

RELATIONSHIP BETWEEN THERAPIST RESPONSE TO
THERAPIST-RELEVANT CLIENT EXPRESSIONS AND
THERAPY PROCESS AND CLIENT OUTCOME



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and Therapy Process and Client Outcome

presented by

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of the requirements for

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Date January 26, 1971

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ABSTRACT

RELATIONSHIP BETWEEN THERAPIST RESPONSE TO THERAPIST-RELEVANT CLIENT EXPRESSIONS AND THERAPY PROCESS AND CLIENT OUTCOME

By

Rosamond Mitchell

The present research was an investigation of the frequency and explicitness with which therapists interpret client statements in relation to themselves or the immediate therapeutic relationship and thereby focus on the client-therapist relationship. The Immediate Relationship Scale (IRS) was constructed to measure the explicitness with which therapists respond to client references to the therapist of varying degrees of overtness. In view of the consensus among therapists regarding the critical role in psychotherapy of the client's feelings about the therapist and the importance attached to the therapist's encouragement of client expression and explorations of such feelings, a positive relationship between therapists' IRS scores and client improvement was predicted.

Two separate studies using tape recordings of actual psychotherapy sessions were conducted. The data for Study I, a process study, was based on tape recordings of first

therapy sessions of 56 different therapist-client dyads. Ratings on the IRS and the E, W, G, and DX scales by Carkhuff and his associates were obtained on five 3-minute segments excerpted from each of the 56 tapes. The results of Study I indicated that for the total sample of therapists, IRS scores were (1) positively related to the therapists' core condition scores and clients' DX scores, (2) ordered therapists according to Orientation from higher to lower as Relationship, Eclectic, Client-Centered, and Analytic, respectively, (3) differentiated Relationship therapists from Analytic therapists and tended to also differentiate Relationship therapists from Eclectic and Client-Centered therapists and (4) did not differentiate between inpatient and outpatient therapists or between high and low experience level therapists within any of the four orientations.

The data in Study II, an outcome study, was based on tape recorded psychotherapy sessions of 40 outpatients seen by four psychiatric residents at Johns Hopkins University. Ratings on the IRS and the E, W, and G scales by Truax were obtained on six 3-minute segments excerpted from the recordings of each client's sessions. Five measures of client outcome were used: global improvement ratings by clients and therapists, Discomfort, Target, and Social Ineffectiveness. The results indicated that although for the total sample of therapists IRS scores and core condition

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scores were unrelated, IRS scores were positively related to the core condition scores for the high functioning therapists but negatively related for the low functioning therapists. The hypothesis predicting a positive relationship between client improvement and therapists' IRS scores for the entire sample was rejected for each of the five outcome measures; indeed, step-wise regression analyses indicated that higher IRS scores were actually predictive of client lack of improvement on one outcome measure. However, additional analyses, which took into account the core condition context of IRS scores, indicated that higher IRS scores in a context of relatively low levels of therapist-offered empathy and genuineness were related to lesser degrees of client improvement on three outcome measures. In contrast, IRS scores in a context of relatively high levels of therapist-offered empathy and genuineness were unrelated to client improvement on any of the outcome measures. These findings were interpreted as indicating that in the context of a therapist's deep understanding and genuine responses to the client the particular way in which a therapist responds to client references to himself, e.g., whether he ignores or explicitly interprets such references, is relatively inconsequential to the client's improvement. But when a therapist interprets client statements in relation to himself and thus attempts to focus on the relationship in the context of the

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therapist's failure to respond genuinely and to accurately understand the client's feelings, the client fails to improve or even deteriorates. Thus, the effectiveness of a therapist's IRS responses is dependent upon the accompanying level of his empathy and genuineness and, consequently, should be evaluated in conjunction with or in the context of his level of functioning on the core conditions.

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By

replied
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INTRODUCTION

There is a consensus among therapists of all theoretical orientations regarding the central importance of the client-therapist relationship for the successful outcome of therapy: this consensus consists of the proposition that a "good client-therapist relationship" is essential to client improvement (Hobbs, 1962; Schofield, 1967; Patterson, 1967; Shoben, 1949). Therapists are not in agreement, however, regarding precisely what is meant by a good client-therapist relationship, and there have been diverse formulations of the nature of such a relationship in the past (Freud, 1959; Fromm-Reichman, 1950; Sullivan, 1954; Rogers, 1957; Rosen, 1953; Whitaker and Malone, 1953). More recently, however, several factor analytic studies have provided a comprehensive yet parsimonious basis for specifying what therapists differing with respect to orientation and training actually denote by a good client-therapist relationship. At the same time, these studies have empirically demonstrated the existence of a consensus among therapists regarding the central role accorded to the therapeutic relationship (McNair and Lorr, 1964; Sundland and Barker, 1962; Wallach and Strupp, 1964).

