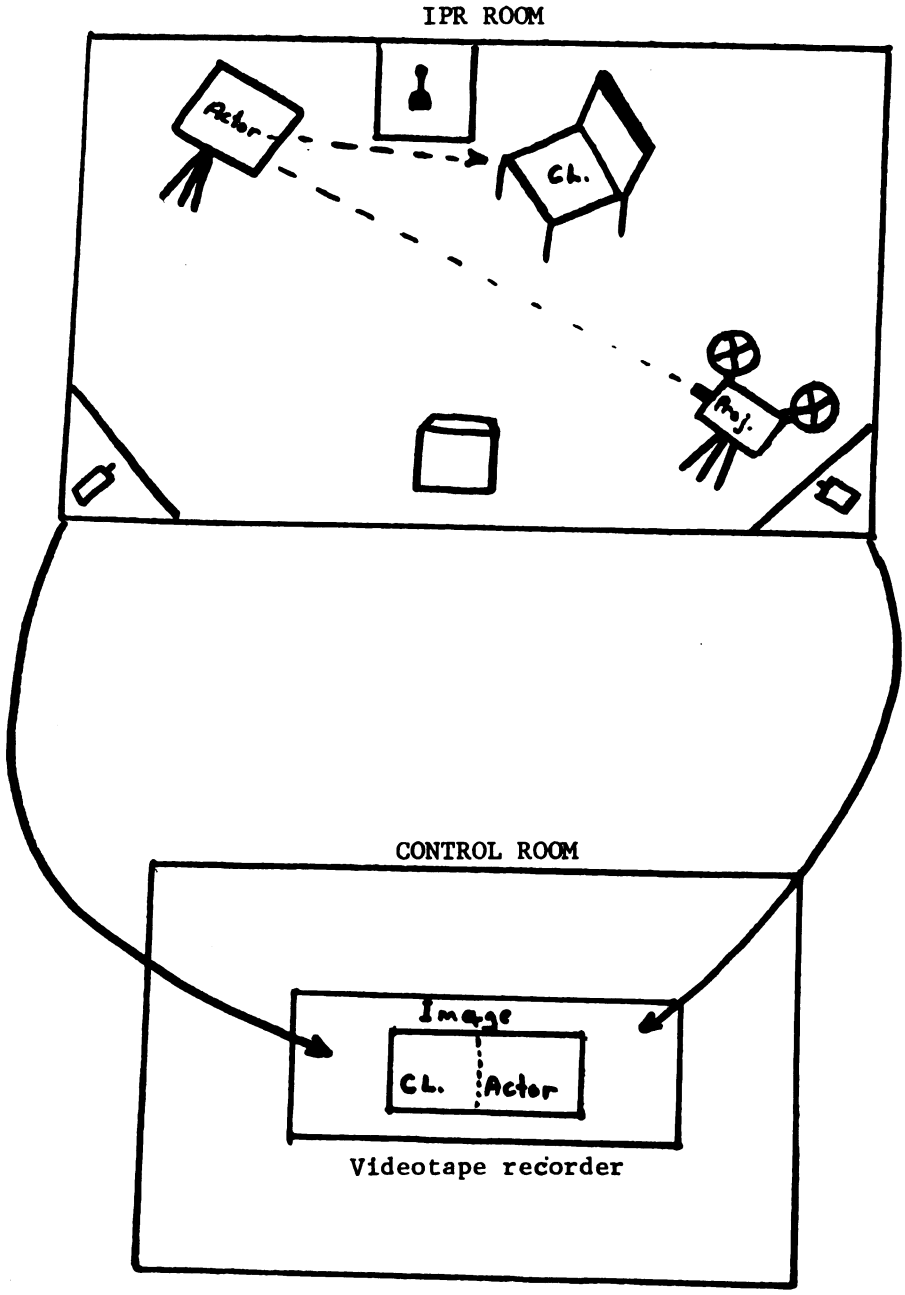

Figure 1: Film of actor portraying emotion is projected on screen for client in viewing room. Client's behavior while watching film is combined with the film to provide a split screen videotape recording for examination in recall.

