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AN EXPLORATORY STUDY OF "CRITICAL SESSIONS" IN INDIVIDUAL ADULT PSYCHOTHERAPY

By

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ABSTRACT

AN EXPLORATORY STUDY OF "CRITICAL SESSIONS"
IN INDIVIDUAL ADULT PSYCHOTHERAPY

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This research sought to study the nature of "critical sessions" in individual adult psychotherapy. Theoretically, a "critical session" was conceptualized as a session in the process of therapy in which the therapist confronted or interpreted some key set of feelings or behaviors to which the client is receptive, and which results in the client having felt some significant emotional impact, having achieved a sense of mutual closeness with the therapist, having had some major cognitive reorganization, having achieved some important insight in a way that is useful, and having shifted some of his or her distorted perceptions of the therapist more toward reality.

The concept of a "critical session" had to be operationally defined. This was accomplished for this study by a survey of experienced psychotherapists. Data from a preliminary set of interviews with experienced therapists was used to construct the Psychotherapist Survey Questionnaire (PSQ). The PSQ was sent to 62 experienced therapists and researchers to collect data on their views on whether "critical sessions" exist, and, if they believed so, what

variables might be present in such sessions. Forty-six respondents agreed with the concept, while six did not, and ten did not respond. The 46 positive respondents, who had a mean experience level of 14.4 years, identified three variables (PSQ items VI, IX, and X) which they considered "extremely important" to a "critical session". A t-test performed on the PSQ data showed the responses for these three items to be significantly different from the total group of PSQ responses ($p<.0005$).

These three PSQ items were converted into seven items on the "Critical Session" Questionnaire (CSQ), an instrument developed for this study with the aim of identifying "critical sessions". Two additional items concerning the importance of the session and the client's goals for therapy were also included in the CSQ. The operational definition for a "critical session" for this study was the highest median for a client's ratings for a session on these nine CSQ items, with at least seven of these items needing to be rated at equal to or greater than + 2.

It was hypothesized that (1) a change in the client's report of his or her affect from the session immediately preceding a "critical session" to the session immediately following a "critical session" as measured by the Multiple Affect Adjective Check List would occur ($p\leq.05$), and (2) that a change in the therapist's report of the client's experienced affect over these same sessions measured by

the same instrument would occur ($p \leq .05$).

Ten adult clients in individual therapy and their therapists were administered the CSQ, the Multiple Affect Adjective Check List (MAACL), and the Therapy Session Report (TSR) after each of ten consecutive sessions. Therapists chose both the clients and the starting points in the therapy process for this research. Five dyads started participating in this study before the twentieth session and five began at some point after the twentieth session.

Eight of the ten dyads were found to have had an operationally defined "critical session." A t-test performed on the CSQ results demonstrated that these eight "critical sessions" were significantly different in their CSQ client ratings than the total group of sessions studied ($p < .0005$). A three-way analysis of variance was performed on the MAACL scores for the eight "critical sessions," the sessions immediately preceding and following them, and on three randomly selected consecutive sessions from these same dyads which served as controls. The results of the analysis of variance (1) failed to support either of the hypotheses, and (2) failed to demonstrate that the identified "critical sessions" were different than other sessions in their client MAACL scores. Three TSR items pertaining to variables in the

theoretical definition of a "critical session" were then subjected to a similar three-way analysis of variance. This statistical analysis also failed to differentiate "critical sessions" from other sessions. Finally, items involving which client affect was felt most, what was talked about most, and what was most beneficial to the client during the eight "critical sessions" were examined in a non-statistical manner. Two trends were discovered: (1) Past or present relationships with members of the client's immediate family was the most frequently reported content matter (43%), and (2) Attaining greater understanding or insight was most frequently reported to be what the client got most out of the session (43%).

Although the hypotheses were not supported, "critical sessions" were identified in eight therapy dyads and some trends concerning the nature of "critical sessions" were uncovered. Some of the methodology utilized in this study may have contributed to the lack of significant results, e.g., the small number of subjects, the types of instruments used and their length, and the examination of only ten sessions rather than the entire course of a therapy. Enough information was collected, however, to suggest the value of further research in the area of "critical sessions" using more refined methodology.

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INTRODUCTION AND REVIEW OF THE LITERATURE

INTRODUCTION

Despite the amount of research done in the field of psychotherapy, many basic questions pertaining to theory and practice have yet to be answered. One essential but little researched question is the possibility of differentiating sessions that are deemed to be important to the progress of a client's psychotherapy from those sessions which are judged as of less or little importance.

It is a problem of both conceptual and pragmatic concern. Often a therapist who has just finished meeting with a client exclaims, "That was a really good session," or "That was an important session." When questioned about this statement and about the "important" session, a therapist may explain the meaning of his exclamation in terms of his own particular theoretical constructs; or he may verbalize it more concretely by describing the behaviors and feelings that ensued during that session; or he might combine these two facets by depicting the processes that occurred; or he may relate his own internal feeling states; or he may simply be unable to offer any other explanation than some sort of intuition. Even among therapists who can cite reasons for their statement, few explanations are similar in content or theory espoused.

One also occassionally hears a therapist refer to a particular session with a particular client as "critical" or as "a turning point in therapy." These phrases are no better defined. Exploring this remark often leads to the same multiplicity of responses as were engendered by the question of what constitutes an "important" session. The wide variety of answers and the amount of uncertainty concerning such common occurrences in the practice of psychotherapy, seems puzzling. Certainly the frequency of such responses indicates this importance in the process of therapy. Even more puzzling is the fact that the frequency of such sessions has not warranted particular interest on the part of researchers to investigate their attributes.

The difference between what constitutes a therapy session evaluated informally (or quantitatively) as "good" or "important" from a session judged "bad," "poor," "neutral," "unimportant," or "of lesser importance" would seem to promise to generate a fair amount of data concerning both the nature and the process of psychotherapy. Taking the extreme example on this continuum, namely sessions rated as "critical" or "turning point," and examining in a comprehensive manner what occurs at these times could conceivably be an even greater source of data for the exploration of the essential components of psychotherapy.

Consequently, this study hopes to formulate a systematic, operational definition of a "critical session."

This study also seeks to examine some of the constituent factors involved in the process of these sessions. Outcome will not be evaluated in this research. This investigation focuses primarily on finding therapist-client interactions and therapeutic processes common to "critical sessions" which serve to differentiate these sessions from all other sessions. This study hopes to examine some of the variables in the process of "critical" therapy sessions and enable the researcher to form some tentative hypotheses concerning the nature of these sessions.

Review of The Research on "Critical Sessions" in Psychotherapy

Of all the research studies performed in the field of psychotherapy in recent years there has not been a single published empirical study that examines "critical sessions" or critical incidents in the process of psychotherapy. Three studies explore the concept of the "good hour" in psychotherapy. Since the notion of the "good hour" as perceived by these researchers is similar to the idea of an important session, these three studies will be examined here.

Mintz, Auerbach, Luborsky, and Johnson (1973) studied four patients for twelve consecutive sessions each. The patients' diagnostic description was supplied. Each patient was seen by a different, experienced, psychoanalytically-oriented psychiatrist. The authors factor

analyzed Orlinsky and Howard's Therapy Session Report into six factors, which they demonstrated to be similar to those obtained by Orlinsky and Howard (1967). They then related these factors to the judgments of client, therapist, and observer, and to the "goodness" of the session. The first set of results showed that all judgments from all three groups (clients, therapists, and observers) correlated about equally with one another, with the range being from r=.40 to r=.49. For the "goodness" of the session the authors correlated the six factors with only a single item on the Therapy Session Report which measures "goodness". This practice of using a single item for so complex a variable greatly reduces the validity of their obtained results and limits the conclusions they may draw. Their findings were that "goodness" of the session correlated highly with the Helpful Involved Therapist factor (r=.66, $p<.01$), and at lower but still significant levels with Active Experiencing Patient (r=.40, $p<.01$) and Affection and Sex (r=.27, $p<.01$).

They conclude that

> "evaluation of the goodness of the therapy hour is intimately and strongly tied to the judge's perception of the therapist's quality of relationship; further, that the judge's perception of the depth and appropriateness of the patient's involvement in the therapeutic process also plays a role in evaluating the session's goodness, although a distinctly lesser role" (p. 88).

Although the overall agreement between the groups and between the observers within their group was good, the agreement between ratings obtained on the Helpful Involved Therapist factor was low for both of these comparisons. For these methodological reasons, the conclusions drawn by Mintz, et al. seem contradictory, confusing, and unreliable.

Auerbach and Luborsky (1968) set out to determine how change comes about in the process of psychotherapy. This study used three judges, whose inter-judge reliability was not previously established, to rate tape recorded therapy sessions. After a training period the judges interpreted the types of therapist or patient variables being expressed in the sessions from listening to the content. In addition to these, the author listed therapist and patient variables compiled from a number of studies, but reported neither the reliability nor the validity of this new scale. The authors used judges' ratings as the only source of data and one variable to determine what constituted a good hour.

This study reports the work of fifteen experienced therapists, each of whom had two clients. The authors subjected the third and fourth sessions for each dyad to content analysis. There are several problems with this study. The patient population was poorly differentiated. The therapist population was adequately described, but no

effort was made to distinguish between the effects of the different types of therapists in the results. The variables used to rate the tapes were listed but the judges gave no operational definitions for them. The authors used the variable for determining the occurrence of a good hour, Therapist Responds Effectively to Patient's Main Communications, but seem to have chosen it arbitrarily with no attempt to fit it into any major theoretical frameworks of psychotherapy. Finally, the two authors admit, they have

> "no outside criterion for the validity of our ratings of this variable--or for any of our other ratings" (p. 163).

Auerbach and Luborsky examined and reported inter-judge reliability on this central variable, which ranged from r=.47 to r=.65 for comparisons among the three judges. Reliabilities for inter-judge ratings were reported for all variables, but the reliabilities were performed upon the research materials used and calculated afterwards. The total inter-judge reliabilities, however, were not mentioned.

Of the 60 sessions rated for Therapist Responds Effectively, the top 18% (10 sessions) were classified as "good hours" and the bottom 18% (11 sessions) were categorized as "poorer hours." The authors found the following variables to be significantly different when contrasting the two groups of sessions, in descending

order of difference: Therapist Skill, Therapist Empathy, Therapist Unconditional Positive Regard, Therapist Security and Maturity, Therapist Warmth, Therapist Creativity, and Therapist Emphasis on the Unconscious. Though the authors made an attempt to clarify these terms, they offer no real operational definitions. No patient variables showed significant differences when these two groups of sessions were compared. The authors concluded by describing their general conceptions of better and poorer hours. The conclusions drawn are clearly equivocal.

The final study on the "good therapy hour" was done by Orlinsky and Howard (1967). They used 17 experienced therapists and 60 female patients with the number of sessions ranging from 8 to 26. The diagnoses for the patients and the professional status of the therapists were reported, but the authors made no attempt to differentiate between the effects of these variables within either of these groups in their results. The Therapy Session Report was administered to all patients and therapists after each session and this was the sole source of data. No observers or other outside judges were used.

"Good" sessions were those rated high on a single item of the Therapy Session Report. The practice of using only one item is methodologically weak since both the reliability and validity of this single measurement procedure tends to be low. Orlinsky and Howard correlated

the ratings from all of the other variables with this one item to determine what occurs in a good session. They found that in terms of dialogue, or content, good sessions (agreed upon by both the patient and therapist) correlated with the patients' discussion of Childhood Relations with Parents, Family (at the $p \leq .01$ level) which the authors say "suggests the importance of a genetic or developmental focus" (p. 624). In addition, the therapists' ratings of the patients' expressions of Sexual Feelings and Experiences, and Feelings About Being Close or Needing Someone correlated with a good session at the $p \leq .01$ level of significance. Both patients and therapists valued sessions in which the patient was interacting, friendly, affective, emotionally involved, and in which the therapist was effective ($p \leq .05$). Summarizing the relationship present in a good hour Orlinsky and Howard state,

> "Were we to characterize the general tone of the relationship in good therapy hours, we might describe it as one of deeply felt actively collaborative engagement--and, if not in the nature of their respective tasks, then at least in the style of relating, a relationship between equals" (p. 626).

They also note that these results contradict both the psychoanalytic and client-centered models of psychotherapy.

For the range of variables that the authors describe as the feeling process, both members of the dyad agreed that in good sessions the patient tended to feel likeable,

accepted, relieved, alert, interested, trusting, and optimistic ($p \leq .01$), and the therapist tended to feel effective, confident, satisfied, optimistic, alert, interested, involved, close, intimate, sympathetic, tender, and pleased ($p \leq .01$). Patients tended to rate good sessions as ones which were globally characterized by positive affect in themselves, while therapists valued sessions in which both positive and negative affect emanated from the patient.

With respect to the cluster of variables that Orlinsky and Howard call the exchange process, in good sessions the patients describe themselves as expressing a desire to work in person-to-person collaboration with their therapists, to gain insight into themselves, and to show positive gains. In these same sessions the therapists saw their patients as seeking insight, not being evasive or withdrawing from person-to-person contact, not filling time simply in order to get the session over, and desiring attention, approval, sympathy, or affection. The therapists' goals in working with their patients in good sessions were increasing their patients' insight and supporting their patients' self-esteem. The patients in good sessions felt satisfied for all nine variables listed.

For session development, the correlations of these items with good sessions were the highest of all items.

For both patients and therapists the patients' perception (focusing on own concerns), performance (communicating freely), and consummation (sense of progress with problems) correlated at the $p \leq .001$ level, with motivation correlating at the $p \leq .01$ level. Both also agreed that for these sessions the therapists' perception (empathy and understanding), performance (helpfulness), and consummation was at the $p \leq .001$ level of significance.

The results of this study of good sessions are the most descriptive and most important of the three performed in this area, and, perhaps, the most applicable to the notion of "critical session." The limitation of the reliability of the instrument, the lack of objective data, the narrow sample of patients, and the lack of data concerning specific types of patients with specific therapists, however, qualifies the conclusions that can be drawn from this research. It is, nonetheless, a good beginning into the examination of what essential ingredients characterize good or important sessions in the process of psychotherapy.

The Value of This Study

One of the main difficulties blocking progress in the field of psychotherapy research has been the approach to empirical investigations employed by most of the researchers. According to Bergin and Strupp (1972):

> "The problem of psychotherapy research in its most general terms, should be reformulated as a standard scientific question: What specific therapeutic interventions produce specific changes in specific patients under specific conditions? In order to answer this ultimate question it is essential to achieve greater clarification of the nature of the therapeutic influence and its effect by implementation of empirical inquiries" (p. 8).

The research here presented is an attempt to explore the nature of the conditions under which a very important or "critical session" will occur. Specific behaviors and reactions on the therapist's part along with specific actions emanating from the client, and the specific modes of interaction between them will be examined. The setting for a "critical session" will be made specific via the utilization of a definite operational definition for determining when a "critical session" occurs and which will be based upon very specific criteria. Meltzoff and Kornreich (1970) ask

> "What are the important aspects or dimensions of the relationship between patient and therapist in the psychotherapeutic situation? There have been few systematic studies of the entire therapeutic relationship, few attempts to map the important connections between patient and therapist. The next question is: important for what reason? Since the ultimate issue is outcome, many of the studies do have outcome referents, implicitly or explicitly. However, within the immediate psychotherapeutic situation, there may be a host of variables that are intimately related to relationship variables. It is possible that these complex relationships change at various stages in a psychotherapeutic series" (p. 453-454).

This study attempts to satisfy some of the criticisms and follow some of the reasoning put forth by Meltzoff and Kornreich in this statement. A "critical session" might be the point at which "the important connections between patient and therapist" reach some climax or high level of intensity. At the very least it can be said that these connections must be present in such sessions in order for them to be critical or very important in the process of therapy. Hopefully, these connections will become clearer upon the empirical examination of the variables inherent in them to be undertaken by this research. In addition, this study attempts to explore in a systematic fashion the relationship variables involved in the process of psychotherapy and to view how these variables change as the process progresses from one stage to another. This study assumes that a "critical session" signals the passing of one stage and the entering into of another stage in the therapeutic relationship. By contrasting the results of the content and process analyses from the sessions preceding and following a "critical session" in this study, stages in psychotherapy may be demonstrated empirically to exist as well as the measurable manner in which both the process and the relationship in psychotherapy do indeed change.

What is the value of any study of psychotherapy which does not deal with outcome per se? Kiesler (1966) argues that outcome and process in psychotherapy are so interrelated that one cannot study one without, in effect, studying the other. On a slightly different but equally germane tack, Bergin and Strupp (1972) suggest,

> "It is . . . advisable to complement controlled experimentation . . . by continued naturalistic observation. Such studies should employ one of the more promising content-analysis schemes as a tool for exploring systematic relationships in the communications of the two participants, even if the resulting indices can not immediately be related to therapeutic outcomes" (p. 39).

The main thrust of these arguments is that the investigation of the process of psychotherapy is valuable in its own right, regardless of whether it is related to outcome. Surely a great deal can be learned from the examination of the process of therapy and the therapeutic relationship in a systematic and empirical manner. Such knowledge also appears to hold great promise for its application to the practice of psychotherapy, since therapists could then learn to apply specific behaviors in order to achieve specific therapeutic outcomes in their work.

Following many of these ideas and recommendations, this research will attempt a first step in examining the nature of a very important "critical session." This

study will use a content-analysis instrument and a process questionnaire to explore the changes that take place around a "critical session" by analyzing the therapeutic relationship and the conjoint processes before, during, and after such a crucial session. Data will be collected on the specific techniques and behaviors manifested by the therapist in his or her attempt to influence the client and on the client's attempt to gain aid from the therapist. This study will also examine the reciprocal impact that both client and therapist exert upon one another at the point when this impact becomes most amenable to observation due to the heightened intensity of the therapeutic relationship. The value of this research is best demonstrated by the production of data about a specific situation in psychotherapy judged by many therapists to be of great importance in the process and which analyzes the specific behaviors of both the therapist and the client.

Review of the Literature on the Nature of a "Critical Session"

While "critical sessions" in psychotherapy have often been described, they are most often employed by the writers as "clinical vignettes to concretely depict some specific point. Rarely does the literature on psychotherapy theories offer references to "critical sessions" or critical incidents as they relate to the

process of therapy. Even sparser, are references to their relation to the basic constructs of any of the schools of psychotherapy. A few theorists refer to critical incidents in passing, but most make no specific mention of such occurrences and their place in the progress of the therapeutic relationship; some allude to the notion of critical situations, and only one set of authors actually describes in theoretical terms the various facets of a "critical session."