In each of these studies factor analytic procedures were applied to therapist ratings of the extent of their agreement with a number of statements representing basic views and attitudes about therapeutic processes and techniques typically associated with different orientations, principally Freudian, Sullivanian, Client-Centered, and Experiential orientations. In each study only a few dimensions were sufficient to describe these therapist attitudes, and although some slight differences among the studies were apparent, the factors which emerged were markedly congruent. The following three factors were found in each study: the extent to which the therapist becomes personally involved in the treatment and the interpersonal relationship with the client, the extent to which the therapist uses classical psychoanalytic techniques, and the extent to which the therapist assumes active control of the treatment process. In addition, Sundland and Barker (1962) found a general factor, Analytic-Experiential, which included these three more specific factors and which they considered to be the single most important dimension upon which to describe therapists. Integrating the results of all three studies indicates that this or a quite similar dimension can be used to describe and differentiate therapists on the basis of their beliefs and attitudes about basic psychotherapy processes and techniques. The Analytic pole of this dimension describes therapists who stress the conceptualization and planning of therapy, unconscious processes,

insight into childhood experiences, interpretation and analysis of dreams, resistance and transference, and the restriction of spontaneity and personal involvement of the therapist. In contrast, the Experiential pole describes therapists who de-emphasize unconscious processes and the conceptualization and planning of therapy and who stress the personality, spontaneity, and personal involvement of the therapist. Consistent with this description of therapists along such a general dimension is Patterson's (1967) conclusion that the results of these factor analytic studies offer support for his earlier proposal that the therapy process can be described by a single dimension or dichotomy, Rational-Affective. The Rational therapy process tends to be planned, objective, and impersonal, while the Affective therapy process is emphasized as being warm, personal, and spontaneous. Moreover, Wolff (1956) had earlier predicted the existence of two basically different kinds of psychotherapy: one based upon a preconceived set of notions in which therapeutic change is accomplished by means of interpretations, and a second based upon an evolving personal relationship in which the relationship itself is the vehicle by which change is accomplished.

The kind of therapeutic relationship therapists consider appropriate, or "good," constitutes a major component of such a general Analytic-Experiential factor. The emergence of this factor indicates that there are two basic, quite different conceptualizations among therapists

regarding what constitutes a good client-therapist relationship and that therapists of diverse orientations can be compared and differentiated by the way in which they conceptualize a good relationship. One conceptualization portrays the therapist as being restrained, aloof, and impersonal in relation to the client and as analyzing and interpreting the client's feelings and behavior in a rational, objective manner in order to facilitate the client's achievement of insight. The parent-child relationship is the prototype for this Analytic kind of relationship (Hobbs, 1962). The conceptualization at the opposite pole portrays the good relationship as mutually spontaneous, open, and intimate and as being the basic therapeutic agent of client change.

A second series of recent factor analytic studies also have provided evidence of two different kinds of relationships similar to those reflected by the Analytic-Experiential factor. The studies also provided additional empirical support for the importance generally accorded to the therapeutic relationship. Among the factors which emerged from factor analysis of therapist and client descriptions of actual therapy sessions were several distinct factors specifically reflecting the relationship. Orlinsky and Howard (1967a, 1967b) found that productive or good and nonproductive or bad therapy sessions, as judged by both the therapist and the client, were differentiated by a factor, Mutual Personal Openness. This factor depicted the quality of the client-therapist relationship in a manner

similar to the Analytic-Experiential factor. This factor characterized good therapy sessions, and thus presumably also a good client-therapist relationship, as involving a person-to-person encounter with recognition and expression of one's own feelings in the immediate here-and-now situation by both the client and therapist. Bad therapy hours, on the other hand, were characterized by both participants feeling neutral, detached and withdrawn from one another. In addition, Howard, Orlinsky, and Hill (1969a) found a distinct content factor related to the relationship, Therapy and Therapist, which reflected dialogue consisting of evaluation of the therapist or therapy and exploration of client feelings about the therapist. And Howard, Orlinsky and Hill (1968) reported a factor, Toying with Therapist, which reflected the client's phenomenological experience during therapy sessions of feeling playful, affectionate, superior, and flirtatious toward the therapist.

The results of the studies by Orlinsky and his associates indicate that therapists translate their beliefs about psychotherapy into actual practice since relationships similar to those derived from self-professed attitudes, Analytic and Experiential, were reported by both therapists and clients to exist in therapy sessions. There is a suggestion, however, that an Experiential type of relationship is experienced as being more satisfactory since this type of relationship was characteristic of therapy sessions described as good whereas the analytic type of relationship

was typical of therapy hours described as unproductive or bad. Hobbs (1962) and Wallach and Strupp (1964) have identified the essence of this basic difference or Analytic-Experiential dichotomy in the client-therapist relationship as consisting of the way in which therapists handle the client's feelings about the therapist or his transference manifestations, including both those based on reality and classical psychoanalytic transferred reactions. There are two basic, quite different ways, corresponding to the Analytic and Experiential types of relationships, in which therapists respond to client feelings about the therapist. Therapists who establish an Analytic type of rational, objective, and personally aloof relationship consider the successful resolution of the transference neurosis to be the ultimate goal of therapy. To achieve this goal transference manifestations are analyzed and interpreted to the client in order to facilitate his gaining insight into the origin of his transference feelings (Wolman, 1967). In contrast, therapists who establish an Experiential type of intimate, personally involved relationship consider the relationship to be curative in and of itself and to provide an opportunity for the client to directly and immediately experience the impact his transference strategems have on another and to experience that these strategems are neither necessary nor appropriate; consequently, the therapist reacts openly and spontaneously to the client's transference feelings. Thus, an essential difference among therapists has been

delineated as the kind of response therapists make to client's feelings regarding the therapist, that is, whether the therapist analyzes and interprets these feelings to the client or whether he responds or reacts to these feelings in the context of an open, intimate relationship.