FIGURE 2:

Videotape recall of affect simulation

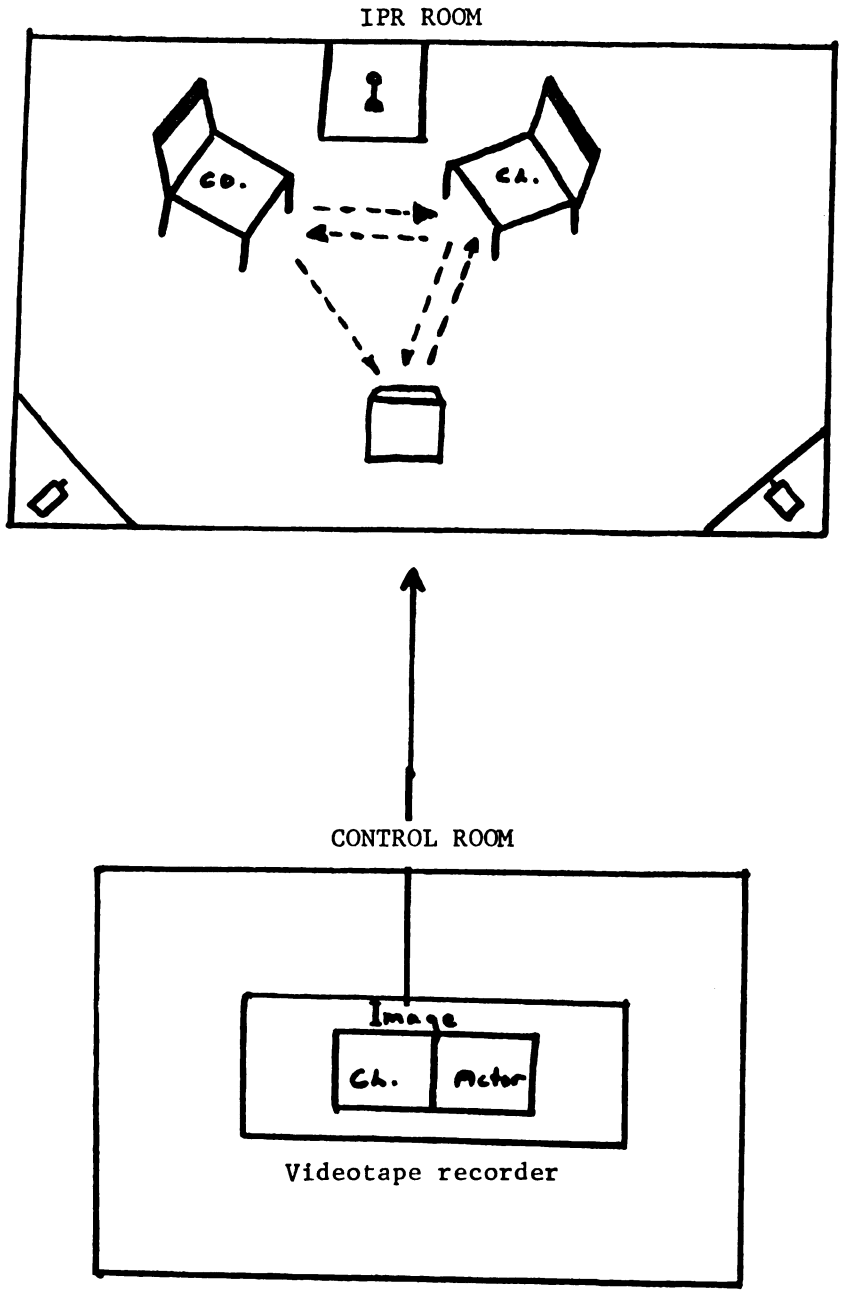

Figure 2: Upon completion of a series of emotional vignettes, client is joined by counselor. A split screen of videotape of emotional vignette and client behavior while watching the vignette is played back to the viewing room. A sound tape to record client and counselor interaction during replay is made. Videotape is started and stopped by remote control switch by either counselor or client

FIGURE 3:

Videorecording Counseling Session

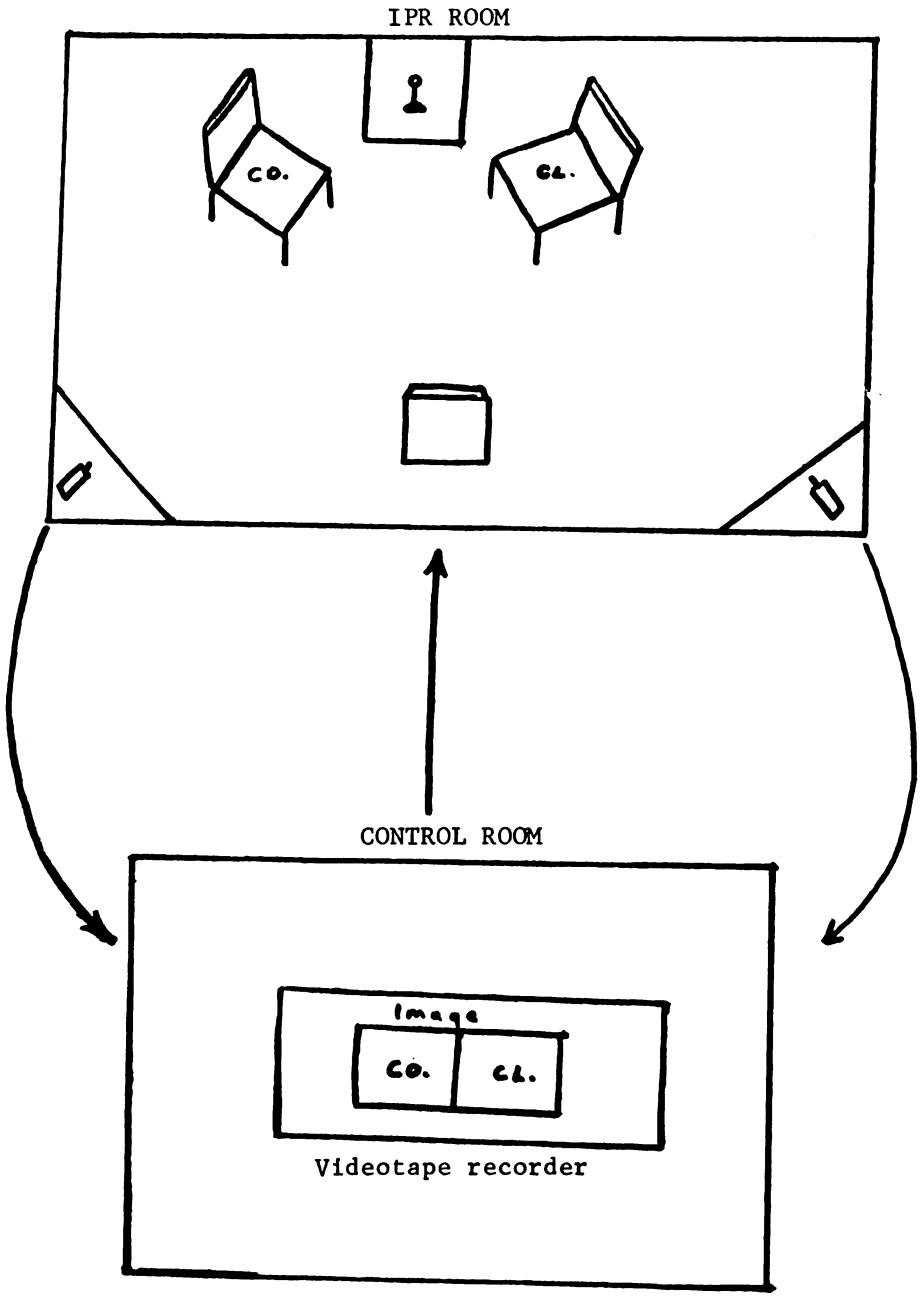

Figure 3: Televising of counseling interview yields split-screen videotape recording of counselor-client interaction. The TV cameras are behind one way glass behind wall in control room, the TV monitor for playback is against the middle wall.

FIGURE 4:

Videotape playback for recall session

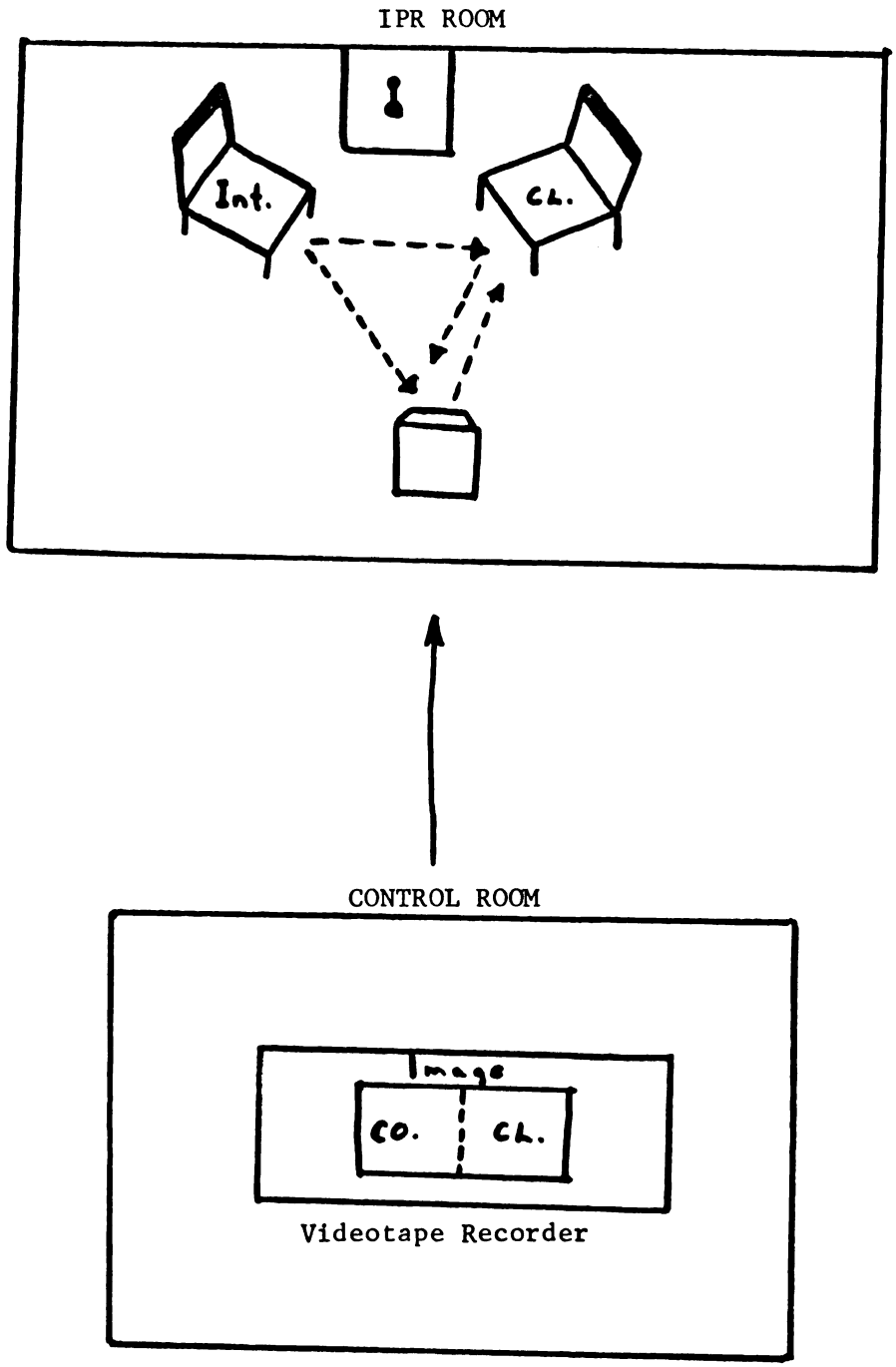

Figure 4: Upon completion of counseling interview (Fig. 1) counselor leaves room and is replaced by interrogator. The videotape is played back to viewing room. A sound tape of selected incidents being viewed is made. Videotape is started and stopped by remote control switch by either interrogator or client.

APPENDIX B:

An Application of Emotional Simulation in Counseling to Accelerate Client Movement: A Pilot Study

An Application of Emotional Simulation in Counseling to Accelerate Client Movement: A Pilot Study

PROBLEM

The purpose of this study was to evaluate the influence of IPR and simulation films on client growth in short-term personal counseling. Because this was a pilot study, designed to work out wrinkles in methodology and evaluation procedures, it was composed of a very small N; the result of the study has been a more systematic and efficient design for further research. The results reported herein are not considered conclusive, but rather indicative of direction for subsequent hypothesis testing studies.

METHOD

Nine clients were selected by professional staff from Division of Vocational Rehabilitation (DVR) caseloads for referral to the IPR project.[1] The clients selected for referral were seen as suffering from personal and adjustment problems which substantially interfered with rehabilitation service or vocational placement. No attempt was made to control for nautre of disability or personality characteristics; the criterion was simply agreement by the DVR staff that prognosis successful community placement for the client was very poor

[1]Appreciation is expressed to the staff of the Michigan Division of Vocational Rehabilitation (Lansing Office) for their cooperation in this study.

unless he received personal counseling. Each referral was assigned a project-staff counselor and was seen for six sessions of one and one-half hours each. (N.b., While some clients continued counseling beyond six sessions, the present report concerns only the first six, since the goal was to establish the immediate effectiveness of IPR methods in accelerating short-term counseling).

The hypotheses tested were:

1. Clients receiving IPR treatment would make more movement withing counseling than would clients receiving counseling without IPR.

2. Clients receiving IPR treatment would make better adjustment outside the counseling relationship.

3. Clients receiving IPR treatment would have better placement prognosis.

PROCEDURE

Three clients were randomly assigned to each of three treatments, which were:

Treatment I:

Three sessions were held, the first 30 minutes of which composed a regular counseling session. Each such session was videotaped, and the remaining hour spent in client recall of the videotape --stimulated by a clinical "interrogator."

During the first 30 minutes of the remaining three sessions, the client viewed four of the simulation films.