Several writers have specifically referenced critical incidents in their descriptions of individual case reports. Frankl (1959) describes a critical incident as the relationship between the therapist and the client growing into a fully human encounter which was not merely an emotional one but a totally existential relationship between two persons. According to Frankl, it is the point at which the therapist and the client become two partners. Snyder (1959) says that the realization that one is the recipient of a deep and sincere "love" has been demonstrated many times to be an experience that is entirely capable of modifying one's lifestyle. Finally, Sorokin (1959) describes the critical point as the moment when the therapist shows "real concern, friendship, or altruistic love" and the patient becomes "convinced of this" and feels it "with his total personality." While they point in a definite direction

these brief descriptions of a critical incident or "critical session" seem either too vague, too general, or too simplistic to explain fully the nature of the events and the changes in the process. However indefinite, these scant passages are some of the best descriptions available in the theoretical literature concerning "critical sessions."

Only in a hypothetical manner can the main aspects of a "critical session" be derived from the literature. In terms of psychoanalysis, a "critical session" may be one in which the therapist interprets some resistance to the client, who responds by revealing the relation of that particular resistance to a deeply-rooted problem in his personality or connects it to some central id impulse seeking discharge.

Such an interpretation might include Greenson's (1967) method of confronting resistance in a patient, especially a resistance emanating from the patient's transference. The result of such an interpretation might be a deeper exploration of the patient's personality and problems in which the patient becomes both experimentally and behaviorally more cooperative in examinaing these newly uncovered dimensions of himself. Such cooperative enterprise could also entail a feeling of closeness and involvement on the part of the patient and the therapist. Similarly, a therapist's interpretation

of a major portion of the patient's transference feelings may combine with a re-orientation toward reality regarding who the therapist really is and toward whom the transference feelings and behaviors are actually directed. This may also bring about a similar result of cooperation and closeness in the analytic setting.

It is also possible that either interpretation may not bring about these positive feelings in the client during a "critical session," that the result may be negative or neutral feelings on the part of the patient. However, for the psychoanalytic model the essence of a critical incident seems to rely on some dramatic change in the patient's behavior, emotions, or cognitive structure. Since an interpretation of resistance or transference is the major tool of analysis, it is logical to hypothesize that the therapist would have the greatest probability of effecting a major change in both the therapeutic relationship and the process of therapy, which is the key assumption underlying the concept of a "critical session." It must be empahsized, however, that no published empirical evidence yet exists to either verify or disprove this key notion, so this entire theoretical construct derived from the psychoanalytic literature must be viewed as a hypothesis.

Although far from the psychoanalytic model and using very different terminology, Carkhuff and Berenson (1967)

describe essentially the same phenomena as those above, when writing on the use of confrontation in psychotherapy. They state that no real progress can be made in therapy until the therapist confronts the client on the maladaptive behaviors and the inappropriate feelings he expresses in the therapy session. While the terms they employ are different than the psychoanalytic terms, the concept of interpretation of resistance and transference as having a major impact upon the process of psychotherapy and the relationship between the therapist and client is clear. Their ideas seem to closely parallel Greenson's constructs in that the personality and the problems of the client can only be fully explored if the resistances and transferences are interpreted, or as Carkhuff and Berenson put it, are confronted directly. The occurrence of such a confrontation could be conceived of as a "critical session," since it fits in well theoretically with the key assumption of a "critical session."

For the client-centered approach, a "critical session" could theoretically be a time when the therapist fully understands some important segment of the client's present experience in the session. The therapist would have to be able to communicate this understanding and his own experience completely to the client, within Rogers' (1961) framework of empathy, genuineness,

and nonpossessive warmth (or unconditional positive regard). Once the client, in turn, is able to experience the therapist's understanding of him and the therapist's own present experience within the Rogers framework, then a mutuality of experience would simultaneously create a bond of closeness between the two and alter the client's experience of the therapeutic situation and the therapist more towards reality.

For this alteration to happen, Rogers (1961) stresses the essentiality of congruence in the therapist's feelings and behavior. This end product of mutuality is accomplished in this model of psychotherapy not by interpretation, but by the ability of the therapist to understand and accept the client fully, to express this understanding and the other necessary therapeutic conditions in a genuine manner, and for the client to accept the therapist's understanding and caring as real. If all this can be achieved, the process of therapy can truly proceed toward healing, for the relationship between the client and therapist has changed toward one of greater cooperation based upon mutual caring and closeness. Such an occurrence in the client-centered framework qualifies as a "critical incident" or "turning point".

The theories of existential psychotherapy would proceed in a manner somewhat similar to the client-centered approach. May's (1958) conception of human

existence postulates that once the therapist, through his therapeutic experience with the client, can aid the client to accept his own sense of being, the relationship between the client and the therapist changes as does the process of therapy. The result is in essence Frankl's (1959) description of a critical incident, because it would constitute a fully human encounter forming a totally existential relationship between the two persons.

The only empirically based findings which add to the theoretical framework are contained in the studies by Auerbach and Luborsky (1968), and Orlinsky and Howard (1967). Both are concerned with the "good hour." Are the components that constitute a "good hour" essentially the same as those of a "critical session?" The argument can be made that the variables are more intensely manifested during the latter. When the variables of the "good hour" are extrapolated to the extreme of a "critical session," they may change qualitatively as well as quantitatively. However, this is a reasonable theoretical approach that can be tentatively maintained until empirical research can demonstrate its validity or falsity.

Since these two studies were reported upon earlier, only the hypothetical extrapolations will be discussed here: active participation by the therapist; accurate

and effective response by the therapist to the client's verbalizations, which means accuracy in interpretation; therapist's affective involvement and his expression of warmth and acceptance; the exploration by the client of intimate interpersonal relationships and self-experience; and the successful cooperation of both persons in attaining significant insights and resolving emotional conflicts for the client. Much of the empirical data collected by these two sets of researchers fits well with the "critical session" concepts of (1) significant interpretations or confrontations by the therapist followed by (2) a feeling of goodwill, and by (3) a mutual collaboration in further exploring the client's personality and conflicts.

By far the most comprehensive and elucidating theoretical work concerning critical incidents and "critical sessions" in psychotherapy has been written by Kell and Mueller (1966). They begin their discussion of critical incidents by describing some of the variables that precede such incidences. They explain,

> "When the client begins to experience some of the feelings that he has defended against, his projections, accusations, and anxiety may substantially increase. The counselor must recognize that the increased client agitation is a critical incident along the path of the client's changing, and that the clients' awareness of disorganizing feelings is precipitating the client's responses . . . . The counselor [must keep] in mind that . . . his participation in the relationship is precisely to trigger this type of response pattern and that this is a necessary antecendent to client change" (p. 8).

Kell and Mueller feel that rising anxiety and agitation in the client are the signs that a critical incident is about to occur. Obviously, therapy process has uncovered material closer and closer to the client's basic conflicts that causes such anxiety. They see a "critical session" not as an isolated event, but rather as a culmination of a chain of events triggered off by the continuing exploration of the client's personality and defenses. The client's desire for help and change becomes balanced by his resistances to the loss of his defenses and the uncovering of anxiety-producing material. Kell and Mueller state,

> "The client's eliciting behaviors continue to have both facilitating and impeding effects on the counseling relationship throughout its course . . . critical incidents will occur at those points where the counselor is confronted with the client's contradictory intent to destroy the relationship" (p. 9).

They continue,

> "The budding signs of defensive resistance in a client create critical incidents in the counseling relationship since these are the moments in the process when the client's defenses and conflicts are most likely to be activated . . . Resistance will substantially increase as the client's defenses are weakened, and the basic conflicts begin to rise to the surface" (pp. 14-15).

The resistance of the client increases as the impact and import of the therapeutic relationship increases for the client. When the intensity of the therapist-client

relationship peaks, a critical incident or "critical session" occurs because the transference and resistance of the client have also increased. These must be confronted by the therapist if therapeutic progress is to follow. Kell and Mueller explain,

> "When the relationship reaches high intensity . . . the client is most vulnerable; for the intensity reflects the significance of the relationship. Whether change occurs in a client is a function of how well the participants surmount the critical incidents that arise when the relationship has reached this level . . . At those decisive times where the counseling relationship is intense and the client's confrontation reaches into the depths of his conflicts, we have noted not only that a client's conflicts are most active and clear, but that the conflicts are experienced and expressed in a compressed way." (p. 33)

Implicit in their statement is the need for the therapist to interpret the client's transference and resistance, or confront him with his inappropriate or maladaptive behaviors and affects. Without such a move from the therapist, the client will continue to experience his conflicts in "a compressed way" and have his anxiety heightened even further by his lack of understanding of what his actions and emotions are and what they mean. Only insight prompted by the actions of the therapist will enable the client to achieve some measure of assurance and control over his emotional experiences in therapy, so that he can continue to work cooperatively with the therapist in further explorations of these

conflict-laden areas. The maintenance of trust in the therapist is an important ingredient if therapy is to progress.

Mueller (1974) also sees several other results emanating out of a "critical session." There will be some changes in the client's perceptions of the therapist, the client will accept the therapist as a more caring person, and some of the client's distortions in his view of the therapist and in his world view will be corrected if the therapist handles the "critical session" in a direct and proper manner.

Mueller postulates a number of effects that will occur in the therapy sessions following a "critical session": the client will experiment more with the behavior worked on or with a living out of the conflict, the client will be able to approach the conflict with greater ego strength than previously, the client will achieve insight faster concerning the emotional conditions surrounding the conflict, the client will experience more freedom to become anxious and as a result will bring up more anxiety-provoking material about the conflict, the client will produce more symbolism about the conflict and the client will report more problems about that conflict as a result of working on it on a deeper level. Mueller claims, however, that there may also be some negative side-effects following a "critical session."

The client may feel guilty, anxious, or depressed as a result of confronting the conflict. Termination of therapy by the client might even occur if his anxiety becomes too diffuse to focus on that conflict again or if he is not willing to face that much anxiety again. All of these theoretical considerations are based upon Mueller's clinical experience, and as with the other theoretical formulations, it needs empirical verification.

Theoretical Definition of a "Critical Session"

A general theoretical definition can be composed for a "critical session." It appears to be the appropriately timed interpretation or confrontation by the therapist concerning a significant set of behaviors, feelings, and cognitive perceptions of the client. The client must eventually in the session be receptive to the offered interpretation, with the result being a mutual feeling of closeness and comradeship leading to further deep explorations into the client's personality or central conflicts. In addition, the client must feel understood and accepted by the therapist as a precondition for further progress in therapy. The client will leave the session having felt some significant emotional impact, having had some major cognitive reorganization, and having perceived the therapist in a more realistic manner. As a result both the therapeutic relationship and the process of psychotherapy will have undergone a major change.

METHOD

The main purpose of this study was to identify "critical sessions" in individual adult psychotherapy, and to measure the relationships between the effects of these sessions and the affective states of the clients empirically. The theoretical definition for a "critical session" includes the criteria that the client will have felt some significant emotional impact, and that this emotional impact is the affective basis required for the exploration of the client's central conflicts, his or her cognitive realizations, and his or her new perceptions. Thus, examining the degree of this emotional impact should provide an important measure of the change in the therapeutic process. It is intended that the measurement of the presence and intensity of client affect before, during, and after such a "critical session" will provide insight into the way in which the target session has changed the therapeutic relationship from the client's perspective.

Operational Definition of a "Critical Session"

Implicit in the theoretical definition for a "critical session" are the requirements that some of the client's central conflicts had been confronted and explored during the session; that the therapist and client achieved a mutual

feeling of closeness; and that the client had experienced some significant emotional impact, achieved some major cognitive reorganization, and perceived the therapist in a more realistic manner. Obviously, it was necessary to translate this general theoretical definition into an operational definition suitable for an empirical study.

Because neither the research nor theoretical literature defines a "critical session" in operational terms, such a definition had to be created. A survey of experienced psychotherapists provided this definition. They were asked what variables might constitute a "critical session" in individual adult psychotherapy. For the purposes of this survey an experienced psychotherapist was defined as a person who has had at least two years of experience performing individual psychotherapy with adults after either earning a doctoral degree in psychology or finishing a residency in psychiatry.

A preliminary interview survey of five experienced psychotherapists at Michigan State University provided the variables which were included in this survey, called the Psychotherapist Survey Questionnaire (PSQ). All variables were operationalized and then listed in the PSQ under an introductory statement on the theoretical conception of a "critical session." This questionnaire was sent to 62 experienced therapists across the United States. The variables chosen by the respondents to be of greatest

importance during a "critical session" were used in formulating the final operational definition for a "critical session." The results of this survey and the process by which these results were converted into an operational definition for a "critical session" will be found in the Results section (pp. 49-54).

Hypotheses

General Hypothesis. It is hypothesized that there is a relationship between therapy sessions clients identify as "critical" and the degree to which the client's central conflicts have been confronted and explored, the therapist and the client have achieved a feeling of closeness, the client has experienced some significant emotional impact, the client has achieved some major cognitive reordering, and the client has perceived the therapist in a more realistic manner.

Two specific hypotheses follow the preceding general hypothesis.*

Hypothesis 1. That there will occur a change in the client's report of his or her affect from the session immediately preceding a "critical session" to the session immediately following a "critical session," with that change being measurable by the Multiple Affect Adjective Check List ($p \leq .05$). It is predicted that these statisti-

*For the purpose of setting forth the hypotheses, the term "critical session" will be used to indicate the session under study.

cally significant differences will occur over the three indicated sessions for each of the following subscales of the MAACL: (a) Anxiety scale, (b) Depression scale, (c) Hostility scale.

No prediction is hypothesized regarding direction of change in these subscales. Available theory concerning the nature of a "critical session," its effects upon the process of therapy, and the affective state of the client does not sufficiently permit meaningful predictions. In fact, current clinical theory is so ambiguous concerning the expectable effects of a "critical session" that speculation about the possibilities can cover a wide range:

(1) Expression of affect by a client during a "critical session" involving a central conflict might increase the client's anxiety. On the other hand, the fact that the client has been able to express some of the affect involved in that conflict may also alleviate some of the anxiety that was previously connected with the suppression of that conflict. Consequently, it seems equally justifiable to predict a change in either direction on the client's score on the Anxiety scale of the MAACL following a "critical session."

(2) As the client begins to face his or her conflicts and the suppressed emotions surrounding them, the affects measured by the Depression scale of the MAACL may decrease. Here, too, the opposite could

occur, if the client's reactions or resistances to dealing with the conflict and affects precipitated in the "critical session" involve an increase in the affects in the MAACL Depression scale.

(3) The nature of a "critical session" may cause the client to feel a sense of warmth and closeness toward the therapist, with a resulting decrease in client hostility. The client's central conflict, however, may involve the expression of hostility which serves to increase the client's score on the Hostility scale of the MAACL. In addition, the client's ambivalence over directly facing these affects and conflicts may activate and add impetus to the client's psychological defenses against the feelings of warmth and closeness with the therapist. This ambivalence can result in an increase in expressions of withdrawal or hostility, or of both these defensive reactions by the client.

In light of these theoretical considerations, the most reasonable course appeared to have been to leave the directionality of the predicted changes open.

A cross-check on the client's reports of his or her affects and on the process of therapy was made to provide increased further data for examination in this study. The therapist in each dyad completed the MAACL from the point of view of the client. Consequently, an independent

judgment of the client's affects was made by an observer who was trained to make such observations and judgments. This cross-check forms the basis of a second hypothesis, conceptually parallel to the first.

Hypothesis 2. That there will occur a change in the therapist's report on a client's experienced affects from the session immediately preceding a "critical session" to the session immediately following a "critical session," with that change being measureable by the Multiple Affect Adjective Check List ($p \leq .05$). It is predicted that these statistically significant differences will occur over the three indicated sessions for each of the following sub-scales of the MAACL: (a) Anxiety scale, (b) Depression scale, and (c) Hostility scale.

Subjects and Settings

The subjects to be analyzed in this study were ten adults in individual psychotherapy who each formed dyads with practicing therapists. These therapists agreed to participate in this research without compensation. The clients and therapists were selected from the Michigan State University Counseling Center, the Grand Blanc Mental Health Services outpatient clinic in Flint, Michigan, the Beth Moser Mental Health Clinic in Jackson, Michigan, and from therapists in private practice in Michigan. The sessions took place in the offices of these therapists.

Clients under 18 years of age or who were judged by their therapists to be psychotic, schizophrenic, psychopathic, or sociopathic, or who were not in individual psychotherapy with a single therapist were excluded from the subject pool. Therapists who had less than two years of full-time work experience in psychotherapy since completing either a doctorate in psychology, a residency in psychiatry, or a masters' degree in social work were eliminated from the subject sample for this study. Therapists who practice any type of verbal psychotherapy except those who performed behavior modification were eligible for this study.

The sample size was too small to provide useful statistical inferences based on demographic variables. The collected demographic data is presented in Appendix L.

Instruments

The following measuring instruments were used in this study:

1. Background Questionnaires (see Appendices B and C). Two forms of this questionnaire were designed for this study, one for the client and one for the therapist. The client form gathered basic demographic information concerning the client and data describing past and present experiences with psychotherapy. The therapist form collected personal information about the therapist and data relevant to his or her role as a therapist. Each

person completed his or her own form.

2. Psychotherapist Survey Questionnaire (see Appendix A). This questionnaire evolved from the informal interview survey of psychotherapists at Michigan State University (see Results section, p. 48-49). It was distributed by mail to 62 experienced psychotherapists in the United States, and was designed to elicit from them opinions about the importance of various terms used to describe a "critical session." The Psychotherapist Survey Questionnaire (PSQ) consisted of an introductory statement describing a general theoretical conception of the "critical session," a list of eleven variables with rating scales for marking importance for a "critical session," and a space for adding another variable to the list and rating its importance. An extra page was included for describing a "critical session" if the respondent disagreed with the initial theoretical statement.

3. "Critical Session" Questionnaire (see Appendices D and E). This instrument was developed specifically for this study. Its purpose was to identify "critical sessions" as defined by the operational definition. The results of this questionnaire can be found in the Results section, (pp. 54 - 57). Statistical analysis yielded three items that the respondents to the PSQ chose as being most important to a "critical session." These three PSQ items were:

VI. Some conflict that the client has been dealing with in a less direct or less affect-laden manner gets confronted directly.

IX. Some material that the client was previously unaware of is brought into the client's awareness in a way that is useful to him or her.

X. Some cognitive reordering occurs in the client so that he perceives the therapy situation, himself, the therapeutic relationship, or his world view in a different way; some important insight is obtained.