The therapist's response to the client's therapist-relevant feelings has also been noted by various other authors as constituting a central component of the therapy process within different theoretical orientations (Hobbs, 1962; Shapiro, 1961; Shoben, 1949; Strupp, 1958; Yulis & Kiesler, 1968). For example, in formulating the common sources of gain in diverse kinds of psychotherapy, Hobbs (1962) proposed that one such gain accrues from the therapist's being alert to and reinforcing any reaching out towards himself by the client so that the client will be increasingly able to express his feelings in the presence of another and "even to go so far as to dare to include the therapist as an object of these feelings" (Hobbs, 1962, p. 743). Shoben (1949) has noted that most therapists, regardless of theoretical orientation, consider those feelings and attitudes that clients have about the therapist to be intimately related to the success or failure of therapy and, in addition, noted the agreement among therapists that these feelings, in particular, must not be ignored or rejected by therapists. Moreover, the desirability of the therapist's encouragement and reinforcement of client expression of feelings about the therapist has also been

stressed from a learning theory framework on the basis that such client expressions provide an opportunity for the reduction or extinction of anxiety associated with interpersonal relationships (Hobbs, 1962; Murray, 1956, 1962; Shoben, 1949). In addition, numerous authors have proposed that the therapist's discussion and sharing with the client of his own feelings regarding the client can be a most effective element in psychotherapy (Fromm-Reichmann, 1948, 1949, 1950; Sullivan, 1949; Berman, 1949; Winecott, 1949; Little, 1951; Heiman, 1950; Tauber, 1954; Spitz, 1956; Whitaker, Felder, Malone, & Warkentin, 1962).

In summary, then, the type of relationship therapists consider to be most appropriate and, more specifically, the manner in which therapists respond to the client's thoughts and feelings regarding the therapist, constitute a major dimension, if not the major dimension, upon which therapists of different orientations and training can be compared and differentiated. Thus, the evidence cited has brought into direct focus the critical role occupied by that dimension of the therapy process consisting of the client's feelings regarding the therapist and the therapist's response to these feelings, regardless of the particular manner or theoretical framework within which the therapist responds to these client feelings, i.e., regardless of whether the therapist analyzes and interprets or spontaneously reacts to these feelings. The therapist who conducts a rational, objective, and personally aloof

Analytic type of therapy considers the analysis and resolution of the transference to be the primary objective of therapy and therefore analyzes and interprets the client's feelings about the therapist: the therapist who conducts a mutually open, intimate, Experiential type of therapy considers the effective element of therapy to be the client-therapist relationship itself and therefore reacts spontaneously to the client's feelings about the therapist. Thus, although the two types of therapists respond in different ways to the client's therapist-relevant expressions, both place equally strong emphasis on the integral, critical role that the client's feelings about the therapist and the therapist's response to these feelings play in the outcome of therapy. Consequently, both types of therapists would be expected to strongly encourage and reinforce client expression of feelings related to the therapist and to devote a major effort in therapy to exploration and discussion of these feelings and to focus extensively on the therapeutic relationship.

In view of this emphasis upon the critical importance to client improvement of the client's feelings about the therapist and the therapist's response to these client feelings, it is noteworthy that relatively so few studies have appeared in the psychotherapy literature that directly and specifically deal with client verbalizations of therapist-relevant feelings and therapist responses to these client verbalizations. This paucity of studies has

also been noted by Shapiro (1961), who specifically called attention to the neglect of both client and therapist verbalizations regarding one another and the therapeutic relationship in investigations of psychotherapy. He also considers this aspect of therapy to be a major dimension characterizing the client-therapist relationship, as well as all social interaction, which can be readily measured and should be investigated. His admonition for investigation of this dimension of the therapeutic relationship has however, for the most part, gone unheeded.

A review of the literature revealed several trends in the relatively few studies in which the client's expression of feelings related to the therapist and/or the therapist's response to such client expressions was specifically investigated. Four early studies focused on the relationship between client expression of feelings regarding the therapist and the success or failure of therapy, but no attempt was made to investigate the therapist's response to these client expressions (Braaten, 1961; Gendlin, Jenney & Shlien, 1960; Lipkin, 1954; Seeman, 1954). Two other studies investigated the relative frequency of relationship-relevant statements and statements unrelated to the relationship by both clients and therapists over the course of therapy (Karl & Abeles, 1969; Murray, 1956). And one experimental study investigated the relative frequency with which high and low anxious therapists explicitly interpreted

client statements in relation to the therapist (Yulis & Kiesler, 1968).

Conflicting findings were obtained within the group of related studies of Client-Centered therapy which investigated the relationship between the extent to which clients increasingly focused on the relationship over the course of therapy and the success or failure of therapy. No attempt was made to investigate therapist responses. Two studies found no relationship between therapist's ratings of client focus on the relationship and therapist's judgment of client outcome (Gendlin et al., 1960; Seeman, 1954) while another study reported a positive relationship with the therapist's judgment of outcome but no relationship with either the client's own perception of his improvement or a diagnostician's assessment of outcome using the TAT (Braaten, 1961). In a departure from the above studies, Lipkin (1954) measured relationship focus as the amount of client discussion regarding the therapist by objective ratings of actual therapy sessions and found a negative relationship with outcome ratings. In an attempt to integrate these contradictory findings, Gendlin et al., (1960) designed a study in which the therapist as a frequent topic of client discussion was differentiated from the client's use of the relationship for significant experiencing and found only the latter to be related to client success. They concluded that client success was related to the manner in which the client focused upon the relationship, i.e., whether he simply

talked about the relationship or whether he used the relationship for achieving new experiences and insights. Moreover, the therapeutic relationship was often found to be a momentary instance of a problem and, in the case of successful clients, to provide a new experience constituting the first step in overcoming the problem.