(Maximum length of any four films was less than ten minutes.) As he watched the films, a videotape was made which produced a split-screen image of the client (on one half of the screen) and the film (on the other half). The remaining hour consisted of a counseling session which focused on the client's videotaped reactions to the films.

Treatment II:

Reversed sequence of Treatment I. The first three sessions consisted of exposure to the simulation films (as in the last three sessions of Treatment I). The remaining three sessions were spent in stimulated recall of regular counseling sessions (as in the first three sessions of Treatment I).

Control Treatment:

Six counseling sessions were conducted with no IPR intervention.

The simulation films and traditional recall were varied in Treatments I and II in order to provide clinical data on any "sequence" effect that might occur, but both groups were compared to the control group in evaluating movement from first to sixth session. Each group was composed of two male clients and one female client; client age ranged from 18 to 30 years

Prior to beginning the first session, a staff member met with each client and explained the facilities and the research orientation of the project. In the first through sixth sessions, the client met with an assigned counselor.[2]

Ratings

Three independent judges[3] rated the pre- and post-treatment videotapes for all subjects. The rating scales used were developed in previous research (Kagan, Schauble, Resnikoff, Danish, and Krathwohl, 1969); the first scale requires judges to compare pre- and post-treatment tapes according to four characteristics of client growth, which are:

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

Each of these characteristics was rated on a nine-point scale:

-4 Very markedly lessened
-3 Markedly lessened
-2 Somewhat lessened
-1 Lessened a little
00 Remained the same
+1 Improved a little
+2 Improved somewhat
+3 Markedly improved
+4 Very markedly improved

[2] The counselors used in this study were advanced Ph.D. students in Counseling Psychology at Michigan State University

[3] The judges were advanced students in Counseling Psychology, who had no knowledge of the types or assignment of treatments.

In addition, the judges checked, on a five-point scale, changes in therapeutic process and client behavior from pre- and post-session. These items related to client insight, lessening of defenses, ability to experience feeling, ability to relate to the counselor, and overall therapeutic relationship; the scale upon which each was rated was as follows:

1. Markedly lessened
2. Lessened somewhat
3. Remained the same
4. Improved somewhat
5. Improved markedly

RESULTS

Interjudge reliability (as determined by the Spearman Brown method) was found for the Characteristics of Client Growth to be: client owns his discomfort, 0.75; commitment to change, 0.69; differentiation of stimuli, 0.69; and behavior change, 0.73. The interjudge reliability on the Therapeutic Process Variables was found to be: client ability to gain insight, 0.59; lowering of defenses, 0.74; ability to experience feeling, 0.66; ability to relate to therapist, 0.76; and overall therapeutic relationship, 0.85.

There were no differences in ratings between the two treatment groups, which were therfore combined for comparison with the control group. T tests of differences between mean change rates (pre- to post-session) for the treatment and control groups were run.

The experimental subjects were found to progress more on the four criteria -- owning of discomfort, commitment to change, differentiation of stimuli, and behaving differently -- (at the 0.05 level) than the control subjects. (See Table I).

Table I

Mean Ratings (for three judges) of Change of Characteristics of Client Growth from Session One to Session Six

	Mean Rating of Change		
Characteristic	Exper. Group	Control Group	t
Owning Discomfort	+0.501	-1.113	1.930*
Commitment to Change	+0.556	-0.553	2.495*
Differentiation of Stimuli	+0.888	-0.890	2.877*
Behavior Difference	+1.276	-1.113	2.967"

*Significant to .05 degree
"Significant to .01 degree

When compared to ratings of change in therapeutic process and client behavior, it was found that each subject in the experimental group either moved or remained at the same level on every variable, whereas only one of the control subjects made any positive movement or remained the same. The remaining two control subjects were rated as moving negatively on all five dimensions. (See Table II)

Table II

Changes in Client Behavior and Therapeutic Process between Pre- and Post-Sessions by Mean Change Ratings (for three judges)

		Number of Clients		
		Positive Movement	No Change	Negative Movement
Client ability to gain insight	Experimental	4	2	-
	Control	-	1	2
Client defenses (lowering of)	Experimental	5	1	-
	Control	1	-	2
Client ability to experience feeling	Experimental	3	3	-
	Control	-	1	2
Client ability to relate to therapist	Experimental	4	2	-
	Control	1	-	2
Overall Therapeutic relationship	Experimental	4	2	-
	Control	1	-	2

DISCUSSION

The dimensions of the scales on which judges attempted to rate client behavior change are, by nature, vague and difficult to quantify. While the interjudge reliability obtained was not as high as desired, it is considered sufficient to indicate that behavior on these dimensions can be reliably rated.