These three PSQ items were formed into seven items in the CSQ in the following manner. Item VI of the PSQ became CSQ client form items 3 and 4:

3. During this session, were you able to talk about one of your main problems directly?

4. During this session, did you express any emotional feelings concerning one of your main problems?

CSQ item 3 addresses the part of PSQ item VI which involves whether one of the client's conflicts had been dealt with in a direct manner. Item 4 of the CSQ expresses the component of PSQ item VI which deals with an increase in the affect involved with one of the client's conflicts. Because many clients do not know or understand the esoteric meaning of "conflict" as used by therapists, this word was changed to "main problem." Although the terms "conflict" and "main problem" may not have been identical in meaning, it was felt that the latter term was the best substitute for the former that could be used with clients

naive in the area of psychotherapy. It was also felt that if the client expressed a great deal of affect about something which he or she thought of as a central problem, then the main elements of this variable had been addressed.

Item IX of the PSQ became item 5 of the CSQ:

5. During this session, did you learn any new and important things about yourself which you will be able to use?

The idea of bringing material into the client's awareness contained in PSQ item IX is expressed by the terms "learn" and "new" in CSQ item 5. The idea of usefulness from PSQ item IX is stated directly in CSQ item 5 and is heightened by the term "important."

PSQ item X was converted into four items in the CSQ, 6, 7, 8, and 9:

As a result of the session you have just completed, how do you view the following?

6. Yourself
7. The course of your therapy
8. Your personal environment
9. Your therapist

In all these translations it was believed that any theoretical language should be transformed into language a layman could more easily understand. "Cognitive Reordering" was changed to the client's "view," since a change in one's reported perspective appeared to be the best and most clearly reportable substitute for the former term.

It was assumed that one's verbalized view of particular events or persons (such as the therapist) reflects what one thinks about or how one conceives of those events or persons. Because absolute precision in substituting concrete terms for abstract ones is likely to be impossible, it was hoped that a clearly understood term such as "view" would provide clients more useful information than the more accurate but also more esoteric term "cognitive reordering." Similarly, the term "the therapy situation" became "the course of your therapy," "himself" became "yourself," "the therapeutic relationship" became "your therapist," and "his world view" became "your personal environment."

The therapist form of the CSQ contained the same items as the client form, except for wording designed to elicit the therapist's viewpoint. The therapist rated the client on these items listed above.

Two additional items from the CSQ were included in the core criteria for a "critical session." These are items 1 and 2. Item 1 dealt with the client's feelings about how "good" the session had been. Item 2 sought to determine if the client felt the session had brought him closer to his goals for himself in therapy. It was assumed that the theoretical definition clearly contains both the idea of having a good session and of making substantial progress towards one's goals in therapy as necessary occur-

rences before the client could feel that the other elements composing a "critical session" had occurred. It was assumed that a "critical session" could not occur if the client felt that the session had been "bad" or that no progress had been made toward his or her therapeutic goals. It appeared clear that these two variables would be necessary concommitants to the other variables and would be present in any session chosen as "critical," so these items were included in the CSQ.

In addition, four free response questions designed to gather further data on the session by having the client use his or her own words were included in the client form of the CSQ. It was assumed that the design of the CSQ gave it face validity for identifying "critical sessions."

4. Therapy Session Report (see Appendices H and I). This questionnaire (Orlinsky and Howard, 1966b) was administered in separate corresponding forms to both client and therapist immediately after each therapy session over consecutive meetings in order to examine the process of therapy.

The Therapy Session Report (TSR) covers a wide range of possible problems that might be experienced and discussed by the patient (Orlinsky, Howard, and Hill, 1970). The concerns of the patient surveyed by the TSR were taken from Erikson's (1950, 1959) formulations of the nuclear ego-conflicts comprising the content of the psychosocial crises in eight stages of the life cycle, and from

Sullivan's (1953) developmental scheme. In addition, the developers of the TSR used their own clinical experience, professional consultation, and pilot data to make the questionnaire as widely applicable as possible. They similarly attempted to cover a wide range of therapist responses and initiatives in relation to these patient concerns.

In their report on TSR's development, Orlinsky and Howard (1967 a) say the TSR attempts to cover the following facets of therapy experience:

> (1) the topical content of the dialogue, as established by the patient in each session; (2) the nature of the relationship as reflected in the patient's and therapist's manner of relating to each other; (3) the joint affective process, as embodied in the feelings experienced by patient and therapist during the session; (4) the exchange process, including the patient's wants, the therapist's goals and the types of satisfaction contained in the patient-therapist interaction; and (5) the development of the therapy session as an interpersonal act having its inception in the motivation of each participant, its implementation in their role performance, and its consummation in the greater or lesser realization of their goals.

Orlinsky and Howard performed their major testing of the TSR in their Psychotherapy Session Project (1966 a). They administered this instrument to 188 non-psychotic female patients who completed it for a range of 5 - 66 consecutive outpatient sessions of individual therapy. The 27 therapists, of whom 18 were male and nine were female, completed questionnaires on from 5 - 64 sessions for from 1 - 15 different patients. The therapists were from all the professions engaged in psychotherapy, had a median experience level of six years, and were "generally dynamic-eclectic" in their orientation. From the data collected in this major undertaking an extensive set of analyses were performed in order to both validate the TSR as an instrument and to provide information on the process and content of psychotherapy.

Orlinsky, Howard, and Hill (1970) reported the problematic concerns of the patients within their project and analyzed these into seven factors that are differentiated by the TSR. In addition, they related the data associated with these factors as measured by the TSR to prevalence of patients' problematic concerns, correlation of therapists' impressions of patients' concerns with listed patients' concerns, relation of patients' concerns, relation of patients' concerns to the developmental theories of Erikson and Sullivan, and to the extent that patterns of concerns reflected stable

individual differences in contrast to session by session variation. These same researchers in another study (Howard, Orlinsky, and Hill, 1969) again utilized their empirically collected data on the TSR to examine the frequency of different topics discussed by patients in psychotherapy, the major themes of these dialogues, individual differences, and agreement between patient's and therapist's report of the dialogue. Using this same data for a third study, Howard, Orlinsky, and Hill (1970) analyzed TSR results to explore typical feelings of patients and therapists during a session, the major dimensions of affective experience in therapy, agreement between the participants in their perceptions of each other's feelings, and the relationship between feelings and conscious problematic concerns. Finally, Orlinsky and Howard (1967 b) used their TSR research data to analyze the components of the "good therapy hour."

The TSR has been expanded for use in this study, and its main body of items has been slightly modified to facilitate the examination of the content and processes of psychotherapy in relation to the concept of "critical sessions." These changes have been designed to identify which of the items in certain sections of the TSR were most important in that session. This identification has been accomplished in the following manner for the client form: (1) Added to the end of the section entitled, "During

this session I talked about:" has been the sentence, "Put a check (✓) in front of the subject from the above list (items 2 - 21) that you talked about most during the session," and (2) Added to the end of the section entitled, "I feel that I got:" has been the sentence, "Put a check (✓) in front of the item from the above list (items 42 - 60) that best describes what you got most out of this session." The same additions have been made to the therapist form using the therapist's perspective. The client and the therapist forms of the TSR are presented respectively in Appendices H and I.

The additional items that were included in the TSR were presumed to measure specific variables postulated as being present in "critical sessions" by the theoretical definition. These TSR items were: 56, 57, 58, 59, 60, 69, 70, 71, 72. The additions were made to both client and therapist forms using their respective perspectives.

5. Multiple Affect Adjective Check List (see Appendices F and G). This questionnaire consisted of 132 items which composed three scales: Anxiety (A) scale, Depression (D) scale, and Hostility (H) scale. The MAACL had the advantage of being easy to understand and administer; the subject simply checked off which of the listed affects applied to him or her in the time period specified in the instructions. This check list was used to provide the quantitative data for determining the differences in the expressed affect of the client between the session preceding and the session

following a "critical session." For the purposes of this study, an instruction to circle the one feeling that the client felt most during the session has been added to the MAACL.

The MAACL is a well-researched instrument. Its reliability and validity have been repeatedly tested. The present instrument began as the Affect Adjective Check List (AACL) and was developed by Zuckerman (1960). After empirical testing, two separate item analyses were performed by Persky, Maroc, Conrad, and DenBreeijen (1959) and by Levitt, DenBreeijen, and Persky (1960). Zuckerman (1960) also reported on the original reliability and validity studies that were done leading to the final development of the Anxiety scale.

Zuckerman and his associates later modified the AACL to become the MAACL. Zuckerman and Lubin (1965) determined population norms for the MAACL by selecting 200 normal subjects from a pool of 1200 job applicants and stratifying these 200 subjects by age, sex, and education to match the 1960 census distribution of these variables. In their research they found significant differences at the $p \leq .05$ level between this normal group and 259 psychiatric patients for all three scales (A, D, and H).

Several validity and reliability studies have been performed on the MAACL. Zuckerman, Lubin, and Robins (1965) administered the MAACL to 266 patients in five

psychiatric hospitals and to 275 normal subjects. They reported that "Most of the patient samples were significantly higher than the normal samples on the A and D scales," and it was added, with less consistent results on the H scale. They also found that "Education, age, and intelligence were not related to MAACL scales in the patient samples." No sex differences were found in the normal sample. In two samples of subjects ratings of observed anxiety and hostility were "significantly related" to MAACL A and H scale scores respectively. They further reported that "Both retest and split-half reliabilities were high for A and D scales in a patient sample; only the retest reliability was high for the H scale . . . The MAACL scales tended to correlate positively and significantly with the D, Pa, Sc, and Hs scales of the MMPI." More recently, Bloom and Brady (1968) correlated MAACL scale scores with both clinical ratings on anxiety, depression, and hostility performed by psychiatric residents and with Beck's Depression Inventory on 82 female and 18 male patients one day after admission to a psychiatric hospital. They found that the D scale had an r=.66 correlation with the results from the Depression Inventory, with a high level of statistical significance ($p \leq .001$). Using a chi square analysis, Bloom and Brady also analyzed the D scale as being related to the clinical ratings ($p \leq .005$). These results lend content validity to the D scale of the MAACL.

Two studies demonstrated high reliability for the MAACL. Zuckerman, Lubin, Vogel, and Valerius (1964) administered the MAACL three times over a period of three weeks to 46 normal college students in order to obtain some base-line data. They obtained Spearman-Brown reliability coefficients of r=.79 for the A scale, r=.92 for the D scale, and r=.90 for the H scale, with all of these results being significant ($p<.01$). Herron (1969) reported reliability coefficients of from r=.64 to r=.82 for the total MAACL over three administrations over a four week period using 33 normal college students, indicating a high degree of at least short-term stability. These researches have suggested that the MAACL is both a valid and a reliable instrument for measuring affect, making it suitable for measuring the dependent variable in this study.

Procedure

This study used ten client-therapist pairs with each pair permitted to contribute only one ten session set. An effort was made to have half of the dyads begin therapy concurrently with the research, while the remainder entered the study after having completed ten or more sessions. Neither clients nor therapists were informed of the specific nature of the study. Therapists who volunteered for participation in this study chose from among their caseload one client who fulfilled the requirements of this

study (see Appendix J). All participating clients and therapists completed their respective forms of the Background Questionnaire. These data are presented in Appendix C.

At the end of each of the sessions encompassed in this study both the client and the therapist completed the "Critical Session" Questionnaire, and the Therapy Session Report, and the Multiple Affect Adjective Check List. All these instruments were completed by the participants from their own individual points of view, except for the therapists who completed the Multiple Affect Adjective Check List as if they were the particular client with whom they had just finished the session.

Selection of an Operationally Defined "Critical Session" for Analysis

The items which were judged by most experienced therapists to be of greatest importance in "critical sessions" on the PSQ formed the core criteria for determining that a particular therapy session was a "critical session." The procedure for selecting "critical sessions" was as follows.

The "Critical Session" Questionnaire was the sole instrument used for measuring the variables chosen as important by the surveyed psychotherapists. The client's ratings on CSQ items 1 through 9 were used in selecting "critical sessions." For each of the therapy pairs the

session which exhibited the highest median score for the client's ratings on items 1 - 9 of the CSQ and in which at least seven of the nine scores were greater than or equal to +2 was operationally defined as a "critical session."

Of the ten subject dyads, at least five had to contain an operationally defined "critical session" because this was the minimum number with which a statistical analysis could have been useful. Eight of the dyads met the criteria of the operational definition for a "critical session."

Statistical Procedures

A three-way analysis of variance was performed upon the data obtained from each of the subscales of the MAACL for each dyad. Statistical significance was determined using a one-tailed test ($p \leq .05$). Sessions preceding and following the "critical sessions" were compared with each other and with the "critical sessions." These three types of sessions were also compared with three consecutive randomly selected sessions from each of the dyads which showed "critical sessions." These randomly selected sessions served as controls.

In addition, the TSR results were examined in an exploratory manner in order to determine if there were any other relationships to be found among the various

dimensions outlined in the theoretical definition for a "critical session." Three items selected on an a priori basis from the TSR which specifically related to the theoretical definition (items 49, 56, and 59) were statistically analyzed using a three-way analysis of variance. This examination was predominantly aimed at uncovering some of the components present in "critical sessions" in an exploratory way; a greater number of TSR items would have been subjected to statistical analysis had any significant findings ($p \leq .05$) emerged in the results of the statistical analyses of the first three TSR items.

RESULTS

The object of this study was to identify and examine "critical sessions" occurring in the process of psychotherapy. Because neither the research nor theoretical literature contained an operational definition for a "critical session," such a definition had to be created. The operational definition for a "critical session" was constructed by: (1) using an informal survey to collect data on the nature of "critical sessions," (2) using this data to formulate the items on the PSQ, (3) sending the PSQ to 62 experienced psychotherapists, and (4) using the data collected from the 46 respondents to the PSQ to choose variables for inclusion in the CSQ.

Results of interviews with five psychotherapists (with at least ten years of experience), which consisted of the therapists' reactions to the concept of "turning points" and "most important sessions", became the cornerstone of this study. Four of the five felt that "critical sessions" as described to them do exist. One therapist felt that all sessions were equally important, and that there were no "turning points" in therapy. The four therapists who gave a positive response were asked to describe the processes occurring during a "critical session." All of the processes described by

these four therapists were converted into PSQ items I through XI (see Appendix A). The wordings of these therapists were kept intact as much as possible.

The PSQ was sent to 62 experienced therapists and researchers throughout the United States in order to obtain their views on what variables and processes might be present in a "critical session" (i.e., if they agreed that such sessions exist). For the purposes of this survey an experienced psychotherapist was defined as someone who has had at least two years of experience in individual psychotherapy with adults after having earned a doctorate in psychology or having finished a residency in psychiatry. In addition, actively publishing researchers in the field of psychotherapy who also practiced therapy were chosen to be part of the survey regardless of length of experience. It was felt that experienced persons in both of these areas would have knowledgeable viewpoints concerning psychotherapy and would be able to provide construct validity to the information collected based upon their expertise. The only group eliminated from potential respondents because of their theoretical viewpoints were those who practiced behavior modification.

The response rate to the PSQ survey was high; 52 of 62 (84%) responded. Forty-six persons (88%) responded to Part 1, including 40 psychologists and six psychiatrists.

Together they had a mean experience level of 14.4 years. Six additional persons (12%) chose to respond to Part 2, rejecting the idea of "critical sessions." Of the ten who did not respond three persons were deceased and seven chose not to respond for unknown reasons.

The median rather than the mean was employed for each set of responses to a PSQ item to eliminate the effects of extreme responses. The medians for the responses to the items in Part 1 of the PSQ were as follows:

PSQ Question No.	Median
X	8.0
IX	8.0
VI	8.0
I	5.5
IV	5.0
III	5.0
VII	4.0
II	3.0
XI	2.0
VIII	2.0
V	0.0

The medians for only three of the items, VI, IX, and X, fell within the range of "extremely important" for a "critical session." A one-tail t-test performed on the

PSQ responses revealed a highly significant difference ($p<.0005$) between the responses for items VI, IX, and X and the PSQ responses as a whole.

The PSQ results also yielded a number of ideas and concepts concerning the nature of "critical sessions" from the 46 respondents to Part 1. Item XII was an optional item consisting of a free response along with a rating of its importance. Ten of the respondents to Part 1 completed this item. Their responses and ratings for item XII were as follows:

"There is a shift in how the whole thing feels. +10"

"Thematic flow - experiential flow enhanced; greater depth in experiencing, peak experience in session. + 10"

"The client experiences greater self confidence, power, feels he can be in charge of his life. +10"

"Client is willing to face the problem more directly and take the initiative. +5"

"The client experiences, acceptantly* (*as a part of himself which he can accept), a feeling previously denied to awareness. +10"

"Therapist's perception of client is changed; new insights and understandings about client is felt by the therapist. +10"

"The client's trust of the therapist increases significantly (which provides him with the willingness to expose himself to greater anxiety). +10"

"The client recognizes his mortality and finiteness. +8"

"An affective-cognitive realization on the part of both therapist and client that somehow rearranges the pieces of the puzzle in a new way, that is both freeing and challenges the client to further self discovery. +10"

"Previous insights merge and heighten the potential for behavior change. +10"

While most responses to item XII indicated that a change of some sort takes place in the client, as can be seen, the opinions on the nature of this change vary widely. Some of these responses also focused on changes in the therapist or client's feelings toward the therapist. Because there was so little correspondence among these free responses, none was included in the CSQ. These ideas were noted, however, and are examined in more detail in the Discussion section.

Six respondents rejected the concept of "critical sessions," and listed their explanations in Part 2 of the PSQ. The reasons, summarized in the language used by the respondents are as follows:

(1) Sessions that were seen as "critical" or "very important" at the time of the occurrence of the session may not seem so at a later time; sessions that seemed no different in their importance at the time may be judged to have been significant at a later time. What may appear significant may not be; what may appear not crucial may be.

(2) Often the most crucial session is the first one, even though very little may appear to occur.

(3) What are described as "critical sessions" in the PSQ introduction may only be "summative" sessions, in which the important processes which led to these

sessions are only recognized or verbalized in a more intense or climactic manner. The more crucial processes, content matter, or events may have taken place in less dramatic "formative" sessions which are preparation for these "summative" sessions.

(4) Part 1 of the PSQ did not cover the full range of processes which are necessary to client change and "critical sessions" as described do not cover the crucial processes of therapy. Merely experiencing feelings with a caring therapist is not sufficient; the client, to progress, must acknowledge these feelings, bear them, overcome his or her defenses, and put these feelings in perspective with the rest of life. While a "critical session" may help to accomplish this, it is only one step in the full process.

(5) Much of the "therapeutic work" goes on between sessions, with this work possibly being more important than the work within interviews.

(6) There may be a number of "important" sessions which contribute to therapeutic progress, rather than a single "critical session."

One respondent to Part 2 did not disagree with the definition of a "critical session," but felt that he could not respond to the choices in Part 1 because they had not been made in terms of a particular presenting problem of a particular client. He felt that the "general"

case did not get at the issues involved.