One very recent study appeared in which the frequency distributions of all relationship-relevant verbalizations of both clients and therapists were investigated throughout individual sessions (Karl and Abeles, 1969). Client verbalizations pertinent to the therapeutic relationship were found to be evenly distributed throughout single sessions, but therapist statements related to the relationship occurred least frequently during the first 10-minute segment of the hour and then increased and stabilized for the remainder of the session.

Information regarding therapist reactions to client feelings about the therapist is provided by several studies, most of which suggest that therapists may not recognize or may be reluctant to respond to such feelings. For example, when a group of therapists, heterogeneous with respect to experience, orientation and sex, and their female clients reported the topics discussed during therapy sessions that were judged to be productive by the therapists, clients and therapists were in agreement on all topics except one: clients reported that they talked about the therapist or the relationship, while "the therapists,

perhaps out of modesty, seemed not to have noticed" (Orlinsky & Howard, 1967b, p. 624). And in a study of the feelings experienced by therapists during therapy sessions, therapists reported having no feelings whatsoever in response to the client's relating to them in a playful, affectionate, superior, and flirtatious manner, although the client perceived the therapist as experiencing an uneasy intimacy and as feeling ineffective (Howard, Orlinsky, & Hill, 1969b).

Several studies suggest that therapists may avoid client expressions of specific kinds of feelings, particularly hostile feelings. For example, Bandura, Lipsher, and Miller (1960) found that therapists were much more likely to avoid client expressions of hostility which were directed toward the therapist than those directed toward an object other than the therapist. This finding was later replicated for experienced therapists but not for interns who were involved in group supervision which emphasized the client-therapist relationship and the therapist's ability to respond to the client's feelings about the therapist (Varble, 1968). Two other studies have also suggested that therapist avoidance responses to client expressions of dependency, particularly those directed toward the therapist, may result in the client's premature termination (Alexander & Abeles, 1968; Winder, Ahmad, Bandura, & Rau, 1962), although other studies failed to confirm this finding (Caracena, 1965; Schuldt, 1966).

A recent experimental study by Yulis and Kiesler (1968) investigated the extent to which therapists explicitly verbalized to the client that the therapist himself was the object of some of the feelings the client was expressing as a function of the therapist's anxiety level. In this well designed study high and low anxious therapists listened to three client tape recordings characterized, respectively, by sexual, aggressive, and neutral content which bore fairly obvious relevance to the therapist. At ten choice points in each tape the therapists were asked to select one of a pair of interpretive responses which differed only in whether or not the response explicitly verbalized the implication the client's statement had in relation to the therapist. While the low anxious therapists chose more responses interpreting client statements in relation to the therapist than did the high anxious therapists, regardless of the specific content of the client's statement, only slightly more than half, 52%, of the responses chosen by the low anxious therapists and 38% chosen by the high anxious therapists verbalized the relevance the client statements bore to the therapist.

And finally, Murray (1956) found that although a group of therapists heterogeneous with respect to experience and orientation made more active responses, i.e., responses that encouraged client continuation of the current discussion, to client statements related to the therapist than to those unrelated to the therapist, they made active responses to only 15% of client therapist-relevant

statements. However, client statements related to the therapist were found to increase significantly over the entire course of therapy from 5.3% to 10.6% of the total number of client statements, and the rate of increase was positively related to the extent to which the therapist responded in an active rather than a passive way to client statements of all kinds, regardless of whether or not the client statements were related to the therapist. In discussing these findings, Murray (1956) states that the client initially brings into therapy a large part of his feelings about the therapist, but direct expression of these feelings is inhibited by anxiety. Consequently, at the beginning of therapy these feelings are expressed as displacements, i.e., the client expresses his feelings about the therapist in a displaced, covert, or indirect way when he is talking about something not manifestly related to the therapist. The therapist's active responses at these points of indirect references to the therapist may serve as a reinforcement and decrease the client's anxiety about direct or overt expression of these feelings. An example presented by Murray provides an illustration of a client's indirect expression of feelings related to the therapist when the manifest content is unrelated to the therapist.

Thus, for example in Case D, the patient spent the first few hours in abstract intellectual discussion. In the content analysis this was scored intellectual defense and properly so. But there was an undercurrent in this intellectual discussion. The patient seemed to be telling the therapist, "Look, I'm clever and I've read a lot of books. I'm worthy of your interest and

respect." Later, the patient spent a good deal of time with physical complaints. Here he seemed to be saying, "I'm frightened and helpless. I need your help." (Murray, 1956, p. 22).

The fact that the client may be expressing feelings about the therapist even though his statements are not manifestly related to the therapist has been recently noted and discussed by several other authors (Beier, 1966; Kell & Mueller, 1966; Searles, 1965; Wiener & Mehrabian, 1968). Searles (1965) has presented the most encompassing formulation of this phenomenon in his statement that everything a client says contains references, whether or not the client is aware of these references, to the immediate psychotherapy situation. Furthermore, he believes that this phenomenon occurs to a very great extent in the everyday conversation of ordinary individuals. He states the case for this phenomenon in the following way. Whenever A is expressing to B a felt attitude about an absent third person, C, then A is simultaneously revealing that he holds the same attitude, in some degree, toward B. A is usually unaware of his communication to B of his own (A's) attitude toward B, and B is unaware of this communication regarding A's attitude about himself unless he has a practiced ear for this kind of communication. Kell and Mueller (1966) have described this phenomenon in their statement that the manifest content of the client's statements mirrors the therapeutic relationship. They report that the choice of content of therapy sessions reflects the nature of the therapeutic relationship

and that, particularly at times of stress, the client talks about past experiences that symbolically communicates to the therapist some of his feelings about the therapist.