Those clients exposed to the IPR treament made significantly more progress on the four characteristics of client growth than did control clients. These results were found despite the fact that the counselors had received their training in traditional counseling procedures and had not used IPR or IPR with simulation prior to this study. This was a deliberate pre-condition for these counselors, as the effectiveness of the techniques for counselors with less enthusiasm and familiarity than the regular research staff was to be observed. The control sessions, then, were not "placebos" in the traditional sense of the word; rather, they allowed a comparison of counseling with the IPR method to traditional counseling by trained, advanced Ph.D. candidates in counseling.

Judges also rated the IPR clients as having more positive change in the five variables ralating to change in therapeutic process. Two of the control clients actually were rated as decreasing on these variables; and, in fact, all control clients were judged to have moved negatively on the characteristics of

client growth. This indicates that positive movement is not necessarily concommitant with counseling experience (at least in the initial stages), and lends support to the "accelerating" influence of the IPR intervention. The dimensions of client behavior used as criteria in this study have been described as seemingly necessary components of change for almost any theoretical approach to therapy (Kagan, Schauble, Resnikoff, Danish, and Krathwohl, 1969). Within the limiations imposed by the small N, it appears that the IPR treatments can be instrumental in influencing psoitive change on these dimensions early in the course of the counseling or therapy experience.

On the basis of these results, the first hypothesis, that experimental subjects would make more movement within counseling than would control subjects, was accepted.

The second hypothesis, that experimental subjects would make better adjustment outside counseling than would control subjects, was somewhat more difficult to evaluate. Employed as criteria were subjective reports submitted to IPR by DVR staff, family, and other personal contacts of the client. Reports of five of the IPR clients were markedly favorable, treating such areas as personal satisfaction on the job (or training placement), a more suitable attitude toward the placement situation and peer and supervisory staff, and social interaction (and communication); the reports on the remaining

IPR client did not furnish enough information on which to make a decision concerning movement.

Of the control subjects, on the other hand, one was reported to have made marked improvement toward adjustment; the remaining two were given negative reports. To quote one of these:

> The influence of your sessions with George was nil. There was absolutely no noticeable change in behavior, unless that he has become more stubborn and obstinate.

Interestingly, this quote refers to the one control subject who was judged by raters as making progress <u>within</u> the counseling relationship. In retrospect, it appears that--with the support of his counselor -- George was "risk-taking" in his placement situation; but this type of behavior (while seemingly very healthy activity for this man) was disruptive and was received unsympathetically. The IPR treatment might have made considerable difference for this subject, in that if he had been able to view and eal with his reactions to vaious interpersonal situations (simulated or with his counselor), the inappropriateness of his "acting-out" behavior might have been reduced.

The final hypothesis, that experimental subjects would have a better placement prognosis that would control subjects, was also supported. Five of the six clients receiving IPR counseling had been placed within a week after their sixth session, but only one of the three clients receiving counseling

alone. While it is not suggested that contact with the IPR project is solely responsible for vocational placement, it remains that some of these individuals had been unsuccessfully seeking placement for more than a year.

REFERENCES

1. Kagan, N., Krathwohl, D. R., et al. Studies in Human Interaction. 1967, East Lansing, Michigan: Michigan State University, Educational Publication Services (Final Report, Grant No. OE 7-32-0410-270).

2. Kagan, N., and Schauble, P. G. Affect simulation in interpersonal process recall, Journal of Counseling Psychology, 1969.

3. Kagan, N., Schauble, P. G. Resnikoff, A., Danish, S. J., and Krathwohl, D. Interpersonal process recall, Journal of Nervous and Mental Diseases, 1969 (in press)

APPENDIX C:

Referral Information Forms for Screening Counselors and Clients

January, 1969

TO: Screening Counslors

FROM: Paul Schauble

SUBJECT: Referral of clients for research

PURPOSE: To investigate the influence of Interpersonal Process Recall (IPR) techniques on client growth in therapy.

SAMPLE: Twelve Counseling Center clients who request personal-social counseling in screening. These may be any clients who might ordinarily be assigned to interns or senior staff by the screening committee.

Clients whom the screening counselor feels might be appropriate for this study should be referred to the two participating interns, Paul Schauble and David Erb. Before referral, the screening counselor will either present or read a brief prepared statement (see the enclosed "letter"). If the client agrees to participate, Paul Schauble will contact him by phone within a week.

PROCEDURE: Twelve clients will participate in this study. Six will be assigned to the Treatment Group and six to the Control Group. Two counselors (Schauble and Erb) will each see two clients in each group.