Ten client-therapist dyads participated in this experiment and completed the CSQ, the MAACL and the TSR after each of ten consecutive sessions. A dyad was considered to have had a "critical session" if: (1) there was a single greatest median in the positive direction for the client's scores on the nine variables of the CSQ for a single session, and (2) the scores of at least seven of the nine variables in this single highest session were equal to or greater than +2.

Eight dyads were determined to have had a "critical session" by this method, while two did not. The results of the data derived from the CSQ are presented in Table 1.

A t-test was used to compare the distribution of the medians for all the scores on the CSQ with the distribution of the medians for the eight identified "critical sessions." A one-tail t-test demonstrated that the sample medians differed from the population medians at a highly significant level, $t(100) = 9.881$, $p < .0005$. These results indicate that the "critical sessions" identified by the CSQ were, as a group, significantly different than the group of other sessions, including the sessions from the two dyads which did not have a "critical session."

This research was originally designed to provide an approximately equal distribution between beginning of therapy dyads and middle or end of therapy dyads.

TABLE 1

Results of "Critical Session" Questionnaire

(Client Form)

Dyad	No. of Sessions	Median for Client's Scores*	Number of Scores >+2 For "Critical Session"**
S1	10	+ 3.9	8
S2	10	+ 3.0	7
S3	10	+ 4.6	8
S4	10	+ 3.1	9
S5	10	+ 3.1	8
S6	10	+ 3.9	7
S7	10	+ 3.8	9
S8	10	+ 3.8	9

*The scale for each item ranges from -5 to +5. The highest possible median is +5.0.

**There are nine items in the questionnaire making for a maximum of nine scores.

However, because the therapists chose what they felt to be appropriate clients, this equal division was not achieved.

The therapists also chose the session with which to begin participation. They were strongly encouraged to start at either the first session or at some session after the tenth, so the beginning and middle or end of therapy process could be examined. Due to the difficulty of obtaining willing therapists and clients, however, a flexible starting point was eventually permitted. This resulted in a maximum number of participating dyads.

For the ten dyads, the study commenced at the following session numbers: 1, 11, 16, 18, 18, 25, 44, 45, 53, 55. If the beginning phase of therapy can be considered to extend arbitrarily to the 20th session, five dyads fell into this category. The middle or end of therapy range was broadly distributed.

The "critical sessions" identified by this study could not be pinpointed as occurring during one particular phase of therapy (i.e., beginning, middle, or end of therapy). The two client-therapist pairs who did not achieve a "critical session" were the dyads which started at session 18 and session 55. "Critical sessions" were equally divided between the dyads which commenced prior to the 20th session and those which commenced after the 20th session. The eight identified "critical sessions"

appeared at sessions numbered 10, 15, 21, 21, 28, 49, 53, 56. These data are presented in Table 2. The distribution of these "critical sessions" defies even a rough grouping, with no estimate of where "critical sessions" would most likely occur being possible.

The dependent measures selected for this study were the three subscales of the MAACL. A separate three-way analysis of variance was performed for the data collected by each of the three subscales, the Anxiety, Depression, and Hostility scales. Statistically significant results at the $p \leq .05$ level were determined to be necessary in order to reject the null hypothesis. The MAACL data from six sessions of each client-therapist pair were used in the analysis of variance. These six sessions were: the "critical session," the session preceding the "critical session," the session following the "critical session," and three consecutive sessions prior to the "critical session" chosen at random. The three randomly chosen sessions were employed as controls with which to compare changes occurring over the three sessions in the "critical session" grouping to determine whether or not these changes occurred by chance. The three levels examined in the various 3 x 2 x 2 analyses of variance were: (1) the "critical session" grouping of three sessions vs. the "non-critical session" or control grouping of three consecutive sessions; (2) the session

TABLE 2

Starting Sessions and Occurrence of "Critical Sessions" for the Therapy Dyads

Subject Dyad	Session Number When Starting in This Study	Session Number for "Critical Session"
S1	44	48
S2	11	14
S3	16	20
S4	18	20
S5	1	9
S6	25	27
S7	45	48
S8	53	55
S9*	18	--
S10*	55	--

*Dyads S9 and S10 had no operationally defined "critical sessions" occurring during the study period.

preceding the "critical session" vs. the first session of the control grouping (the "before" [B] sessions), the "critical session" vs. the second session of the control grouping (the "target" [T] sessions), and the session following the "critical session" vs. the third session of the control grouping (the "after" [A] sessions); and (3) the clients vs. the therapists.

All three analyses of variance for the subscales of the MAACL failed to produce any significant results for any level or any dimension. The results of the anlayses of variance for the three subscales of the MAACL are presented in Table 3, Table 4, and Table 5. No major differences were found in dependent variables between: (1) the session preceding a "critical session" and the "critical sessions" along any dimensions, (2) the "critical session" and the session following a "critical session," or (3) the "critical session" and a randomly chosen control session.

An additional set of three-way analyses of variances was performed for each of the three items in the Therapy Session Report chosen for their relevance to the theoretical definition for a "critical session." Three TSR items, 49, 56, and 59, were selected because they directly pertained to the client's experiencing of affect, gaining insight, and enlarging his or her awareness, respectively.

TABLE 3

Analysis of Variance

for MAACL Anxiety (A) Scale

Source	SS	df	MS	F*
Critical Grouping	128.34	1	128.34	0.44
X Non-Critical Grouping	2050.25	7	292.89	
Session Before				
X Critical Session	5.06	2	2.53	0.03
X Session After (BCA)	1231.78	14	87.98	
Clients x Therapists	0.09	1	0.09	0.00
	269.16	7	38.45	
Critical Grouping + Non-Critical Grouping	180.19	2	90.10	0.45
X BCA	2836.97	14	202.64	
Critical Grouping + Non-Critical Grouping	86.27	1	86.27	1.00
X Clients + Therapists	606.64	7	86.66	
BCA X Clients + Therapists	108.07	2	54.04	1.28
	592.43	14	42.32	
Critical Grouping + Non-Critical Grouping	22.01	2	11.00	0.20
X BCA	785.10	14	56.08	
X Clients + Therapists				

*The $p=.05$ level of significance is achieved by an F ratio of 5.59 for dfs of 1 and 7, and an F ratio of 3.74 for dfs of 2 and 14.

TABLE 4

Analysis of Variance

for MAACL Depression (D) Scale

Source	SS	df	MS	F*
Critical Grouping	10.01	1	10.01	0.05
X Non-Critical Grouping	1527.24	7	218.18	
Session Before				
X Critical Session	56.52	2	28.26	0.26
X Session After (BCA)	1505.65	14	107.55	
Clients X Therapists	1.76	1	1.76	0.05
	261.82	7	37.40	
Critical Grouping +				
Non-Critical Grouping	66.89	2	33.45	0.16
X BCA	4045.11	14	288.94	
Critical Grouping +				
Non-Critical Grouping	0.01	1	0.01	0.00
X Clients + Therapists	425.91	7	60.84	
BCA X Clients +	69.27	2	34.64	1.75
Therapists	276.90	14	19.78	
Critical Grouping +				
Non-Critical Grouping	38.40	2	19.20	3.19
X BCA	84.12	14	6.01	
X Clients + Therapists				

*The $p=.05$ level of significance is achieved by an F ratio of 5.59 for dfs of 1 and 7, and an F ratio of 3.74 for dfs of 2 and 14.

TABLE 5

Analysis of Variance

for MAACL Hostility (H) Scale

Source	SS	df	MS	F*
Critical Grouping	10.01	1	10.01	0.17
X Non-Critical Grouping	419.07	7	59.87	
Session Before				
X Critical Session	162.14	2	81.07	1.69
X Session After (BCA)	670.53	14	47.90	
Clients X Therapists	31.51	1	31.51	0.60
	365.57	7	52.22	
Critical Grouping + Non-Critical Grouping	281.40	2	140.70	1.70
X BCA	1157.27	14	82.66	
Critical Grouping + Non-Critical Grouping	1.76	1	1.76	0.04
X Clients + Therapists	292.33	7	41.76	
BCA X Clients + Therapists	32.27	2	16.14	0.50
	454.40	14	32.46	
Critical Grouping + Non-Critical Grouping	46.27	2	23.14	0.56
X BCA	582.41	14	41.60	
X Clients + Therapists				

*The $p=.05$ level of significance is achieved by an F ratio of 5.59 for dfs of 1 and 7, and an F ratio of 3.74 for dfs of 2 and 14.

The three TSR items (client form) were:

I feel that I got:

49. More ability to feel my feelings, to know what I really want.

56. More insight into my problems.

59. An awareness of some new things about myself which I didn't know before.

The three TSR items on the therapist form expressed the same idea, but from the therapist's perspective.

The results of the analyses of variance for these three TSR items failed to reach $p \leq .05$ level of statistical significance for any item on any dimension. No differences were found in this dependent variable between any session identified as "critical" by the operational definition and the session preceding it, the session following it, or the control session. Thus, no statistically significant results which differentiate "critical sessions" from other psychotherapy sessions along the dimensions hypothesized by either the operational or the theoretical definition can be reported from this study.

A different type of examination of the eight identified "critical sessions" sought to discover whether there were any important trends in the affect, content, or client perceptions in these sessions.

To further examine affect, both clients and therapists were instructed to circle the one feeling that the client

felt most during the session. These responses are presented in Table 6. Only one dyad (S2) perceived the client's salient affect in the same way. All of the other responses were completely different from each other within dyads, and with only one exception, between dyads. Consequently, no trends were discovered regarding salient affects expressed by clients during "critical sessions."

To examine content further, clients and therapists were instructed to check which of a list of subjects contained in the TSR (items 2 - 21) was talked about most during the session. The therapists' and clients' perceptions of which subject was discussed most are presented in Table 7. There was greater agreement between clients and therapists in this area than for expressed affect, with three dyads (S4, S5, and S6) in agreement (38%). Two other dyads had client and therapist responses which were similar in nature (S1 and S3), although not identical. Some trends were reflected in the subjects talked about most during a "critical session": (1) Past or present relationships with members of the client's immediate family (7 responses, 43%), and (2) Hopes or fears about the future (4 responses, 27%). There was so much variability in total responses, however, that no definitive statement can be made concerning the content of "critical sessions."

TABLE 6

The One Feeling Felt Most by the Client During His or Her "Critical Session"

	Therapists		Clients	
Subject Dyad	MAACL Item Number	Affect	MAACL Item Number	Affect
S1	3	Affectionate	100	Satisfied
S2	122	Unhappy	122	Unhappy
S3	8	Alive	118	Thoughtful
S4	4	Afraid	26	Cool
S5	12	Angry	62	Hostile
S6	132	Young	105	Steady
S7	21	Cheerful	31	Daring
S8	8	Alive	66	Inspired

TABLE 7

The One Subject Talked About Most by the Client During His or Her "Critical Session"

Subject Dyad	TSR Item No.	Therapist's Perception	TSR Item No.	Client's Perception
S1	19	Attitudes or feelings towards his therapist	20	Therapy - Feelings and progress as a patient
S2	17	Hopes or fears about the future	8	Work, career or education
S3	5	His/her childhood	6	My adolescence
S4	10	Relations with the opposite sex	10	Relations with the opposite sex
S5	17	Hopes or fears about the future	17	Hopes or fears about the future
S6	2	His/her mother	2	My mother
S7	14	Feelings about children or being a parent	5	My childhood
S8	17	Hopes or fears about the future	12	Feelings about spouse or being married

To further examine client perceptions, clients and therapists were also asked to check which of a list of TSR responses (items 42 - 60) described what the client got most out of the session. These responses are presented in Table 8. Here, too, there was no agreement between clients and their therapists. Some trends did emerge, however, concerning what the client got most out of a "critical session": (1) Greater understanding or insight (7 responses, 43%), and (2) Relief from tension and unpleasant feelings (2 responses, 13%). Although it appears that obtaining insight may have been a common factor in many of these "critical sessions," the expression of affect, a close relationship between client and therapist, therapist support and empathy for the client, and the client's feeling hope were also listed as primary benefits from these sessions. Despite their variety, all the responses in Table 8 relate to the theoretical definition of a "critical session." These trends may lend some support to the hypotheses of this study.

The clients were given the opportunity to relate in their own words what they felt was most helpful to them during the session in response to CSQ item 13. The responses for the eight "critical sessions" are presented in Table 9. Seven of the client responses (88%) were concerned with the gaining of insight. One involved the

TABLE 8

What the Client Got Most Out of

His or Her "Critical Session"

Subject Dyad	Person	TSR Item No.	Response
S1	Therapist	55	Getting my client to take a more active role and responsibility for progress in therapy
S1	Client	51	More of a person-to-person relationship with my therapist
S2	Therapist	46	Helping my client understand the reasons behind his/her reactions
S2	Client	53	A more realistic evaluation of my thoughts and feelings
S3	Therapist	56	Helping my client get more insight into his/her problem
S3	Client	46	More understanding of the reasons behind my behavior and feelings
S4	Therapist	56	Helping my client get more insight into his/her problems
S4	Client	43	Hope: a feeling that things can work out for me
S5	Therapist	48	Encouraging attempts to change and try new ways of behavior
S5	Client	56	More insight into my problems
S6	Therapist	49	Moving my client closer to experiencing emergent feelings
S6	Client	45	Relief from tension and unpleasant feelings
S7	Therapist	47	Supporting my client's self-esteem and confidence

Table 8 (cont'd.)

Subject Dyad	Person	TSR Item No.	Response
S7	Client	46	More understanding of the reasons behind my behavior and feelings
S8	Therapist	54	Sharing empathically in what my client was experiencing
S8	Client	45	Relief from tension and unpleasant feelings

TABLE 9

Clients' Responses to CSQ Item 13:

"What was most helpful to you in today's session?"

for His or Her "Critical Session"

Subject Dyad	Client Response
S1	My therapist helped me to objectively analyze some things.
S2	The therapist suggesting a different way to look at how I think and feel.
S3	I understood some new things about myself.
S4	Being verbally torn apart. It showed me that I truly did know what I was talking about.
S5	My therapist was able to tell me that my decisions were made on external pressure not internal direction. My therapist was able to spot what was causing many of my feelings and was able to be very supportive.
S6	Exploring my feelings and attempt to gain some insight in them. Helping me look at the conflictual nature of my child-adult perspective.
S7	Certain things are suddenly becoming clear to me.
S8	A chance to express a lot of good feelings - it was sort of a "show-off" session for me.

expression of good feelings. In view of what these clients chose to emphasize, these results may lend support to the theoretical definition for a "critical session," for which obtaining insight is a core element.

Although there were no satisfactory significant results supporting the specific hypotheses in this study, there were other results which indicated trends in the direction predicted by the theoretical definition for a "critical session." In addition, these results may indicate some support for the general hypothesis of this study.

DISCUSSION

The present study was undertaken (1) to explore the possibility that a useful operational definition of psychotherapy sessions variously described as "turning points," "important," or "critical sessions" could be constructed, and (2) to apply this operational definition in real psychotherapy settings. In addition, supporting hypotheses regarding the nature of several changes in the mind of the client thought to take place in "critical sessions" were developed and an experiment was designed to identify these changes and to demonstrate that these particular changes differentiate "critical sessions" from all other individual therapy sessions.

This section contains a discussion of:

1) the inferences that can be derived from the results of the experiment,
2) methodological considerations affecting the results, and
3) the implications of the present study for future research.

Findings

The results produced by this study suggest that a meaningful operational definition for a "critical session" can be applied to psychotherapeutic situations. The results of a survey of researchers and therapists pointed to variables that these respondents believed were involved in a "critical session" or a "turning point" in the process of psychotherapy.

These variables were scaled and used to construct the "Critical Session" Questionnaire. From the CSQ, "critical sessions" in eight of ten different client-therapist dyads meeting for ten sessions were identified. These "critical sessions" were found to have CSQ scores significantly different ($p<.0005$) than the scores from the total group of sessions studied.

The success of the CSQ in determining whether valid "critical sessions" do exist can only be considered tentative by virtue of the results of this investigation. Nor is it clear how seriously these results undermine the value of this concept. For example, the CSQ is an instrument involving only one item per variable. It may not tap necessary variables with adequate representativeness or reliability. Furthermore, there are no established norms for the items listed, and it is not clear to what extent there may have been within individual variation in the self-reports. Finally, the number of clients, therapists,

and sessions in which the CSQ was used was relatively small. This, of course, limits the power and extent of the conclusions reached from its results. The CSQ is at this stage, therefore, a rather gross instrument, and the results obtained must be viewed accordingly. The results do suggest that further refinement of the CSQ would be fruitful, however. These refinements of the CSQ will be described below with the recommendations for future research.

The first two objectives of the present study, the construction of an operational definition for a "critical session" and the identification of "critical sessions" using this operational definition can be said to have been fulfilled. Identifying these "critical sessions," however, does not mean that any single, most outstanding and most important session for the course of the entire therapy has been pinpointed. The theoretical definition requires that a "critical session" in the form of a single "turning point" or most crucial session for the whole therapeutic relationship be identified. But in view of the necessary restrictions involved in this study, e.g., the collection of questionnaire data from clients and therapists, a limit of ten sessions was imposed. Such restrictions may obscure the nature of "critical sessions" as established by the theoretical definition. As an example, if the entire course of any particular therapy

had been examined, another session might have shown a far higher median on the CSQ than the one identified in the present study. These other "critical sessions" might have yielded different results upon analysis. The failure of this study to support hypotheses 1 and 2 indicates that a valid means for identifying a single most important, or "turning point" session for a therapy is yet to be demonstrated.

The eight sessions identified as "critical" appear to be related to some interesting responses. The clients, according to their CSQ responses, felt each to have been a "good" session in terms of their goals for therapy: confronting one of their main problems directly; expressing feelings concerning one of their main problems; learning important and useful things about themselves; and improving their view of themselves, the course of their therapy, their personal environment, and their therapists. By their own reports, clients indicated that more positive elements had occurred in these eight sessions than in almost all of the other sessions. Seemingly, some important steps or progress had been made in the eight sessions. In fact, there were more than eight sessions in which these CSQ scores were elevated. The two dyads which were not considered to have had a "critical session" were excluded because they had more than one session with a high median, and the operational definition required that

only one be present. Such occurrences could imply that more than one "critical session" occurs over the length of therapy or that a number of such sessions occur.

In theoretical terms, a number of confrontations of the main problems, with accompanying emotional release and close contact with the therapists, may be necessary if the client is to be motivated to continue therapy. Experiencing these sessions may be necessary in order that the client can continue facing main problems and the distress of experienced anxiety in the other sessions. It seems logical that clients would only desire to continue treatment if they felt that some significant amount of progress was being made toward understanding and solving their main problems. In this light, it may be far more productive for clients to have a series of moderately impactful "important" sessions during the course of therapy than a single, highly impactful "critical session." Frequent sessions showing what looks like "progress" may do more than a single session to sustain the client through periods of difficulty and anxiety, to enable the client to absorb and utilize new understandings, establish a higher level of self-esteem, to help the client to practice expressing troublesome affect, and to promote the sense of hope for a better future. A series of "turning points" may also lead the client to establish a pattern of success in tackling the difficult work of understanding

and working through the conflicts, whereas a single "critical session" may, in fact, only serve to heighten expectations which would not be fulfilled.