Kell and Mueller (1966), Murray (1956), and Searles (1965) have suggested that the therapist's ability to recognize and respond to client feelings about the therapist, including both manifest and covert feelings, is a critical component of therapist effectiveness and the success or failure of therapy. Moreover, Murray (1956) has specifically stated the need for investigation of the relationship between client improvement and the amount and quality of therapist responses to manifest and indirect therapist-relevant client statements. However, to this writer's knowledge, no such investigation has been conducted to date.

Accordingly, this study is an investigation of the relationship between client outcome and the extent to which therapists focus on the client-therapist relationship in therapy by verbalizing the client's feelings, both manifest and covert, which are related to the therapist. More specifically, it is an investigation of the frequency with which therapists respond to implicit and explicit client references to the therapist by either acknowledging and verbalizing or by avoiding and ignoring the client references and the implication or relevance they bear to the therapist or the client-therapist relationship. It is hypothesized that there will be a significant positive relationship between client improvement and the extent to

which the therapist explicitly relates client statements to himself and thus focuses directly on the client's feelings regarding the therapist and on the client-therapist relationship.

The extent to which therapists verbalize or interpret client statements in relation to themselves or therapy will be measured by a scale, the Immediate Relationship Scale (IRS), specifically constructed for this purpose by this writer (see Appendix A). The underlying assumption of the scale is that all client statements, regardless of the manifest content of those statements, contain some reference to the therapist or the therapeutic situation: this reference may be direct and explicit, indirect and implicit, or opaque so that it is not readily or clearly discernible. The scale quantifies the therapist's response to these client references. It consists of six stages which are conceived as lying along a continuum reflecting the extent to which the therapist attempts to focus directly on the immediate client-therapist relationship by verbalizing or interpreting the implications the client statements have in relation to the therapist or the therapeutic situation. At the lowest stage of the scale, stage 1, the client makes a direct and explicit reference to the therapist, thereby providing the therapist with maximal opportunity to acknowledge or interpret the client statement to himself and to focus on the therapeutic relationship, but the therapist responds by completely ignoring the direct reference to

himself. In contrast, at the highest stage, stage 6, the therapist responds by clearly and directly focusing on the immediate relationship by making explicit the client reference to the therapeutic relationship, regardless of the manifest content of the client statements or the degree of directness of the reference, i.e., the opportunity provided by the client. Thus, at the lowest stage the therapist actually avoids personal involvement and focus on the relationship even though a clear invitation to do so is presented by the client, while at the highest stage the therapist directly and explicitly relates or connects the client reference to himself and focuses on the relationship, regardless of the opportunity afforded by the client's statements. For all six stages of the scale, each succeeding higher stage indicates that the therapist has advanced a step away from out-right refusal to discuss the client-therapist relationship and advanced a step closer toward a direct focus on the relationship.

The essential elements of the IRS scale are summarized in Table 1. The scale is used to rate two distinct kinds or classes of responses which the therapist makes in response to these client references: responses which ignore the reference and make no attempt to relate the reference to himself and to focus on the relationship, and responses which attempt to relate the reference to himself and to focus on the relationship. Therapist avoidance responses in which an attempt to focus on the relationship is absent

Table 1. Therapist and Client Responses Measured by IRS.

Stage	Determination of Hypothetical Readiness of Therapist to Discuss Relationship					
	Description of Client and Therapist Responses Rated at Each Stage	Therapist Response to Reference	Therapist's Approach or Avoidance	Opportunity Provided by Client	Directness of Therapist's Response	Therapist Readiness
1	Direct	Ignore	Avoidance	Maximum	----- (Absent)	Strong Avoidance
2	Indirect	Ignore	Avoidance	Moderate	----- (Absent)	Moderate Avoidance
3	Opaque	Ignore	Avoidance	Least	----- (Absent)	Mild Avoidance
4	Indirect or Opaque	Open-Ended	Approach	----- (Regardless)	Least	Mild Approach
5	Direct, Indirect, or Opaque	Indirect	Approach	----- (Regardless)	Moderate	Moderate Approach
6	Direct, Indirect, or Opaque	Direct	Approach	----- (Regardless)	Maximum	Strong Approach

are rated at stages 1, 2, or 3; therapist responses in which such attempts are present are rated at stages 4, 5, or 6. Whether the therapist's avoidance response is rated at stage 1, 2, or 3 is determined by the degree of directness or overtness of the reference contained in the client statements. Whether the therapist's approach response is rated at stage 4, 5, or 6 is determined by the degree of directness or explicitness of the therapist's response, regardless of the directness of the client's reference.

Thus, ratings at stages 1, 2, and 3, respectively, indicate the absence of a therapist attempt to focus on the relationship in response to a client reference which is progressively less overt or direct: at stage 1 the client reference is overt and explicit; at stage 2 the reference is indirect and implicit but clearly conveys a message regarding the therapeutic situation; and at stage 3, although an implicit reference is assumed, that reference is unclear and opaque and cannot be readily determined or deciphered. In contrast, ratings at stages 4, 5, and 6, respectively, indicate a therapist attempt to focus on the relationship which is progressively more direct and explicit, regardless of the degree of overtness or directness of the client's reference: at stage 4 the therapist's response does not relate the client's reference to any specific person or situation, including the therapeutic situation, but rather is structured in an open-ended fashion which provides an opportunity or tends to increase the probability for the client to

generalize, apply, or translate the reference to the therapist or their relationship; at stage 5 the therapist relates the client's reference to the relationship in an indirect, tentative, hesitant, or cautious manner; and at stage 6 the therapist directly and explicitly relates the client's reference to the therapeutic relationship and clearly attempts to focus discussion on the relationship.