Clients well be seen for (a minimum of) six sessions. The format is as follows:

Treatment Group

Films, video	Session 1:	Counseling session, pre-testing
	Session 2:	Counseling session with exposure to simulation films and videotape (approximately one and one-half hours)
	Session 3:	Same as #2
Video of cnslg session	Session 4:	Counseling session which is videotaped, then played back for stimulated recall
	Session 5:	Same as #4
	Session 6:	Same as #5

Synopsis: Each client receiving experimental treatment is seen for six sessions, five of which involve videotape feedback.

Referral of clients for research

Control Group

Will be seen for six "traditional" counseling interviews. The client will not be exposed to IPR techniques, but will be seen for sessions of one and one-half hours each and will then fill out the interview rating forms.

Traditional Counseling Group

Michigan State University
Counseling Center
207 Student Services Building
East Lansing, Michigan 48823

Dear Student:

We at the counseling center believe that one of the ways we can become increasingly helpful to students like yourself is through careful study of your problems and our effectiveness in helping you with them. We are presently in the process of evaluating the use of longer contact sessions with students as a possible means of facilitating "growth" in counseling. We would like you to consider participating in this project.

If you agree to participate, commitment will consist of meeting with your counselor for 1½ hours for your first seven sessions, (instead of 1 hour per session). Your counseling sessions would be recorded on audiotape and you will also be asked to complete some tests and inventories before and after counseling.

Your responses to the test material and the audiotapes made are strictly confidential. We can assure you that your responses will be used anonymously in our research endeavors.

If you agree to participate, the project will take somewhat less than fourteen hours for the seven weeks of contact. (Any additional counseling contacts would be on the more common 1 hour per week basis.) We recognize that this is a considerable investment of your time, but our experience indicates that it will be of considerable value in our work together, as well as in our research.

In summary, your participating--including time for testing--would involve an additional seven hours over seven weeks. If you agree to participate in (or have any questions about) this project, you will be contacted in about a week.

Thank you for considering participating.

Sincerely,

Paul G. Schauble
Counseling Intern

William Mueller
Assistant Director for
Research

Counseling with IPR Group

Michigan State University
Counseling Center
207 Student Services Building
East Lansing, Michigan 48823

Dear Student:

We at the counseling center believe that one of the ways we can become increasingly helpful to students like yourself is through careful study of your problems and our effectiveness in ehlping 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.

If you agree to participate, commitment will consist of meeting with your counselor for 1½ hours for your first (instead of 1 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 will also be asked to complete some tests and inventories before and after counseling.

Your responses to the test material and the videotapes made are strictly confidential. We can assure you that your responses will be used anonymously in our research endeavors.

If you agree to participate, the project will take somewhat less that fourteen hours for the seven weeks of contact. (Any additional counseling contacts would be on the more common 1 hour per week basis). We recognize that this is a considerable investment of your time, but our experience indicates that it will be of considerable value in our work together, as well as in our research.

In summary, your participating--including time watching videotapes and testing--would involve an additional seven hours over seven weeks. If you agree to participate in (or have any questions about) this project, you will be contacted in about a week.

Thank you for considering participating.

Sincerely,

Paul G. Schauble
Counseling Intern

William Mueller
Assistant Director for
Research

APPENDIX D:

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 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 minimal 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 behavior 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.

Committment 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 committment 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 committment to the change process.

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

Level 3

The client vacillates between an overt desire and/or committment 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 in his committment 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 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 a 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 problems. 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 committment 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 distict 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 recongizes individuality in himself and in others, and responds in an appropriate manner.

APPENDIX E:

Degree of self exploration scale

Scale VIII

HELPEE SELF-EXPLORATION IN INTERPERSONAL PROCESSES, II

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 client.

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

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

Level 2

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

Example: The second person simply discusses the material without exploring the significance or meaning of the material or attempting further exploration of the feeling in our 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.

Level 3

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

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

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

Level 4

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

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

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

Level 5

The second person actively and spontaneously engages in an inward probing to newly discover 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 be doing so, perhaps, fearfully and tentatively.

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

[1]The present scale "Self-exploration in interpersonal processes" has been derived in part from "The measurement of depth of intrapersonal exploration (Truax 1963) which has been validated in extensive process and outcome research on counseling and psychotherapy (Carkhuff and Truax, 1965, 1965a, 1965b; Rogers, 1962, Truax, 1963; Truax and Carkhuff, 1963, 1964, 1965). In addition, similar measures of similar constructs have received extensive support in the literature of

counseling and therapy (Blau, 1953; Braaten, 1958; Peres, 1947; Seeman, 1949; Steele, 1948; Wolfson, 1949).

The present scale represents a systematic attempt to reduce the ambiguity and increase the reliability of the scale. In the process many important delineations and additions have been made. For comparative purposes, Level 1 of the present scale is approximately equal to Stage 1 of the 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 F:

WISCONSIN RELATIONSHIP ORIENTATION SCALE

WISCONSIN RELATIONSHIP ORIENTATION SCALE

DIRECTIONS: Check the item which best describes your feelings toward the counselor.