An alternate theoretical speculation is that these "high progress" sessions may merely be necessary stepping-stones to a very powerful "critical session" in which the main conflicts are confronted even more dramatically. Perhaps a great deal of groundwork is required for the major "critical session" or "turning point" to occur, and while the "groundwork" sessions may at the time be viewed by the client as "high progress" sessions, they may be only rated afterwards as less important than the "critical session." In other words, the perspective of the client at the end of the course of therapy may be very different and perhaps more useful in rating these "high progress" sessions than before the client has experienced a truly "critical session."

Respondents to the PSQ who rejected the notion of a single "critical session" as defined in this study had set forth the above notions on the existence of: (1) a number of "high progress" sessions which are similar to "critical sessions" in their process and which lay the groundwork for the occurrence of "critical sessions," and (2) temporal effects on a client's perspective. While it appears that this study has produced information

regarding a particular view of "critical sessions," any match between these operationally defined "critical sessions" and the ones described by the theoretical definition remains to be demonstrated.

The findings from the two dependent measures, the MAACL and the TSR, failed to demonstrate either that the theorized changes predicted as a result of a "critical session" actually happened, or that the identified "critical sessions" differed in qualitative ways from other sessions. This lack of significant results may be related to the choice of instruments used to measure the dependent variables.

The MAACL, however, was selected because of its past, apparently reliable, and valid application in assessing changes in affect, a crucial component of a "critical session." But the obtained results may indicate that the MAACL may not be well suited to detecting the types of affect and affect changes that occur prior to, during, and following a "critical session." The MAACL does not sufficiently identify qualitative changes in affect and degree of affect experienced, which may be more important changes occurring in "critical sessions" than the changes in discrete affects that this instrument does measure. In addition, a number of written and verbal comments by both therapists and clients indicated that this check list did not allow them to express the feelings they had experienced

adequately. An inspection of the data also appeared to indicate that some subjects did not fill out the check list reliably. Occasionally, client responses for a particular session contradicted each other on similar or corresponding items in the three instruments.

The TSR was selected for use in this study because of its ability to distinguish between various factors that are occurring in the process of therapy, its previous use in examining "good" sessions, and its tested reliability and validity. Its exhaustive treatment of the therapy session, and therefore its length, however, seems to have been its major drawback here. It appears that some subjects experienced testing fatigue and used little care in filling out the long TSR. There were several complaints about its length, and a few clients dropped out of the study because of this after completing only a few questionnaires. This testing fatigue may have contributed to lowering the reliability of the TSR results. In addition, the quality and experience of change in the client or in the client-therapist relationship may not have been accurately estimated or accounted for by this type of instrument.

Consequently, qualitative differences between "critical sessions" and other sessions may exist, although they were not detected through the use of these

measurements. The fact that the CSQ seems useful for identifying "critical sessions" in a number of therapy dyads offers some evidence for the existence of "turning points" in the process of therapy, especially as they reflect both judgments of clients and experienced therapists. These judgments may be verifiable if appropriate techniques are used. For example, factor analysis of the data from a large number of client-therapist pairs over a longer period of therapy than studied here might be more useful and more effective in detecting "critical session" occurrence patterns.

Methodological Considerations

This study contains certain basic assumptions upon which its research methodology is built. Although these basic assumptions are widely employed, a number of reviewers of the psychotherapy research literature have questioned the validity of applying some of these assumptions.

For example, the assumption that "critical sessions" can be found in a wide variety of client-therapist pairs was employed here because of this researcher's theoretical conviction and because he deemed it necessary to explore this essentially uninvestigated area. No previous research has helped establish guidelines in the search for "critical sessions."

Nevertheless, worth consideration is the fact that a number of psychotherapy researchers (Sanford, 1953; Kiesler, 1966; Paul, 1967; Marsden, 1971; and Bergin and Strupp, 1972) state that instead of trying to find general principles applicable to all of psychotherapy, research should concentrate on trying to determine particular sets of therapeutic factors and behaviors that are appropriate for particular types of clients and therapists within particular contexts. They argue that the styles of psychotherapy commonly practiced and the types of clients coming for help are too varied to have a certain fixed set of therapeutic variables generalizable to all therapy situations. This reasoning may explain some of the results obtained in this study, since the results reflect that a number of "critical sessions" were identified but that no generalizable conditions over all the dyads could be found. However, the objections to this assumption are at present still open to debate and remain unsupported by empirical efforts.

Another assumption in this study, that examining only part of the psychotherapy process can yield valid information, is challenged by Kiesler (1966). He states that investigations must exhaust the full domain of variables operative in the therapy interaction in order to be comprehensive enough to explain the psychotherapy process adequately. Although the present study used two lengthy

questionnaires to generate data for the dependent variables, they fell short of covering the full range of processes in therapy. Though it is a desirable method of research, administering to clients and therapists the necessary comprehensive set of instruments required by this method would have been impossible with the resources available to this researcher. Furthermore, it may be that Kiesler's view of how research should be conducted, while possibly valid, is highly impractical, considering both the difficulty in enlisting therapist participation and the testing fatigue that was experienced when only three instruments were used.

A third assumption, that client and therapist self-report was an adequate means of identifying and examining "critical sessions" may have been the most telling cause for the lack of significant results. While clients and therapists may be able to walk out of a session feeling that the session had been "good," they may not be able to analyze and report what facets of the interaction led to this feeling, especially within the highly structured confines of questionnaires like the MAACL and the TSR. Also, as time passes, clients and therapists may change their minds; sessions that seemed "ordinary" or "not particularly significant" immediately after the session may be looked back upon after the passage of time as having been "important," "significant," or "critical" in

the perspective gained following it. Conversations with experienced therapists yielded the opinion that this attitude shift was not an uncommon experience. It may be that sessions that were considered by clients at the time to have been "bad" or "irrelevant to their problems" may have indeed been in accord with the theoretical definition of a "critical session" but were not identifiable by the operations used because of the reliance on the client's feelings for the measurements. A "critical session" might be considered by a client to have been a "bad" session if the client, following the session, experienced a great deal of emotional turmoil as a result of having one of his or her main conflicts confronted and dealt with in the session. The client may then respond to this emotional turmoil following the session rather than to a more objective appraisal of the session's importance.

The study attempted to control for some of this variance in client response by including therapists' perceptions of clients' responses on the MAACL. However, the results failed to demonstrate any significant differences between therapists' and clients' responses on the dependent variables. While these results show some measure of agreement between clients and therapists on the perceptions of the clients' affects and behaviors in the

session, they are questionable indicators of the validity of therapist reports. Because of their involvement in the therapy process, therapists may be no more objective in their assessment of a session's "importance" or "critical" nature than clients. Without other sorts of data against which to check these views, ascertaining the degree of objectivity in a client's or therapists view of a particular session is extremely difficult.

Perhaps the most significant contributing factor to invalidating a client's self-report is the nature of his or her problems. For example, can a client whose main difficulties include an inability to perceive or accept positive feelings of others towards him or her be able to report accurately on the warmth and caring expressed by the therapist during and following the therapist's confrontation of his or her conflicts in the theorized "critical session"? Can the client who is experiencing the pain associated with the conflict confronted by the therapist feel that the session has been "good" or "important" or a "turning point"? Then again, the client may not have had the affective experience, education, experiences with psychotherapy, or developed conceptualizing abilities necessary to recognize and report on some of the esoteric factors involved

in a "critical session." An indication that this premise may be accurate lies in the nature of responses by clients concerning the most helpful and least helpful circumstances of a particular session, and what enabled them to talk about the problems and feelings they discussed in that session (questions 13, 14, and 10 respectively on the CSQ). For the most part, client responses to these unscaled free response items were vague; they were either very general or very specific, unconnected to the question, unsophisticated, or simply "nothing" or "I don't know." Such answers tend to cast doubts upon both the reliability and validity of the scaled items in the TSR which more specifically ask the same questions, but require only a minimum of thought plus little understanding or conceptualizing to circle a number. Clients may not be able to verbalize their "inner experiences" adequately in the language presented to them by current research techniques. It is a possibility that the "inner experience" can neither be detected nor collected by client self-report, although this is a matter that has been much debated in the past and still remains unresolved. Regardless of the eventual answer to this question, the present study tends to indicate that in examining "critical sessions" other means of data collection must be employed in addition to self-report to obtain accurate and objective information on these sessions.

Moreover, the problems that appear to be inherent in the methodology of the present study may also apply to most of the quantitative research methods currently employed in psychotherapy research. An unresolved difficulty in empirical investigations in psychotherapy is that it is extremely hard, and perhaps impossible, to assign numerical ratings to "inner experiences," feelings, and perceptions of clients and therapists. In addition, there is the immense problem of generalizing the unique and often idosyncratic responses of individual respondents over a large population of clients and therapists.

Implications for Future Research

The present investigation failed to provide support for hypotheses 1 and 2, but suggests several ways in which improvements in research design may establish the extent that the concept of "critical sessions" is useful.

Several different kinds of studies might shed light on the nature of the concept. One such study, for example, would redesign and improve upon the present investigation in the following manner: refine the CSQ to identify the "best" or "most important" session for a particular dyad, as opposed to possible "very good" or "important" sessions. A new survey that listed a greater number of variables would be administered to

a far greater number of researchers and therapists. A new CSQ could then be constructed using several items for each variable with the reliability and validity of the items to be tested in a pilot study.

In order to determine one "superior" session rather than a session that is "good" or "important" relative to only a few other sessions, it would be necessary to administer the CSQ to clients and therapists after every session over the entire course of therapy. Clients whose therapy lasts for a short, moderate or long duration could be divided into separate groups in order to determine if there is a difference over the time dimension in distinguishing "superior" sessions. The median of the scores on the CSQ for the "critical session" must be clearly and significantly outstanding in relation to the medians for the other sessions. Further, a minimum positive median should be established as a result of the CSQ pilot study to be the minimum level for "criticalness" (e.g., a median of +3.0 on a scale of 0.0 to 4.0), with a certain high percentage of the items also required to be above a particular minimum level.

At the termination of therapy the clients and therapists could be given a form and/or interview asking them to identify the session which had been most important to the progress of therapy. This form or the

interview could then ask them to describe what happened and what made it important. This retrospective view would add to the validity of the identified "critical sessions" because this judgment would be more likely free of coloration caused by the emotional turmoil in clients immediately following an individual session.

These terminated clients could also be surveyed to gather their perceptions of the ingredients found in an "important" session or "turning point" in therapy. The nature of this complex design using these instruments and techniques requires a much larger number of subjects than the number of therapists and clients used in the present study to provide acceptably valid results.

Dividing the therapy dyads into groups that are roughly similar would enable researchers to begin answering the question of whether "critical sessions" are phenomena common to most therapy situations or merely to a few particular types of dyads. Clients could be categorized by diagnosis after undergoing a complete psychological evaluation employing a full battery of standard tests administered by psychologists unconnected with the research. Therapists could be typed according to their style of therapy, including both their reported theoretical orientation and the observation of their therapeutic style by trained raters

with established inter-rater reliability.

By using appropriate statistical techniques with a large enough sample, the occurrence of "critical sessions" by types of clients, types of therapists, and types of therapeutic situation could be pinpointed.

From the data collected in this manner, a researcher might extend the scope of the study to include a correlation of the occurrence of "critical sessions" with the outcome of therapy through the use of outcome measurements. These outcome measurements would need to rely on "internal" as well as "external" or behavioral criteria, and should be as comprehensive as possible. A complete set of outcome measurements should include a standardized assessment interview, a self-rating checklist, a behavioral assessment, a self-concept measure, a thematic story test, a therapist rating scale, the Personal Orientation Inventory to measure health-oriented qualities, and a factor-analytic battery such as the Sixteen Personality Factor Questionnaire. This additional focus would connect the study of therapy process and therapy outcome, thus yielding some very useful information leading toward a better understanding of psychotherapy as a whole.

Several instruments could be employed to collect the data on dependent variables in this proposed study. Each instrument should examine one specific aspect of

the therapy process in which the instrument has been shown to have high validity and reliability. All the information collected would complete a comprehensive picture of the changes which occur in a particular therapeutic dyad. One criterion for choosing these instruments is that they be relatively short to prevent fatigue in the respondents. The sample should be large enough to allow for employing factor analysis. This statistical technique could be of great use in defining sets of behaviors, feelings, or changes that occur uniquely in the process of a "critical session."

For non-quantitative investigation, information collected about "critical sessions" would be thematic and experiential instead of quantitative. This method of research, however, should still follow an empirical procedure in order to assure the validity of its results. First, a team of two or more judges would be selected. Judges would be experienced and well-qualified therapists who are generally considered to be perceptive, sensitive, and good therapists by their colleagues and clients alike. These judges would be employed to view videotapes and listen to audiotapes of many therapy sessions and to make judgments on what they see and hear.

Next, many therapists across the nation would be solicited to send in tapes of sessions that they and their clients agree are "superior," "good" or "important,"

and tapes of sessions deemed to be "inferior", "bad" or "unimportant." The judges would then listen to these tapes and by their professional judgments determine what themes, actions, expressions, therapeutic situations, emotions, key interactions, and inner experiences or other occurrences or lack of occurrences differentiate sessions in terms of "good" from "bad," "superior" from "inferior," and "important" from "unimportant." A great number of sessions would be needed so that these judges could come to agreement on the types of processes which support these distinctions. Through these reviews these judges can develop the experience, skill, and knowledge necessary both to formulate an operational definition for a "critical session" and identify these sessions when they occur. The third step for these judges would be to listen to the tapes of the sessions examined by quantitative methods and identify "critical sessions" in those dyads to validate their findings against the quantitative approach.

Working independently, a second set of judges chosen in the same way as the first would at this point continue the investigation. They would not be informed of the nature of the study or the concept of "critical sessions." They would be trained in the use of several psychotherapy rating systems until they had a high degree of inter-rater reliability on each system. They would

then listen to all of the tapes for all of the client-therapist pairs from the quantitative study, with the tapes being presented to them in a random order. They would then apply both the rating systems and their professional judgments along the dimensions identified by the first set of judges to each session. In addition, a member of this second set of judges would interview the clients and therapists after every fifth session in order to determine their perceptions on what had transpired, what had resulted, and what changes had taken place over the previous five sessions. A short interview after every fifth session would be often enough to capture the needed information before it is forgotten while not being so frequent that it would interrupt the process of therapy. After therapy is terminated, a judge would interview each of them to obtain as much information as possible on how they viewed the progress of therapy and what was most important in enabling them to reach the outcome they achieved. By the point of termination, of course, much would be forgotten about what had occurred during the therapy, but what was remembered and why it was remembered would provide important clues to what had been of significance in the therapy.

The data obtained from the rating systems would be analyzed by statistical methods, but the thematic and

judgmental information would be compiled and discussed in a reportorial manner. Since the same client-therapist pairs would be used throughout all aspects of the study the quantitative results could be compared with both the judges' data and the judges' assessments to provide a broad, comprehensive examination of the concept of "critical sessions." Such a study combining the dual foci of quantitative and qualitative research would go far in determining the existence of, the identification of, the occurrence of, and the therapeutic impact of "critical sessions." Further research studies could be well guided by the findings produced by this type of comprehensive and exploratory initial investigation. Otherwise, researchers may expend much effort examining small segments of this area and not arrive at an accurate total picture of the nature of "critical sessions."

The present study indicated some guideposts for further investigation, enabling future researchers to have a greater possibility of providing some definitive and valid data in a largely unexplored area of psychotherapy research.

SUMMARY AND CONCLUSIONS

This research sought to study the nature of "critical sessions" in individual adult psychotherapy. Theoretically, a "critical session" was conceptualized as a session in the process of therapy in which the therapist confronted or interpreted some key set of feelings or behaviors to which the client is receptive, and which results in the client having felt some significant emotional impact, having achieved a sense of mutual closeness with the therapist, having had some major cognitive reorganization, having achieved some important insight in a way that is useful, and having shifted some of his or her distorted perceptions of the therapist more toward reality.

The concept of a "critical session" had to be operationally defined. This was accomplished for this study by a survey of experienced psychotherapists. Data from a preliminary set of interviews with experienced therapists was used to construct the Psychotherapist Survey Questionnaire (PSQ). The PSQ was sent to 62 experienced therapists and researchers to collect data on their views on whether "critical sessions" exist, and, if they believed so, what variables might be present in such sessions. Forty-six respondents agreed with the concept, while six

did not, and ten did not respond. The 46 positive respondents, who had a mean experience level of 14.4 years, identified three variables (PSQ items VI, IX, and X) which they considered "extremely important" to a "critical session". A t-test performed on the PSQ data showed the responses for these three items to be significantly different from the total group of PSQ responses ($p<.0005$).

These three PSQ items were converted into seven items on the "Critical Session" Questionnaire (CSQ), an instrument developed for this study with the aim of identifying "critical sessions". Two additional items concerning the importance of the session and the client's goals for therapy were also included in the CSQ. The operational definition for a "critical session" for this study was the highest median for a client's ratings for a session on these nine CSQ items, with at least seven of these items needing to be rated at equal to or greater than + 2.

It was hypothesized that (1) a change in the client's report of his or her affect from the session immediately preceding a "critical session" to the session immediately following a "critical session" as measured by the Multiple Affect Adjective Check List would occur ($p\leq.05$), and (2) that a change in the therapist's report of the client's experienced affect over these same sessions measured by the same instrument would occur ($p\leq.05$).

Ten adult clients in individual therapy and their therapists were administered the CSQ, the Multiple Affect Adjective Check List (MAACL), and the Therapy Session Report (TSR) after each of ten consecutive sessions. Therapists chose both the clients and the starting points in the therapy process for this research. Five dyads started participating in this study before the twentieth session and five began at some point after the twentieth session.

Eight of the ten dyads were found to have had an operationally defined "critical session". A t-test performed on the CSQ results demonstrated that these eight "critical sessions" were significantly different in their CSQ client ratings than the total group of sessions studied ($p<.0005$). A three-way analysis of variance was performed on the MAACL scores for the eight "critical sessions", the sessions immediately preceding and following them, and on three randomly selected consecutive sessions from these same dyads which served as controls. The results of the analysis of variance (1) failed to support either of the hypotheses, and (2) failed to demonstrate that the identified "critical sessions" were different than other sessions in their client MAACL scores. Three TSR items pertaining to variables in the theoretical definition of a "critical session" were then subjected to a similar three-way analysis of variance.