The scale may be conceived as providing an index or measure of the strength of the therapist's attempts or lack of attempts to relate client references to himself and to focus on the immediate therapeutic relationship or, in other words, the strength of the therapist's approach or avoidance of focusing on the relationship. Stages 1, 2, and 3, respectively, reflect avoidance response of decreasing magnitude. At each of these three stages a therapist avoidance response is indicated by the failure of the therapist to attempt to relate client references to the therapeutic situation, and the strength of that avoidance response is indicated by the overtness of the client reference, i.e., by the opportunity which the client statements seemingly provide the therapist to focus on the therapeutic situation. A strong avoidance response is reflected at stage 1 where the client reference is explicit and overt and thus provides maximal opportunity for responding to it, a moderate avoidance response is reflected at stage 2 where the client reference is indirect and implicit yet clearly discernible, and a mild avoidance response is reflected at stage 3 where the reference is

assumed but is not clearly discernible. Stages 4, 5, and 6, respectively, reflect therapist approach responses of increasing magnitude. An approach response is indicated at each of these three stages by the presence of therapist attempts to relate client references to the therapeutic situation and to focus on the relationship, and the strength of that approach is indicated by the directness or explicitness with which the therapist attempts to relate the reference to himself and to engage the client in discussion of the immediate relationship. A mild approach response is reflected at stage 4 where the therapist's response is open-ended and does not attempt to specifically relate the client reference to the therapeutic situation but, rather, prepares the way for the client to make the application to the therapeutic situation; a moderate approach response is reflected at stage 5 where the therapist makes a very tentative or indirect attempt to relate the reference to himself and to focus on the immediate relationship; and a strong approach response is reflected at stage 6 where the therapist makes a direct and explicit attempt to focus on the immediate relationship.

Thus, the IRS scale provides a measure of whether the therapist avoids or approaches the client's references to the therapist or to the therapeutic situation. When the therapist's response is one of avoidance, the strength or degree of the therapist's reluctance or unwillingness to deal directly with the reference to the therapeutic relationship

is measured by the directness or overtness of the client's reference. When the therapist's response is one of approach, the strength of the therapist's attempts to focus on the immediate relationship is measured by the directness and explicitness of the therapist's response.

Recent reviews and discussions of psychotherapy research have advocated the use of multidimensional models in which the independent variable is investigated or described in relation to relevant therapist, client, and time variables (Kiesler, 1966; Paul, 1967; Strupp & Bergin, 1969). In accordance with this suggested approach, the present research investigates the IRS variable not only in relation to client outcome, but also in relation to certain relevant therapist and client variables as well as at different periods of time within the psychotherapy process. The IRS variable is investigated in relation to three therapist variables--the core conditions, orientation, and experience level--and two client variables--depth of self-exploration and inpatient or outpatient status. These variables, with the exception of the relatively global client status variable, have been subjected to a great deal of empirical research and are among those proposed by Strupp and Bergin (1969) as showing the greatest promise for unraveling the psychotherapy process.

Therapeutic Core Conditions

Certain characteristics of therapist behavior, the core conditions of empathy, genuineness, and nonpossessive warmth, cut across virtually all theories of psychotherapy and are common elements in a wide variety of approaches to psychotherapy (Truax & Carkhuff, 1967; Bordin, 1955; Rogers, 1957; Shoben, 1953). Operational definitions of each of the three components of the therapeutic core conditions are provided by the research scales constructed by Truax which concretely specify along quantified dimensions these three central ingredients (Truax & Carkhuff, 1967).

Therapist Genuineness is described as the therapist's openness to experiencing himself and his feelings during the therapy encounter. A high level of Genuineness does not mean that the therapist must overtly express his feelings but only that he does not deny them. A therapist who is highly genuine is integrated, authentic, nondefensive and presents himself to the client as a real person, without phoniness and without hiding behind a professional facade or role. The Truax (1962c) scale of therapist genuineness descriptively specifies five stages along a continuum beginning at a very low level where the therapist presents a facade and defends or denies feelings and continuing to a high level of self-congruence where the therapist is freely and deeply himself. At the lowest level the scale includes such descriptions as "there is explicit evidence of a very considerable discrepancy between his experiencing

and his current verbalizations," "the therapist makes striking contradictions in his statements," and "the therapist may contradict the content with voice qualities." At intermediate stages "the therapist responds in a professional rather than a personal manner," and "there is a somewhat contrived or rehearsed quality." At the highest stages "there is neither implicit nor explicit evidence of defensiveness or the presence of a facade," and "there is an openness to experiences and feeling by the therapist of all types, both pleasant and hurtful, without traces of defensiveness or retreat into professionalism."

Therapist Warmth is described as the therapist's interest in and respect for the client and is communicated by his nondominating, nonjudgmental attitude toward the client. The therapist who communicates a high degree of warmth conveys a deep interest, concern, and respect for the client, does not approach the client in a moralistic manner, but rather, accepts the client for what he is and not for what he should be. The Truax (1962a) scale of therapist Nonpossessive Warmth consists of five stages ranging from a high level where the therapist warmly accepts all of the client's experience as part of the client without imposing conditions, to a low level where the therapist evaluates the client or his feelings, expresses dislike or disapproval, or expresses warmth in an evaluative way. The lowest level of the scale includes such descriptions as "the therapist acts in such a way as to make himself the focus of

evaluation, he may be telling the client what would be 'best' for him or may be in other ways actively trying to control his behavior," and "the therapist responds mechanically to the client and thus indicates little positive warmth," and "the therapist ignores the client where an unconditionally warm response would be expected--complete passivity that communicates a lack of warmth." At higher levels the therapist "clearly communicates a very deep interest and concern for the welfare of the client. Attempts to dominate or control the client are for the most part absent, except that it is important that the client be more mature or that the therapist himself is accepted and liked." At the highest level "the client is free to be himself even if this means that he is temporarily regressing, being defensive, or even disliking or rejecting the therapist himself."