_____1. I would attempt to avoid any kind of interaction or relationship with this person.

_____2. If no one else were available, I might consult this person for specific information of a factual, e.g., educational or vocational nature, but I would avoid any personal exposure.

_____3. I would be willing to talk with this person about factual, e.g., educational or vocational concerns, and some of the personal meanings connected with these.

_____4. I would be willing to talk with this person about many of my personal concerns.

_____5. I have the feeling that I could probably talk with this person about almost anything.

APPENDIX G:

Therapy Session Report Items

Therapy Session Report Items*

This booklet contains six questions about the therapy session 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 Identification_____

Date of Session_____

1. HOW DO YOU FEEL ABOUT THE SESSION WHICH YOU HAVE JUST COMPLETED?
(Circle the one answer which best applies)

THIS SESSION WAS:

1. Very poor
2. Pretty poor
3. Fair
4. Pretty good
5. Very good
6. Excellent
7. Perfect

2. HOW MOTIVATED FOR COMING TO THERAPY WAS YOUR PATIENT THIS SESSION?

1. Had to make herself (himself) keep the appointment
2. Just kept her (his) appointment
3. Moderately motivated
4. Strongly motivated
5. Very strongly motivated

3. HOW MUCH PROGRESS DID YOUR PATIENT SEEM TO MAKE IN THIS SESSION?

1. Seems to have gotten worse
2. Didn't get anywhere this session
3. Some progress
4. Moderate progress
5. Considerable progress
6. A great deal of progress

4. HOW WELL DOES YOUR PATIENT SEEM TO BE GETTING ALONG AT THIS TIME?

   1. Quite poorly; seems in really bad condition
   2. Fairly poorly; having a rough time
   3. So-so; manages to keep going with some effort
   4. Fairly well; has ups and downs
   5. Quite well; no important complaints
   6. Very well; seems in really good condition

5. HOW MUCH WERE YOU LOOKING FORWARD TO SEEING YOUR PATIENT THIS SESSION?

   1. I anticipated a trying or somewhat unpleasant session
   2. I felt neutral about seeing my patient this session
   3. I had no particular anticipations but found myself pleased to see my patient when the time came
   4. I had some pleasant anticipation
   5. I definitely anticipated a meaningful or pleasant session

6. TO WHAT EXTENT WERE YOU IN RAPPORT WITH YOUR PATIENT'S FEELINGS?

   1. Little
   2. Some
   3. A fair amount
   4. A great deal
   5. Almost completely
   6. Completely

Therapy Session Report Items*

This booklet contains six questions about the therapy session 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 Identification _____

Date of Session _____

*These items were selected from the Therapy Session Report,

CLIENT FORM THERAPY SESSION REPORT

1. HOW DO YOU FEEL ABOUT THE SESSION WHICH YOU HAVE JUST COMPLETED?
(Circle the one answer which best applies.)

THIS SESSION WAS:

1. Very poor
2. Pretty poor
3. Fair
4. Pretty good
5. Very good
6. Excellent
7. Perfect

2. HOW DID YOU FEEL ABOUT COMING TO THERAPY THIS SESSION?

1. Unwilling; felt I didn't want to come at all
2. Somewhat reluctant to come
3. Neutral about coming
4. Somewhat looking forward to coming
5. Very much looking forward to coming
6. Eager; could hardly wait to get here

3. HOW MUCH PROGRESS DO YOU FEEL YOU MADE IN DEALING WITH YOUR PROBLEMS THIS SESSION?

1. In some ways my problems seem to have gotten worse this session.
2. Didn't get anywhere this session
3. Some progress
4. Moderate progress
5. Considerable progress
6. A great deal of progress

4. HOW WELL DO YOU FEEL THAT YOU ARE GETTING ALONG, EMOTIONALLY AND PSYCHOLOGICALLY, AT THIS TIME?

   I AM GETTING ALONG:

   1. Quite poorly; can barely manage to deal with things
   2. Fairly poorly; life gets pretty tough for me at times
   3. So-so; manage to keep going with some effort
   4. Fairly well; have my ups and downs
   5. Quite well; no important complaints
   6. Very well; much the way I would like to

5. HOW WELL DID YOUR THERAPIST SEEM TO UNDERSTAND WHAT YOU WERE FEELING AND THINKING THIS SESSION?

   MY THERAPIST:

   1. Misunderstood how I though 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

6. HOW HELPFUL DO YOU FEEL YOUR THERAPIST WAS TO YOU THIS SESSION?

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