This statistical analysis also failed to differentiate "critical sessions" from other sessions. Finally, items involving which client affect was felt most, what was talked about most, and what was most beneficial to the client during the eight "critical sessions" were examined in a non-statistical manner. Two trends were discovered: (1) Past or present relationships with members of the client's immediate family was the most frequently reported content matter (43%), and (2) Attaining greater understanding or insight was most frequently reported to be what the client got most out of the session (43%).

Although the hypotheses were not supported, "critical sessions" were identified in eight therapy dyads and some trends concerning the nature of "critical sessions" were uncovered. Some of the methodology utilized in this study may have contributed to the lack of significant results, e.g., the small number of subjects, the types of instruments used and their length, and the examination of only ten sessions rather than the entire course of a therapy. Enough information was collected, however, to suggest the value of further research in the area of "critical sessions" using more refined methodology.

APPENDICES

APPENDIX A

APPENDIX A

The Psychotherapist Survey Questionnaire

Dear

I am a graduate student in clinical psychology working on my doctoral dissertation, and I would like to request your assistance in filling out a very short questionnaire for my research. This questionnaire should take no more than 5 minutes of your time. Your reply will be extremely helpful to me in resolving the main problem I have had in progressing with my study.

My research concerns an analysis of particular sessions in individual psychotherapy. Many therapists tend to describe some sessions with a client as "more important" or "better" than others. Carrying this idea to its extreme, I have decided to examine what transpires in sessions rated as "the most important" in the course of psychotherapy, how the processes occurring in these sessions differ from those of other sessions, and what changes take place within the client, the therapist, and their relationship. One additional question I hope to begin to shed some light on is whether these sessions are "critical" to the therapy process, or in other words, whether they are "turning points" in the course of psychotherapy.

In order to formulate an operational definition of this type of session, I have gathered information from therapists in my area as to what they see occurring in such "critical sessions" and I have formed a composite list of all the assorted variables that these therapists have perceived as being present in those sessions (with no one therapist seeing all of these variables listed as being present). As an experienced psychotherapist and psychotherapy researcher it would be of great aid to me if you could rate these variables according to the rating scales provided. If you agree that "critical sessions" as I have briefly defined them in Part 1 of the questionnaire do occur with at least some clients, please fill out <u>all</u> of Part 1 only. If you do not agree that "critical sessions" as defined in Part 1 occur at all, please ignore Part 1 and fill out Part 2 <u>only</u>. Fill out <u>either</u> Part 1 <u>or</u> Part 2, but not both.

I would greatly appreciate your assistance in aiding me with my research by filling out this short questionnaire. Please return this questionnaire to me as soon as possible. For your convenience I have enclosed a stamped, self-addressed return envelope. Feel free to make any comments on either my project or my questionnaire. If you wish I will send you the results of this questionnaire once the data is analyzed.

Thank you for your time and your cooperation.

Sincerely,

Neil E. Rand

Psychotherapist Survey Questionnaire

Years of psychotherapy experience _____ Degree _____

PART 1

In the process of individual psychotherapy there are sometimes particular sessions which are critical to the successful outcome of the therapy. In the cases where they occur these key sessions can be called "turning points," for what is involved is a subtle or overt change in the process of therapy which leads to the achievement of the goals of therapy (whatever these goals may be for that particular client-therapist pair). Some crucial changes take place in the sessions where these turning points occur which provide the necessary tools or atmosphere for that client-therapist pair to reach a successful outcome; tools or atmosphere which for whatever reason were not available for full use of the client-therapist pair prior to the occurrence of the turning point. Operating under the assumption that such turning points or critical sessions do exist at least in some cases, use your experience as a therapist, your conceptual knowledge of individual psychotherapy, and your theoretical base to rate the list of variables in the following manner:

Positive Ratings: This variable occurs in "critical" sessions and is of importance to what transpires during that session.

+1 = Slightly important
+5 = Moderately important
+10 = Extremely important

Neutral (0) Rating: This variable occurs in "critical" sessions but is neither important nor unimportant to what transpires during that session.

Negative Ratings: This variable occurs in "critical" sessions but is not important to what transpires during that session.

-1 = Slightly unimportant
-5 = Moderately unimportant
-10 = Extremely unimportant

X Rating: This variable does not occur in "critical" sessions.

Part 1 (continued)

Variables

Circle the appropriate rating for each item.

I. Greater total affect is expressed by the client than previously.

X -10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5 +6 +7 +8 +9 +10

II. Greater anxiety is experienced by the client than previously.

X -10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5 +6 +7 +8 +9 +10

III. The session was felt by the client to be important in terms of progress toward his or her goals in psychotherapy.

X -10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5 +6 +7 +8 +9 +10

IV. The session was felt by the therapist to be important in terms of his or her goals for the client in psychotherapy.

X -10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5 +6 +7 +8 +9 +10

V. The therapist expresses more affect than previously.

X -10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5 +6 +7 +8 +9 +10

VI. Some conflict that the client has been dealing with in a less direct or less affect-laden manner gets confronted directly.

X -10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5 +6 +7 +8 +9 +10

VII. Some part of the client's distortions about the therapist are removed; the therapist is perceived by the client more as he or she really is.

X -10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5 +6 +7 +8 +9 +10

Part 1 (continued)

VIII. The client experiences the therapist as more caring.

X -10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5 +6
+7 +8 +9 +10

IX. Some material that the client was previously unaware of is brought into the client's awareness in a way that is useful to him or her.

X -10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5 +6
+7 +8 +9 +10

X. Some cognitive reordering occurs in the client so that he perceives the therapy situation, himself, the therapeutic relationship, or his world view in a different way; some important insight is obtained.

X -10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5 +6
+7 +8 +9 +10

XI. The therapeutic goals of the client and therapist are clarified and made more compatible or more similar.

X -10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5 +6
+7 +8 +9 +10

(Optional) XII. Other: _____

X -10 -9 -8 -7 -6 -5 -4 -3 -2 -1 0 +1 +2 +3 +4 +5 +6
+7 +8 +9 +10

☐ I wish to have the results of this questionnaire sent to me.

PART 2

If you do not agree with the definition of "critical sessions" as stated in Part 1, please briefly describe what you do see occurring in "critical" or "very important" sessions, or why you feel that such sessions do not occur.

APPENDIX B

APPENDIX B

The Client Background Questionnaire

INSTRUCTIONS: Fill out all of the blanks in Questions #1 and #2 and as many of the rest of the questions that apply for you.

1. Client Identification Code_____
   (Your code is your initials of your first and last name plus the year you were born. Example: John Doe who was born in 1948 would have the code -- JD 1948)

Birthdate_____ Occupation _____

Today's Date_____ Sex ____ Marital Status _____

Approximate Annual Income _____

Your Therapist's Name _____

2. Briefly (in one or two sentences) describe the problem that caused you to seek out psychotherapy.

_____

_____

_____

_____

_____

3. Have you ever been in any form of psychotherapy before? CIRCLE ONE: YES NO

   If YES, What kind? CIRCLE ONE:

   INDIVIDUAL GROUP MARITAL FAMILY CHILD

   OTHER _____

   If YES, For how long? _____

4. How many psychotherapy sessions have you had with your present therapist not counting today's session?

CIRCLE ONE: 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
17 18 19 20 MORE THAN 20

APPENDIX C

APPENDIX C

The Therapist Background Questionnaire

INSTRUCTIONS: Please answer all questions.

1. Therapist Identification Code _____
   Today's Date _____
   (Code is formed by the initials of your first and last names and the year of your birth. Example: John Doe in 1948 would have the code--JD1948)

Age _____ Sex _____ Degree _____

Years of Full Time psychotherapy experience (Do not count experience prior to your degree) _____

2. Which term BEST describes your therapeutic orientation? CIRCLE ONE:

Analytic Bioenergetic Client-Centered Gestalt Jungian

Rankian Rational Emotive Reality Eclectic TA Other_____

If your answer is ECLECTIC, describe which theories or elements of theories contribute to your therapeutic style by CIRCLING WHICHEVER THEORIES YOU USE IN THE LIST BELOW. Circle a particular theory even if you only use one element of that theory. THEN--Place an "X" ACROSS whichever theory is most predominant in your therapeutic style (if you have one that is predominant).

Analytic Bioenergetic Client-Centered Gestalt Jungian

Rankian Rational Emotive Reality TA Other_____

3. ESTIMATE (as best you can) the average number of sessions that your previous individual adult psychotherapy clients have attended.

CIRCLE ONE: 1-5 6-10 11-15 16-20 21-25 26-30 Over 30

4. ESTIMATE the average number of sessions that individual adult psychotherapy clients you have seen for LONGER than 10 sessions.

CIRCLE ONE: 1-5 6-10 11-15 16-20 21-25 26-30 Over 30

5. ESTIMATE the number of individual adult psychotherapy clients you have seen for LONGER than 10 sessions.

CIRCLE ONE: 1-5 6-10 11-15 16-20 21-25 26-30 31-35

36-40 41-45 46-50 Over 50

Please return this questionnaire to Neil Rand when completed.

APPENDIX D

APPENDIX D

The "Critical Session"

Questionnaire (Client Form)

YOUR CLIENT IDENTIFICATION CODE: _____
(Your client identification code is formed by the initials of your first and last names and the year in which you were born. Example: John Doe born in 1948 would have the code--JD1948)

YOUR THERAPIST'S INITIALS: _____

DATE OF SESSION: _____

☐ Check here if this is the FIRST SESSION you have ever had with THIS THERAPIST.

☐ Check here if this is the FIRST TIME you have FILLED OUT THIS FORM.

PLEASE RETURN THIS FORM TO THE SECRETARY WHEN YOU HAVE FINISHED.

BE SURE TO ANSWER ALL OF THE QUESTIONS.

PLEASE ANSWER ALL QUESTIONS.

1. WHAT ARE YOUR FEELINGS ABOUT THE SESSION YOU HAVE JUST COMPLETED?

Instructions: +5 = The way you would feel if you had just completed the best possible session.

0 = The way you would feel if you had just completed an average session.

-5 = The way you would feel if you had just completed the worst possible session.

Using the above as a guideline, CIRCLE ONE NUMBER on the scale below that best represents how you felt about the session you have just completed.

WORST POSSIBLE					AVERAGE				BEST POSSIBLE	
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

2. HOW WAS THE SESSION FOR YOU IN TERMS OF YOUR GOALS FOR YOURSELF IN THERAPY?

Instructions: +5 = The best possible session for you in terms of your goals for yourself.

0 = An average session for you in terms of your goals for yourself in therapy.

-5 = The worst possible session for you in terms of your goals for yourself.

Using the above as a guideline, CIRCLE ONE NUMBER on the scale below that best represents how the session you have just completed was for you in terms of your goals for yourself in therapy.

WORST POSSIBLE					AVERAGE				BEST POSSIBLE	
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

3. DURING THIS SESSION, WERE YOU ABLE TO TALK ABOUT ONE OF YOUR MAIN PROBLEMS DIRECTLY?

Instructions: +5 = It was as easy as it could possibly be for me to talk about one of my main problems in this session and I was able to do it.

0 = I was able to talk about one of my main problems as much as I usually can in an average session.

-5 = It was as difficult as it could possibly be for me to talk about one of my main problems in this session and I was unable to do it.

DIFFICULT AS IT POSSIBLY COULD BE				AS MUCH AS USUAL ON THE AVERAGE			EASY AS IT POSSIBLY COULD BE			
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

4. DURING THIS SESSION DID YOU EXPRESS ANY EMOTIONAL FEELINGS CONCERNING ONE OF YOUR MAIN PROBLEMS?

Instructions: +5 = I expressed as many feelings concerning one of my main problems as I could possibly express.

0 = I expressed about the same amount of feelings concerning my main problems as I usually do in an average session.

-5 = I expressed as few feelings concerning one of my main problems as possible.

AS FEW AS POSSIBLE				AS MUCH AS USUAL ON THE AVERAGE				AS MANY AS POSSIBLE		
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

5. DURING THIS SESSION, DID YOU LEARN ANY NEW AND IMPORTANT THINGS ABOUT YOURSELF WHICH YOU WILL BE ABLE TO USE?

Instructions: +5 = I learned as much about myself as I possibly could in one therapy session.

0 = I learned about the same amount about myself as I usually do in an average session.

-5 = I learned as little about myself as I possibly could in one therapy session.

AS LITTLE AS POSSIBLE				AS MUCH AS USUAL ON THE AVERAGE						AS MUCH AS POSSIBLE
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

6. AS A RESULT OF THE SESSION YOU HAVE JUST COMPLETED, HOW DO YOU VIEW THE FOLLOWING?

YOURSELF--

I SEE MYSELF AS BEING IN THE WORST POSSIBLE WAY				I SEE MYSELF AS BEING ABOUT THE SAME AS I USUALLY AM						I SEE MYSELF AS BEING IN THE BEST POSSIBLE WAY
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

THE COURSE OF YOUR THERAPY--

MY THERAPY SEEMS TO BE GOING IN THE WORST POSSIBLE WAY				MY THERAPY SEEMS TO BE GOING ABOUT THE SAME AS IT USUALLY DOES						MY THERAPY SEEMS TO BE GOING IN THE BEST POSSIBLE WAY
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

AS A RESULT OF THE SESSION YOU HAVE JUST COMPLETED, HOW DO YOU VIEW THE FOLLOWING?

YOUR PERSONAL ENVIRONMENT--

I SEE THE PEOPLE AND THINGS AROUND ME AS BEING AS BAD AS THEY COULD POSSIBLY BE				I SEE THE PEOPLE AND THINGS AROUND ME AS BEING ABOUT THE SAME AS THEY USUALLY ARE				I SEE THE PEOPLE AND THINGS AROUND ME AS BEING AS GOOD AS THEY COULD POSSIBLY BE		
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

YOUR THERAPIST--

I SEE MY THERAPIST AS BEING AS BAD AS A THERAPIST COULD POSSIBLY BE				I SEE MY THERAPIST AS BEING ABOUT THE SAME AS HE/SHE USUALLY IS				I SEE MY THERAPIST AS BEING AS GOOD AS A THERAPIST COULD POSSIBLY BE		
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

Instructions for Questions #10 through #14: ANSWER THE FOLLOWING QUESTIONS AS BRIEFLY AS POSSIBLE. One or two sentences will be enough for each question.

10. WHAT ENABLED YOU TO TALK ABOUT THE PROBLEMS AND FEELINGS YOU HAVE DISCUSSED TODAY?

11. WHAT DID YOU LIKE MOST ABOUT THIS SESSION?

12. WHAT DID YOU LIKE LEAST ABOUT THIS SESSION?

13. WHAT WAS MOST HELPFUL TO YOU IN TODAY'S SESSION?

14. WHAT WAS LEAST HELPFUL TO YOU IN TODAY'S SESSION?

APPENDIX E

APPENDIX E

The "Critical Session"

Questionnaire (Therapist Form)

THERAPIST IDENTIFICATION CODE: _____
(Your identifying code is formed from the initials of your first and last names and the year you were born. Example: John Doe born in 1948 would have the code--JD1948)

DATE OF SESSION: _____

CLIENT IDENTIFICATION CODE (For the client you saw this session): _____
(Your client's identification code is formed the same way as your code. If you do not know your client's year of birth, just put his or her initials and the name of your agency here: _____)

ONLY FILL OUT THIS SECTION THE FIRST TIME THAT YOU SEE THIS CLIENT FOR THIS RESEARCH PROJECT.

☐ CHECK HERE IF THIS IS THE FIRST SESSION YOU HAVE EVER SEEN THIS CLIENT.

IF YOU HAVE SEEN THIS CLIENT BEFORE THIS RESEARCH PROJECT STARTED, CIRCLE THE SESSION NUMBER THAT TODAY'S SESSION IS (DO NOT COUNT MISSED OR CANCELLED SESSIONS.) IF THIS IS NOT YOUR FIRST SESSION WITH THIS CLIENT, YOU SHOULD NOT HAVE SEEN HIM OR HER FOR TEN SESSIONS OR LESS AND STILL INCLUDE HIM OR HER IN THIS PROJECT.

11 12 13 14 15 16 17 18 19 20 21 22 23 24 25

26 27 28 29 30 31 32 33 34 45 36 37 38 39 40

41 42 43 44 45 46 47 48 49 50

If more than 50 sessions, write number here: _____

BRIEFLY (IN ONE OR TWO SENTENCES) DESCRIBE THE CLIENT'S PROBLEM(S) AS YOU SEE IT (OR THEM). PLEASE DO NOT JUST WRITE A DIAGNOSIS.

PLEASE ANSWER ALL QUESTIONS.

1. WHAT ARE YOUR FEELINGS ABOUT THE SESSION THAT JUST ENDED?

Instructions: +5 = The way you would feel if it had been the best possible session.

0 = The way you would feel if it had been an average session.

-5 = The way you would feel if it had been the worst possible session.

USING THE ABOVE AS A GUIDELINE, CIRCLE ONE NUMBER ON THE SCALE BELOW that best represents how you felt about the session that has just ended.

WORST POSSIBLE					AVERAGE					BEST POSSIBLE
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

2. HOW WAS THIS SESSION IN TERMS OF YOUR CLIENT'S GOALS FOR HIMSELF/HERSELF IN THERAPY?

Instructions: +5 = The best possible session in terms of my client's goals.

0 = An average session in terms of my client's goals for himself/herself.

-5 = The worst possible session in terms of my client's goals.

USING THE ABOVE AS A GUIDELINE, CIRCLE ONE NUMBER ON THE SCALE BELOW that best represents your ESTIMATE of how this session was for your client in terms of his/her goals for himself/herself in therapy.

WORST POSSIBLE					AVERAGE					BEST POSSIBLE
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

3. WAS YOUR CLIENT ABLE TO TALK ABOUT ONE OF HIS/HER MAIN PROBLEMS IN A DIRECT MANNER?

Instructions: +5 = It was as easy as it could possibly be for my client to talk about it in a direct way.

0 = It was about as much effort as it usually is for my client and he/she was able to talk about it somewhat.

-5 = It was as difficult as it could possibly be for my client to talk about it in a direct way and he/she could only do it indirectly, if at all.

DIFFICULT AS IT POSSIBLY COULD BE				AS MUCH AS USUAL ON THE AVERAGE				EASY AS IT POSSIBLY COULD BE		
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

4. DID YOUR CLIENT EXPRESS ANY AFFECT CONCERNING ONE OF HIS/HER MAIN PROBLEMS?

Instructions: +5 = My client expressed as much affect as could possibly be expressed concerning one of his/her main problems.

0 = My client expressed about the same amount of affect concerning one of his/her main problems as he/she usually does.