Therapist Empathy is defined as the therapist's ability to perceive the client's feelings, including those which are partially hidden as well as those which are obvious, and to communicate his perception in words attuned to the client's feelings in order to clarify and expand what the client has hinted at by voice, posture, or cues. The Truax Accurate Empathy scale (1961) is a 9-stage scale which measures on a continuum the therapist's perception and communication of the sum total of the client's feelings. The lower stages of the scale include such descriptions as the therapist "seems completely unaware of even the most

conspicuous of the client's feelings. His responses are not appropriate to the mood and content of the client's statement and there is no determinable quality of empathy." At intermediate stages "he often responds accurately to more exposed feelings. He also displays concern for more hidden feelings which he seems to sense must be present, though he does not understand their nature." At the highest stages the therapist accurately interprets all of the client's present, acknowledged feelings. He "moves into feelings and experiences that are only hinted at and does so with sensitivity and accuracy. He offers additions to the client's understanding so that not only are underlying emotions pointed to, but they are specifically talked about."

In summary, then, the essence of non-possessive warmth is to preserve the client's self respect as a person and a human being and to provide a trusting, safe atmosphere; the purpose of genuineness is to provide an honest nondefensive relationship which allows us to point to unpleasant truths about the relationship and about the client rather than to hide behind a facade; accurate empathic understanding serves as the work of the therapeutic relationship (Truax & Mitchell, 1970, pp. 34-35).

Research evidence to date suggests that for a therapist to have effective therapeutic impact, he must not be decidedly low on any of the three component core conditions and must be moderately high on at least any two of them (Truax & Mitchell, 1970).

Carkhuff and his associates have condensed and revised the Truax Accurate Empathy, Nonpossessive Warmth, and Genuineness scales (Truax, 1961, 1962a, 1962c) in an

attempt to reduce the ambiguity and increase the reliability of those scales. The revised Empathy scale (Berenson, Carkhuff, & Southworth, 1964) collapses the 9-stage Truax scale into five stages, and the revised Warmth scale (Carkhuff, Southworth, & Berenson, 1964) is essentially a simplified restatement of the Truax scale. Similarly, the revised Genuineness scale (Carkhuff, 1964a) is a rewording of the Truax scale although the scoring of the therapist's negative reactions to the client are made more explicit at the lower stages of the scale. Both the Truax scales for the measurement of the core conditions and the revised scales by Carkhuff and his associates have been used in a great number of studies and have been demonstrated to be reliable (Carkhuff & Berenson, 1967; Truax & Mitchell, 1970).

A great deal of converging research has produced extensive evidence indicating the critical importance of these three central ingredients to the psychotherapy process for changing client behavior (Bergin, 1967; Carkhuff, 1969b, 1969c; Carkhuff & Berenson, 1967; Rogers, Gendlin, Kiesler, & Truax, 1967; Strupp & Bergin, 1969; Truax & Carkhuff, 1967; Truax & Mitchell, 1968, 1970). Moreover, these ingredients have been found to be of major importance in a wide variety of situations in addition to psychotherapy which involve human relationships, including teacher-student relationships (Aspy, 1965; Aspy & Hadlock, 1966; Dickinson & Truax, 1966; Truax & Tatum, 1966; Wagner & Mitchell, 1969),

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rehabilitation counseling (Truax & Mitchell, 1970), parent-child relationships (Shapiro, Krauss, & Truax, 1969), verbal conditioning (Truax, 1966; Vitalo, 1970), educational-personal counseling by untrained housewives (Stoffer, 1968) and by college dormitory counselors (Wyrick & Mitchell, 1970), peer relationships among college students (Shapiro et al., 1969; Shapiro & Voog, 1969), as well as therapists' personal and social interpersonal relationships involving spouse, colleagues, and friends (Collingwood, Hefelee, Muehlberg, & Drasgow, 1970; Hefelee, Collingwood, & Drasgow, 1970). Indeed, the core conditions of Empathy, Warmth, and Genuineness have been conceptualized as personality characteristics or attributes not only of psychotherapists but of all individuals, and as playing a critical role in all human encounters which are intended to change human behavior or to be helpful (Carkhuff, 1967b; Carkhuff & Berenson, 1967; Truax & Carkhuff, 1967).