-5 = My client expressed as little affect as could possibly be expressed or none at all concerning one of his/her main problems.

USING THE ABOVE AS A GUIDELINE, CIRCLE ONE NUMBER ON THE SCALE BELOW that best represents your ESTIMATE of how much affect your client expressed in this session concerning one of his/her main problems.

AS LITTLE AS POSSIBLE				AS MUCH AS USUAL ON THE AVERAGE				AS MUCH AS POSSIBLE		
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

5. DID YOUR CLIENT LEARN ANY NEW AND IMPORTANT THINGS ABOUT HIMSELF/HERSELF WHICH HE/SHE WILL BE ABLE TO USE?

Instructions: +5 = My client learned as many important things about himself/herself as he/she possibly could in a single session.

0 = My client learned about the same amount about himself/herself as he/she usually does in an average session.

-5 = My client learned as few important things about himself/herself as he/she possibly could in a single session, or nothing at all.

USING THE ABOVE GUIDELINE, CIRCLE ONE NUMBER ON THE SCALE BELOW that best represents your ESTIMATE of whether your client learned any new, important, and useful things about himself/herself in this session.

AS FEW AS POSSIBLE				AS MANY AS USUAL ON THE AVERAGE				AS MANY AS POSSIBLE		
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

AS A RESULT OF THE SESSION THAT HAS JUST ENDED, MAKE AN ESTIMATE OF HOW YOUR CLIENT NOW VIEWS THE FOLLOWING:

6. HIMSELF OR HERSELF--

SEES SELF AS BEING IN THE WORST POSSIBLE WAY				SEES SELF AS BEING ABOUT THE SAME AS USUAL				SEES SELF AS BEING IN THE BEST POSSIBLE WAY		
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

7. THE COURSE OF HIS/HER THERAPY--

SEES THERAPY AS GOING IN THE WORST POSSIBLE WAY				SEES THERAPY AS GOING ABOUT THE SAME AS USUAL				SEES THERAPY AS GOING IN THE BEST POSSIBLE WAY		
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

8. HIS/HER PERSONAL ENVIRONMENT--

SEES THE PEOPLE AND THINGS AROUND HIM/HER AS BEING AS BAD AS THEY COULD POSSIBLY BE				SEES THE PEOPLE AND THINGS AROUND HIM/HER AS BEING ABOUT THE SAME AS USUAL				SEES THE PEOPLE AND THINGS AROUND HIM/HER AS BEING AS GOOD AS THEY COULD POSSIBLY BE		
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

9. YOU, THE THERAPIST--

SEES YOU AS BEING AS BAD AS A THERAPIST COULD POSSIBLY BE				SEES YOU AS BEING ABOUT THE SAME AS USUAL				SEES YOU AS BEING AS GOOD AS A THERAPIST COULD POSSIBLY BE		
-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

10. BRIEFLY (IN ONE OR TWO SENTENCES) DESCRIBE WHAT WAS MOST HELPFUL TO YOUR CLIENT IN TODAY'S SESSION:

APPENDIX F

APPENDIX F

The Multiple Affect

Adjective Check List (Client Form)

DIRECTIONS FOR THIS PAGE: Listed below are words which describe different kinds of moods and feelings. Blacken in the space beside the words which describe how you felt during the session you have just completed. Some of the words may sound alike, but we want you to check all the words that describe your feelings in the session.

THEN--CIRCLE the ONE FEELING that you FELT THE MOST during the session.

1. ACTIVE
2. ADVENTUROUS
3. AFFECTIONATE
4. AFRAID
5. AGITATED
6. AGREEABLE
7. AGGRESSIVE
8. ALIVE
9. ALONE
10. AMIABLE
11. AMUSED
12. ANGRY
13. ANNOYED
14. AWFUL
15. BASHFUL
16. BITTER
17. BLUE
18. BORED
19. CALM
20. CAUTIOUS
21. CHEERFUL
22. CLEAN
23. COMPLAINING
24. CONTENTED
25. CONTRARY
26. COOL
27. COOPERATIVE
28. CRITICAL
29. CROSS
30. CRUEL
31. DARING
32. DESPERATE
33. DESTROYED
34. DEVOTED
35. DISAGREEABLE
36. DISCONTINUED
37. DISCOURAGED
38. DISGUSTED
39. DISPLEASED
40. ENERGETIC
41. NERAGED
42. ENTHUSIASTIC
43. FEARFUL
44. FINE
45. FIT
46. FORLORN
47. FRANK
48. FREE
49. FRIENDLY
50. FRIGHTENED
51. FURIOUS
52. GAY
53. GENTLE
54. GLAD
55. GLOOMY
56. GOOD
57. GOOD-NATURED
58. GRIM
59. HAPPY
60. HEALTHY
61. HOPELESS
62. HOSTILE
63. IMPATIENT
64. INCENSED
65. INDIGNANT
66. INSPIRED

67. INTERESTED
68. IRRITATED
69. JEALOUS
70. JOYFUL
71. KINDLY
72. LONELY
73. LOST
74. LOVING
75. LOW
76. LUCKY
77. MAD
78. MEAN
79. WEEK
80. MERRY
81. MILD
82. MISERABLE
83. NERVOUS
84. OBLIGING
85. OFFENDED
86. OUTRAGED
87. PANICKY
88. PATIENT
89. PEACEFUL
90. PLEASED
91. PLEASANT
92. POLITE
93. POWERFUL
94. QUIET
95. RECKLESS
96. REJECTED
97. ROUGH
98. SAD
99. SAFE
100. SATISFIED
101. SECURE
102. SHAKY
103. SHY
104. SOOTHED
105. STEADY
106. STUBBORN
107. STORMY
108. STRONG
109. SUFFERING
110. SULLEN
111. SUNK
112. SYMPATHETIC
113. TAME
114. TENDER
115. TENSE
116. TERRIBLE
117. TERRIFIED
118. THOUGHTFUL
119. TIMID
120. TORMENTED
121. UNDERSTANDING
122. UNHAPPY
123. UNSOCIABLE
124. UPSET
125. VEXED
126. WARM
127. WHOLE
128. WILD
129. WILLFUL
130. WILTED
131. WORRYING
132. YOUNG

PLEASE BE SURE TO CIRCLE THE ONE

FEELING YOU FELT MOST.

APPENDIX G

APPENDIX G

The Multiple Affect Adjective Check List (Therapist Form)

PUT YOUR IDENTIFICATION CODE HERE: _____

DIRECTIONS FOR THIS PAGE: Listed below are words which describe different kinds of moods and feelings. Circle the words which describe how your client felt during the session you have just completed. Circle as many of the feelings as apply.

THEN--UNDERLINE THE ONE FEELING that your client seemed to have FELT MOST during the session.

1. ACTIVE
2. ADVENTUROUS
3. AFFECTIONATE
4. AFRAID
5. AGITATED
6. AGREEABLE
7. AGGRESSIVE
8. ALIVE
9. ALONE
10. AMIABLE
11. AMUSED
12. ANGRY
13. ANNOYED
14. AWFUL
15. BASHFUL
16. BITTER
17. BLUE
18. BORED
19. CALM
20. CAUTIOUS
21. CHEERFUL
22. CLEAN
23. COMPLAINING
24. CONTENTED
25. CONTRARY
26. COOL
27. COOPERATIVE
28. CRITICAL
29. CROSS
30. CRUEL
31. DARING
32. DESPERATE
33. DESTROYED
34. DEVOTED
35. DISAGREEABLE
36. DISCONTENTED
37. DISCOURAGED
38. DISGUSTED
39. DISPLEASED
40. ENERGETIC
41. ENRAGED
42. ENTHUSIASTIC
43. FEARFUL
44. FINE
45. FIT
46. FORLORN
47. FRANK
48. FREE
49. FRIENDLY
50. FRIGHTENED
51. FURIOUS
52. GAY
53. GENTLE
54. GLAD
55. GLOOMY
56. GOOD
57. GOOD-NATURED
58. GRIM
59. HAPPY
60. HEALTHY
61. HOPELESS
62. HOSTILE
63. IMPATIENT
64. INCENSED
65. INDIGNANT
66. INSPIRED

67. INTERESTED
68. IRRITATED
69. JEALOUS
70. JOYFUL
71. KINDLY
72. LONELY
73. LOST
74. LOVING
75. LOW
76. LUCKY
77. MAD
78. MEAN
79. MEEK
80. MERRY
81. MILD
82. MISERABLE
83. NERVOUS
84. OBLIGING
85. OFFENDED
86. OUTRAGED
87. PANICKY
88. PATIENT
89. PEACEFUL
90. PLEASED
91. PLEASANT
92. POLITE
93. POWERFUL
94. QUIET
95. RECKLESS
96. REJECTED
97. ROUGH
98. SAD
99. SAFE
100. SATISFIED
101. SECURE
102. SHAKY
103. SHY
104. SOOTHED
105. STEADY
106. STUBBORN
107. STORMY
108. STRONG
109. SUFFERING
110. SULLEN
111. SUNK
112. SYMPATHETIC
113. TAME
114. TENDER
115. TENSE
116. TERRIBLE
117. TERRIFIED
118. THOUGHTFUL
119. TIMID
120. TORMENTED
121. UNDERSTANDING
122. UNHAPPY
123. UNSOCIABLE
124. UPSET
125. VEXED
126. WARM
127. WHOLE
128. WILD
129. WILLFUL
130. WILTED
131. WORRYING
132. YOUNG

PLEASE BE SURE TO UNDERLINE THE ONE FEELING YOUR CLIENT FELT MOST.

APPENDIX H

APPENDIX H

The Therapy Session Report (Client Form)

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

Circle one:

1. Very well; much the way I would like to.
2. Fairly well; I have my ups and downs.
3. So-so; manage to keep going with some effort.
4. Fairly poorly; life gets pretty tough for me at times.
5. Quite poorly; can barely manage to deal with things.

WHAT SUBJECTS DID YOU TALK ABOUT DURING THIS SESSION? (For each subject, circle the answer which best applies.)

DURING THIS SESSION I TALKED ABOUT:

		NO	SOME	A LOT
2.	MY MOTHER	0	1	2
3.	MY FATHER	0	1	2
4.	MY BROTHERS OR SISTERS	0	1	2
5.	MY CHILDHOOD	0	1	2
6.	MY ADOLESCENCE	0	1	2
7.	RELIGIOUS FEELINGS, ACTIVITIES OR EXPERIENCES	0	1	2
8.	WORK, CAREER OR EDUCATION	0	1	2
9.	RELATIONS WITH OTHERS OF THE SAME SEX	0	1	2
10.	RELATIONS WITH THE OPPOSITE SEX	0	1	2
11.	FINANCIAL RESOURCES OR PROBLEMS WITH MONEY	0	1	2
12.	FEELINGS ABOUT SPOUSE OR ABOUT BEING MARRIED	0	1	2
13.	HOUSEHOLD RESPONSIBILITIES OR ACTIVITIES	0	1	2
14.	FEELINGS ABOUT CHILDREN OR BEING A PARENT	0	1	2
15.	BODY FUNCTIONS, SYMPTOMS, OR APPEARANCE	0	1	2
16.	STRANGE OR UNUSUAL IDEAS AND EXPERIENCES	0	1	2

17.	HOPES OR FEARS ABOUT THE FUTURE	0	1	2
18.	DREAMS OR FANTASIES	0	1	2
19.	ATTITUDES OR FEELINGS TOWARD MY THERAPIST	0	1	2
20.	THERAPY: FEELINGS AND PROGRESS AS A PATIENT	0	1	2
21.	OTHER:_____	0	1	2

PUT A CHECK (✓) IN FRONT OF THE SUBJECT FROM THE ABOVE LIST THAT YOU TALKED ABOUT MOST DURING THIS SESSION.

BE SURE THAT YOU HAVE ANSWERED EVERY ITEM ON THIS PAGE.

WHAT PROBLEMS OR FEELINGS WERE YOU CONCERNED ABOUT THIS SESSION? (For each item, circle the answer which best applies.)

DURING THIS SESSION I WAS CONCERNED ABOUT:

		NO	SOME	A LOT
22.	GETTING A CHANCE TO LET GO AND GET THINGS OFF MY CHEST	0	1	2
23.	GETTING RELIEF FROM TENSIONS OR UNPLEASANT FEELINGS	0	1	2
24.	UNDERSTANDING THE REASONS BEHIND MY FEELINGS AND BEHAVIOR	0	1	2
25.	GETTING SOME REASSURANCE	0	1	2
26.	HAVING MY THERAPIST RESPOND TO ME ON A PERSON-TO-PERSON BASIS	0	1	2
27.	GETTING BETTER SELF CONTROL	0	1	2
28.	GETTING STRAIGHT ON WHICH THINGS I THINK AND FEEL ARE REAL AND WHICH ARE MOSTLY IN MY MIND	0	1	2
29.	BEING DEPENDENT ON OTHERS	0	1	2
30.	MEETING MY OBLIGATIONS AND RESPONSIBILITIES	0	1	2
31.	BEING ASSERTIVE OR COMPETITIVE	0	1	2
32.	LIVING UP TO MY CONSCIENCE: SHAMEFUL OR GUILTY FEELINGS	0	1	2
33.	BEING LONELY OR ISOLATED	0	1	2
34.	SEXUAL FEELINGS AND EXPERIENCES	0	1	2
35.	EXPRESSING OR EXPOSING MYSELF TO OTHERS	0	1	2
36.	LOVING: BEING ABLE TO GIVE OF MYSELF	0	1	2
37.	ANGRY FEELINGS OR BEHAVIOR	0	1	2
38.	WHO I AM AND WHAT I WANT	0	1	2
39.	FEARFUL OR PANICKY EXPERIENCES	0	1	2

40.	MEANING LITTLE OR NOTHING TO OTHERS: BEING WORTHLESS OR UNLOVABLE	0	1	2
41.	OTHER:_____	0	1	2

PLEASE BE SURE THAT YOU HAVE ANSWERED EVERY ITEM.

WHAT DO YOU FEEL THAT YOU GOT OUT OF THIS SESSION?
(For each item, circle the answer which best applies.)

I FEEL THAT I GOT:

		NO	SOME	A LOT
42.	ACCEPTANCE OF WHO I AM BY MY THERAPIST	0	1	2
43.	HOPE: A FEELING THAT THINGS CAN WORK OUT FOR ME	0	1	2
44.	HELP IN TALKING ABOUT WHAT WAS REALLY TROUBLING ME	0	1	2
45.	RELIEF FROM TENSIONS AND UNPLEASANT FEELINGS	0	1	2
46.	MORE UNDERSTANDING OF THE REASONS BEHIND MY BEHAVIOR AND FEELINGS	0	1	2
47.	REASSURANCE AND ENCOURAGEMENT ABOUT HOW I'M DOING: SUPPORT	0	1	2
48.	CONFIDENCE TO TRY TO DO THINGS DIFFERENTLY	0	1	2
49.	MORE ABILITY TO FEEL MY FEELINGS, TO KNOW WHAT I REALLY WANT	0	1	2
50.	IDEAS FOR BETTER WAYS OF DEALING WITH PEOPLE AND PROBLEMS	0	1	2
51.	MORE OF A PERSON-TO-PERSON RELATIONSHIP WITH MY THERAPIST	0	1	2
52.	BETTER SELF CONTROL OVER MY MOODS AND ACTIONS	0	1	2
53.	A MORE REALISTIC EVALUATION OF MY THOUGHTS AND FEELINGS	0	1	2
54.	EMPATHY FOR WHAT I WAS EXPERIENCING	0	1	2
55.	CONFIDENCE TO TAKE GREATER RESPONSIBILITY FOR MY PROGRESS IN THERAPY	0	1	2
56.	MORE INSIGHT INTO MY PROBLEMS	0	1	2
57.	A DIFFERENT VIEW OF MY THERAPY OR MY RELATIONSHIP WITH MY THERAPIST	0	1	2
58.	A DIFFERENT VIEW OF MYSELF	0	1	2

59.	AN AWARENESS OF SOME NEW THINGS ABOUT MYSELF WHICH I DIDN'T KNOW BEFORE	0	1	2
60.	SOME CLARIFICATION AS TO THE WAY PEOPLE REALLY ARE	0	1	2
	NOTHING IN PARTICULAR: I FEEL THE SAME AS I DID BEFORE THE SESSION	0	1	2
	OTHER: _____	0	1	2

PUT A CHECK (✓) IN FRONT OF THE ITEM FROM THE ABOVE LIST THAT BEST DESCRIBES WHAT YOU GOT MOST OUT OF THIS SESSION.

BE SURE THAT YOU HAVE ANSWERED EVERY ITEM

FOR EACH ITEM, CIRCLE THE ANSWER WHICH BEST APPLIES:

DURING THIS SESSION, HOW MUCH:		Slightly or Not At All	Some	Pretty Much	Very Much
61.	DID YOUR THERAPIST TALK?	0	1	2	3
62.	WAS YOUR THERAPIST ATTENTIVE TO WHAT YOU WERE TRYING TO GET ACROSS?	0	1	2	3
63.	DID YOUR THERAPIST TEND TO ACCEPT OR AGREE WITH YOUR IDEAS AND POINT OF VIEW?	0	1	2	3
64.	WAS YOUR THERAPIST NEGATIVE OR CRITICAL TOWARD YOU?	0	1	2	3
65.	DID YOUR THERAPIST TAKE INITIATIVE IN BRINGING UP THINGS TO TALK ABOUT?	0	1	2	3
66.	DID YOUR THERAPIST TRY TO GET YOU TO CHANGE YOUR POINT OF VIEW OR WAY OF DOING THINGS?	0	1	2	3
67.	WAS YOUR THERAPIST FRIENDLY AND WARM TOWARDS YOU?	0	1	2	3
68.	DID YOUR THERAPIST SHOW FEELING?	0	1	2	3
69.	DID YOUR THERAPIST CONFRONT YOU ON WHAT YOU WERE SAYING OR DOING?	0	1	2	3
70.	DID YOUR THERAPIST MAKE INTERPRETATIONS ON YOUR THOUGHTS, DREAMS, FEELINGS OR BEHAVIOR?	0	1	2	3
71.	WHAT IMPACT DID YOUR THERAPIST HAVE UPON YOU?	0	1	2	3
72.	DID YOU ACHIEVE A SENSE OF MUTUAL CLOSENESS WITH YOUR THERAPIST?	0	1	2	3

73.	DID YOUR THERAPIST REVEAL SPONTANEOUS IMPRESSIONS OR REACTIONS?	0	1	2	3
74.	WAS YOUR THERAPIST IN RAPPORT WITH YOUR FEELINGS?	0	1	2	3
75.	DID YOUR THERAPIST UNDERSTAND WHAT YOU SAID AND DID?	0	1	2	3

PLEASE BE SURE THAT YOU HAVE ANSWERED EVERY ITEM.

THANK YOU FOR YOUR HELP.

APPENDIX I

APPENDIX I

The Therapy Session Report (Therapist Form)

1. HOW WELL DO YOU FEEL THAT THE CLIENT SEEMS TO BE GETTING ALONG, EMOTIONALLY AND PSYCHOLOGICALLY, AT THIS TIME? CIRCLE ONE:

    1. Very well; much the way he/she would like to.

    2. Quite well; no important complaints.

    3. So-so; manages to keep going with some effort.

    4. Fairly poorly; life gets pretty tough for him/her at times.

    5. Quite poorly; can barely manage to deal with things.

WHAT SUBJECTS DID YOUR CLIENT TALK ABOUT DURING THIS SESSION? (For each subject, circle the answer which best applies.)

DURING THIS SESSION HE/SHE TALKED ABOUT:	NO	SOME	A LOT
2. HIS/HER MOTHER	0	1	2
3. HIS/HER FATHER	0	1	2
4. HIS/HER BROTHERS OR SISTERS	0	1	2
5. HIS/HER CHILDHOOD	0	1	2
6. HIS/HER ADOLESCENCE	0	1	2
7. RELIGIOUS FEELINGS, ACTIVITIES OR EXPERIENCE	0	1	2
8. WORK, CAREER, OR EDUCATION	0	1	2
9. RELATIONS WITH OTHERS OF THE SAME SEX	0	1	2
10. RELATIONS WITH THE OPPOSITE SEX	0	1	2
11. FINANCIAL RESOURCES OR PROBLEMS WITH MONEY	0	1	2
12. FEELINGS ABOUT SPOUSE OR ABOUT BEING MARRIED	0	1	2
13. HOUSEHOLD RESPONSIBILITIES OR ACTIVITIES	0	1	2
14. FEELINGS ABOUT CHILDREN OR BEING A PARENT	0	1	2
15. BODY FUNCTIONS, SYMPTOMS OR APPEARANCE	0	1	2
16. STRANGE OR UNUSUAL IDEAS AND EXPERIENCES	0	1	2
17. HOPES OR FEARS ABOUT THE FUTURE	0	1	2

18.	DREAMS OR FANTASIES	0	1	2
19.	ATTITUDES OR FEELINGS TOWARD HIS/HER THERAPIST	0	1	2
20.	THERAPY: FEELINGS AND PROGRESS AS A PATIENT	0	1	2
21.	OTHER: _____	0	1	2

PUT A CHECK (✓) IN FRONT OF THE SUBJECT FROM THE ABOVE LIST THAT YOUR CLIENT TALKED ABOUT MOST IN THE SESSION.

BE SURE THAT YOU HAVE ANSWERED EVERY ITEM

WHAT PROBLEMS OR FEELINGS WAS YOUR CLIENT CONCERNED ABOUT THIS SESSION? (For each item, circle the NUMBER answer which best applies. Circle a LETTER answer ONLY if you circle a "1" or a "2" for that item. If you circle a "0" do NOT circle a letter answer for that item.)

Letter answers: A = Relatively Affectless and Uninvolved
B = Moderately Affective and Involved
C = Strongly Affective and Involved

DURING THE SESSION HE/SHE WAS CONCERNED ABOUT:		NO	SOME	A LOT	A	B	C
22.	GETTING A CHANCE TO LET GO AND GET THINGS OFF HIS/HER CHEST	0	1	2	A	B	C
23.	GETTING RELIEF FROM TENSIONS OR UNPLEASANT FEELINGS	0	1	2	A	B	C
24.	UNDERSTANDING THE REASONS BEHIND HIS/HER FEELINGS AND BEHAVIOR	0	1	2	A	B	C
25.	GETTING SOME REASSURANCE	0	1	2	A	B	C
26.	HAVING HIS/HER THERAPIST RESPOND TO HIM/HER ON A PERSON-TO-PERSON BASIS	0	1	2	A	B	C
27.	GETTING BETTER SELF CONTROL	0	1	2	A	B	C

28.	GETTING STRAIGHT ON WHICH THINGS HE/SHE THINKS ARE REAL AND WHICH ARE MOSTLY IN HIS/HER MIND	0	1	2	A	B	C
29.	BEING DEPENDENT ON OTHERS	0	1	2	A	B	C
30.	MEETING HIS/HER OBLIGATIONS AND RESPONSIBILITIES	0	1	2	A	B	C
31.	BEING ASSERTIVE OR COMPETITIVE	0	1	2	A	B	C
32.	LIVING UP TO HIS/HER CONSCIENCE: SHAMEFUL OR GUILTY FEELINGS	0	1	2	A	B	C
33.	BEING LONELY OR ISOLATED	0	1	2	A	B	C
34.	SEXUAL FEELINGS AND EXPERIENCES	0	1	2	A	B	C
35.	EXPRESSING OR EXPOSING HIM/HERSELF TO OTHERS	0	1	2	A	B	C
36.	LOVING: BEING ABLE TO GIVE OF HIM/HERSELF	0	1	2	A	B	C
37.	ANGRY FEELINGS OR BEHAVIOR	0	1	2	A	B	C
38.	WHO HE/SHE IS AND WHAT HE/SHE WANTS	0	1	2	A	B	C
39.	FEARFUL OR PANICKY EXPERIENCES	0	1	2	A	B	C
40.	MEANING LITTLE OR NOTHING TO OTHERS: BEING WORTHLESS OR UNLOVABLE	0	1	2	A	B	C
41.	OTHER: _____						

PLEASE BE SURE THAT YOU HAVE ANSWERED EVERY ITEM

IN WHAT DIRECTION WERE YOU WORKING WITH YOUR CLIENT THIS SESSION? (For each item, circle the answer which best applies.)

I WAS WORKING TOWARD:		NO	SOME	A LOT
42.	HELPING MY CLIENT FEEL ACCEPTED IN OUR RELATIONSHIP	0	1	2
43.	GETTING A BETTER UNDERSTANDING OF MY CLIENT, OF WHAT WAS REALLY GOING ON	0	1	2
44.	HELPING MY CLIENT TALK ABOUT HIS/HER FEELINGS AND CONCERNS	0	1	2

45.	HELPING MY CLIENT GET RELIEF FROM TENSIONS OR UNHAPPY FEELINGS	0	1	2
46.	HELPING MY CLIENT UNDERSTAND THE REASONS BEHIND HIS/HER REACTIONS	0	1	2
47.	SUPPORTING MY CLIENT'S SELF-ESTEEM AND CONFIDENCE	0	1	2
48.	ENCOURAGING ATTEMPTS TO CHANGE AND TRY NEW WAYS OF BEHAVIOR	0	1	2
49.	MOVING MY CLIENT CLOSER TO EXPERIENCING EMERGENT FEELINGS	0	1	2
50.	HELPING MY CLIENT LEARN NEW WAYS FOR DEALING WITH SELF AND OTHERS	0	1	2
51.	ESTABLISHING A GENUINE PERSON-TO-PERSON RELATIONSHIP WITH MY CLIENT	0	1	2
52.	HELPING MY CLIENT GET BETTER SELF CONTROL OVER FEELINGS AND IMPULSES	0	1	2
53.	HELPING MY CLIENT REALISTICALLY EVALUATE REACTIONS AND FEELINGS	0	1	2
54.	SHARING EMPATHICALLY IN WHAT MY CLIENT WAS EXPERIENCING	0	1	2
55.	GETTING MY CLIENT TO TAKE A MORE ACTIVE ROLE AND RESPONSIBILITY FOR PROGRESS IN THERAPY	0	1	2
56.	HELPING MY CLIENT GET MORE INSIGHT INTO HIS/HER PROBLEMS	0	1	2
57.	HELPING MY CLIENT GET A DIFFERENT PERCEPTION OF THE THERAPY SITUATION AND THERAPEUTIC RELATIONSHIP	0	1	2
58.	HELPING MY CLIENT GET A DIFFERENT VIEW OF HIMSELF/HERSELF	0	1	2
59.	HELPING MY CLIENT GET AN AWARENESS OF SOME NEW THINGS ABOUT HIMSELF/HERSELF THAT HE/SHE WAS PREVIOUSLY UNAWARE OF	0	1	2
60.	HELPING MY CLIENT GET CLARIFICATION ON THE WAY PEOPLE REALLY ARE	0	1	2

PUT A CHECK (✓) IN FRONT OF THE ITEM FROM THE ABOVE LIST THAT BEST DESCRIBES WHAT YOUR CLIENT SEEMED TO HAVE GOTTEN MOST OUT OF THIS SESSION.

DURING THIS SESSION, HOW MUCH:	Slightly or Not At All	Some	Pretty Much	Very Much
61. DID YOU TALK?	0	1	2	3
62. WERE YOU ATTENTIVE TO WHAT YOUR CLIENT WAS TRYING TO GET ACROSS?	0	1	2	3
63. DID YOU TEND TO AGREE WITH OR ACCEPT YOUR CLIENT'S IDEAS OR SUGGESTIONS?	0	1	2	3
64. WERE YOU CRITICAL OR DISAPPROVING TOWARDS YOUR CLIENT?	0	1	2	3
65. DID YOU TAKE INITIATIVE IN DEFINING THE ISSUES THAT WERE TALKED ABOUT?	0	1	2	3
66. DID YOU TRY TO CHANGE YOUR CLIENT'S POINT OF VIEW OR WAY OF DOING THINGS?	0	1	2	3
67. WERE YOU WARM AND FRIENDLY TOWARDS YOUR CLIENT?	0	1	2	3
68. DID YOU EXPRESS FEELING?	0	1	2	3
69. DID YOU CONFRONT YOUR CLIENT ON WHAT HE/SHE WAS SAYING OR DOING?	0	1	2	3
70. DID YOU MAKE INTERPRETATIONS ON YOUR CLIENT'S THOUGHTS, DREAMS, FEELINGS OR BEHAVIOR?	0	1	2	3
71. WHAT IMPACT DID YOU HAVE ON YOUR CLIENT?	0	1	2	3
72. DID YOU ACHIEVE A SENSE OF MUTUAL CLOSENESS WITH YOUR CLIENT?	0	1	2	3
73. DID YOU REVEAL YOUR SPONTANEOUS IMPRESSIONS OR REACTIONS TO YOUR CLIENT?	0	1	2	3
74. WERE YOU IN RAPPORT WITH YOUR CLIENT'S FEELINGS?	0	1	2	3
75. DID YOU FEEL YOU UNDERSTOOD OF WHAT YOUR CLIENT SAID AND DID?	0	1	2	3

PLEASE BE SURE THAT YOU HAVE ANSWERED EVERY ITEM

THANK YOU FOR YOUR HELP

APPENDIX J

APPENDIX J

Instructions to Therapists

The selection of clients to participate in this research project will be performed by the therapists.

GUIDELINES FOR SELECTION OF CLIENTS

Choose ONE or TWO clients who meet the following criteria:

1) At least 18 years old

2) NOT psychotic, schizophrenic, psychopathic, or sociopathic--this is to be determined by your judgment.

3) If you decide to have TWO clients in this project, TRY to select one male and one female IF YOU CAN--this is preferable but not a necessity. Whether you choose to have one or two clients in the project, don't bother with selecting clients according to any demographic variables (i.e. age, race, religion, etc.).

4) Are in INDIVIDUAL therapy with you--no multiple or co-therapy.

5) Choose clients who by your judgment will stay in therapy for 12 sessions from the starting point of the project--this is difficult to predict, so make the best guess that you can when selecting a client.

You may choose clients who EITHER

Are about to start their FIRST SESSION with you

OR

Are about to start their ELEVENTH OR GREATER SESSION with you.

From this starting point questionnaires are to be completed immediately after each of the next TEN consecutive sessions (or as soon after each of these sessions as is possible). Missed or cancelled sessions are not to be counted toward the total of ten sessions.

APPENDIX K

APPENDIX K

Consent for Participating

in Research Form

A research project is being undertaken by Neil E. Rand of the Michigan State University Department of Psychology in order to better understand the processes involved in therapy and what happens in certain sessions at particular points in time that is helpful to people coming in for therapy. To do this, both clients and therapists will complete a form at the end of each therapy session. The information obtained will be statistically analyzed. This research should not interfere with the regular therapy procedures that people normally experience.

I, (YOUR NAME)_____, understand the nature of the research to be undertaken and I agree that information obtained during the course of my therapy sessions may be used for research purposes. This permission covers the use of any test results, therapist reports, and my own reports. This permission is given with the understanding that all information collected is confidential, that this information will be treated in a professional manner, and that adequate safeguards will be taken to insure anonymity.

I also understand that my therapist will not see any information collected about me in this research project without additional written permission.

Signed _____

Address _____

_____

Telephone Number _____

Date _____

APPENDIX L

APPENDIX L

Results Obtained From the Therapist and Client Background Questionnaires

Mean Therapist Age = 38

Number of male therapists = 8

Number of female therapists = 2

Therapists with doctoral degrees = 7

Therapists with medical (psychiatry) degrees = 1

Therapists with masters degrees in social work = 2

Mean years of full-time psychotherapy experience = 8.4

Therapeutic orientation:
- Analytic = 2
- Eclectic = 7
- Transactional Analysis = 1

Predominant therapeutic style for those therapists who listed their therapeutic orientation as "eclectic":
- Analytic = 4
- Client-centered = 2
- Existential = 1

Therapists' estimates of the average number of sessions that their previous individual adult psychotherapy clients have attended:
- 6 - 10 sessions = 4
- 11 - 15 sessions = 1
- 16 - 20 sessions = 1
- 21 - 25 sessions = 1
- 26 - 30 sessions = 1
- over 30 sessions = 2

Therapists' estimates of the average number of sessions that individual adult psychotherapy clients attend in that therapist's agency:

6 - 10 sessions	= 3
11 - 15 sessions	= 4
16 - 20 sessions	= 1
21 - 25 sessions	= 1
over 30 sessions	= 1

Therapists' estimates of the number of individual adult psychotherapy clients they have seen for longer than ten sessions:

6 - 10 clients	= 1
11 - 15 clients	= 2
16 - 20 clients	= 1
21 - 25 clients	= 1
31 - 35 clients	= 1
36 - 40 clients	= 1
over 50 clients	= 3

Mean age of clients = 29.7 years

Clients' occupations:

- Student = 5
- Housewife = 2
- Factory worker = 1
- College instructor = 1
- None reported = 1

Number of male clients = 3

Number of female clients = 7

Marital status of clients:

- Married = 4
- Single = 4
- Divorced = 2

Mean annual income of clients: $9100

Mix of clients and therapists by sex:

- Male client with male therapist = 3
- Male client with female therapist = 0
- Female client with male therapist = 5
- Female client with female therapist = 2

Number of clients previously in therapy = 6
Type of previous therapy:
Individual adult = 5
Individual child = 1

Reported length of previous therapy:
1 client reported 5 or 6 sessions
2 clients reported 2 or 3 months
3 clients reported 5 or 6 months

Clients' descriptions of the problems that caused them to seek out psychotherapy:

"I became intensely anxious over my 3 1/2 year old child's fear of 'growing up', especially in regard to great resistance to toilet training, and therefore sought advice from an 'expert'."

"Problems with husband and children. I suppose caused by low self-image."

"I was in a deep depression about what I was doing with my life."

"I was extremely anxious while on campus. I had negative feelings about school work, and found they were interfering with my accomplishments. I often was depressed because I thought I wasn't doing as well in school as I could."

"Relational problems with family, poor self-identity."

"The reason I decided to seek out professional help was that I always felt insecure in a relationship when there was no need to feel that way. I also felt that I couldn't cope or deal with major or minor problems in a relationship (male-female)."

"Whenever I'm around people, I get upset; shake, perspire, panic!"

"I was extremely depressed (for 10 years) and had ideas that my friends were plotting against me."

"At this point in my life, I felt that I did not have control over my life--what I did and what happened to/at me. I did not like this."

BIBLIOGRAPHY

BIBLIOGRAPHY

Auerbach, A. and Luborsky, L. Accuracy of judgments of psychotherapy and the nature of the "good hour". In Shlien, J. (ed.), Research in psychotherapy, Vol. 3. Wash., D.C.: American Psychological Association, 1968, 155-168.

Bergin, A. E. and Strupp, H.H. Changing frontiers in the science of psychotherapy. Chicago: Aldine, 1972.

Carkhuff, R. R. and Berenson, B. G. Beyond counseling and therapy. New York: Holt, Rinehart and Winston, 1967.

Frankl, V. E. Commentary in Standal, S. W. and Corsini, R. J. (eds.), Critical incidents in psychotherapy. Englewood Cliffs, N.J.: Prentice-Hall, 1959, 10.

Greenson, R. The technique and practice of psychoanalysis, Vol. 1. N.Y.: International Universities Press, 1967.

Kell, B. L. and Mueller, W. J. Impact and change: A study of counseling relationships. N.Y.: Appleton-Century-Crofts, 1966.

Kiesler, D. J. Some myths of psychotherapy research and the search for a paradigm. Psychological Bulletin, 1966, 65(2), 110-136.

Marsden, G. Content-analysis studies of psychotherapy: 1954 through 1968. In Bergin, A. and Garfield, S. (eds.), Handbook of psychotherapy and behavior change. N.Y.: John Wiley, 1971.

May, R. Existence. N.Y.: Simon and Schuster, 1958.

Meltzoff, J. and Kornreich, M. Research in psychotherapy. N.Y.: Atherton, 1970.

Mintz, J.; Auerbach, A.; Luborsky, L.; and Johnson, M. Patient's, therapist's and observer's views of psychotherapy: A "Rashomon" experience or a reasonable consensus? British Journal of Medical Psychology, 1973, 46(1), 83-89.

BIBLIOGRAPHY (cont'd.)

Mueller, W. Personal communication. Michigan State University, 1974.

Orlinsky, D. E. and Howard, K. I. The good therapy hour: Experimental correlates of patients' and therapists' evaluations of therapy sessions. Archives of General Psychiatry, 1967, 16, 621-632.

Paul, G. L. Strategy of outcome research in psychotherapy. Journal of Consulting Psychology, 1967, 31, 109-118.

Rogers, C. R. On becoming a person. Boston: Houghton Mifflin, 1961.

Sanford, N. Clinical methods: Psychotherapy. Annual Review of Psychology, 1953, 4, 317-342.

Snyder, W. U. Commentary in Standal, S. W. and Corsini, R. J. (eds.), Critical incidents in psychotherapy. Englewood Cliffs, N.J.: Prentice-Hall, 1959, 20.

Sorokin, P. A. Commentary in Standal, S. W. and Corsini, R. J. (eds.). Critical incidents in psychotherapy. Englewood Cliffs, N.J.: Prentice-Hall, 1959, 22.