The critical role of the core conditions in the psychotherapy process has been empirically demonstrated by repeated findings indicating that therapeutic progress varies as a function of therapists' characteristics of Empathy, Warmth, and Genuineness. This extensive research has been widely reviewed (Bergin, 1967; Strupp & Bergin, 1969; Truax, 1967), and summaries are published periodically which include current research on the core conditions (Carkhuff & Berenson, 1967; Truax & Carkhuff, 1967; Truax & Mitchell, 1968, 1970). The research converging on the

therapeutic core conditions in psychotherapy lead to the following major conclusions. The level of therapist functioning on the core conditions is related to client change: most improved clients receive higher levels of the core conditions than least improved clients, and clients of therapists with relatively high levels on the core conditions show more improvement than either clients of therapists with relatively low levels on the core conditions or clients in no-therapy control groups. Moreover, not only are high levels of therapist-offered core conditions related to and predictive of client improvement, but low levels are related to no improvement or even deterioration, i.e., clients of low functioning therapists are no better off or actually worse off after therapy than before therapy. Consequently, therapy can be "for better or worse." These conclusions indicating that therapists who are empathic, warm, and genuine are indeed effective, are based on the research of numerous researchers and appear to hold for a variety of therapists and counselors regardless of their training and orientation and with a variety of clients, including college underachievers, college counselees, juvenile delinquents, hospitalized schizophrenics, mild to severe outpatient clients, and hospitalized clients with mixed diagnoses. Moreover, the findings appear to hold up across diverse therapeutic settings including hospitals, outpatient clinics, college counseling centers, rehabilitation centers, and private practice, and in both individual

and group psychotherapy. Truax and Mitchell (1970) have recently compiled and presented in tabular form the results of studies which have related the Truax E, W, and G scales to client outcome measures.

The findings that client improvement or deterioration is related to the high or low level of therapist functioning on the core conditions strongly indicates that all therapists cannot be assumed to constitute a homogeneous group and to be relatively equally helpful and effective. Kiesler (1966) has specifically cautioned against the assumption, which he designates the "therapist uniformity myth," that therapists constitute a homogeneous group. Since differences among therapists on the core conditions have been demonstrated to be associated with important and significant differences in client outcome, it would appear that failure to take into account the therapists' level of functioning on the core conditions implies subscription to the Therapist Uniformity Myth. Such studies run the risk of obtaining misleading results in which diverse trends in the data mask or cancel each other. Moreover, studies using different or unspecified compositions of therapists with respect to the core conditions may produce findings which cannot be compared across studies. Indeed, Truax and Mitchell (1970) have even suggested that previous research on therapist characteristics which failed to take account of the core condition variable needs to be re-done.

Consequently, this study investigates the relationship between the IRS and core condition variables and attempts to demonstrate that the IRS variable is related to the core conditions but, at the same time, is distinct and can be differentiated from the core condition variable. That is, it is predicted that although the two variables are related, they are not identical and do not simply measure the same thing. In addition to the attempt to control for the therapist uniformity myth there is a second, equally compelling, reason for the inclusion of the core condition variable in this study. To date, no other therapist variables have been subjected to a comparable programmatic research effort and have been as consistently related to client therapeutic progress and outcome.

Two specific hypotheses are tested regarding the relationship between the IRS and core condition variables. The first hypothesis states that there is a significant positive correlation between the extent to which therapists focus directly upon the immediate client-therapist relationship and their level of functioning on the core conditions. The second hypothesis which deals with the assessment of both the utility of the IRS variable in predicting client outcome and the distinctness of the IRS variable from the core condition variable states that the IRS variable significantly predicts measures of client outcome independently of the core condition variable, i.e., with the effect of the core conditions on outcome measures controlled statistically.

Therapist Orientation and
Experience Level

The attitudes of therapists regarding psychotherapy processes and techniques have been investigated in a number of studies as a joint function of therapist experience level and orientation or training. In a frequently cited series of studies Fiedler (1950a, 1950b, 1951) concluded that the nature of the therapeutic relationship is a function of the therapist's experience and not a function of orientation or school. In contrast, studies by McNair and Lorr (1964), Sundland and Barker (1962), and Wallach and Strupp (1964) indicated that therapist attitudes differed as a function of orientation and not as a function of experience level. Attempts have been made to explain the contradictory findings regarding the relative influence of orientation and experience level as determinants of therapist attitudes in terms of differences in the kind of therapist attitudes sampled (Gardner, 1964; Sundland & Barker, 1962). Sundland and Barker (1962) suggested that when therapists are compared on attitudes with which most therapists tend to agree, such as those regarding empathy and understanding as Fiedler did, then therapists differ as a function of experience, but when therapists are compared on controversial attitudes and preferences for diverse therapy techniques, as was done in the three later studies, then therapists differ as a function of orientation.

There is more recent evidence, however, to suggest that contrary to Fiedler's results, orientation has a greater effect than experience in determining therapist attitudes and preferences. Spilken and Jacobs (1968), using a much larger sample of therapists than Fiedler used, examined self-professed attitudes of therapists regarding ten therapist variables, including empathy, warmth, sincerity or genuineness, and respect, which were similar to the attitudes examined by Fiedler. Therapists were found to differ as a function of orientation and training, but differences occurred as a function of experience level on only one variable, directiveness.

Quite similar results regarding therapist attitudes and preferences for therapy techniques as a function of orientation were obtained in the three studies by McNair and Lorr (1964), Sundland and Barker (1962), and Wallach and Strupp (1964). When therapists were classified into three orientations--Freudian, Sullivanian, and Rogerian--the three groups differed on nine of the 16 scales used to measure attitudes, with the Sullivanians consistently being in the middle position (Sundland & Barker, 1962). In comparison with the Rogerians, the Freudians differed on all scales specifically measuring attitudes regarding the nature of the therapeutic relationship and preferred a relationship in which the therapist analyzes and conceptualizes the nature of the client's relationship with the therapist rather than responding spontaneously to the client's behavior as it

occurs in therapy. When therapists were classified into four orientations--Orthodox Freudian, Psychoanalytic-General, Sullivanian, and Rogerian--and compared on their preference for a client-therapist relationship characterized by the therapist's maintenance of personal distance, the Orthodox Freudians were highest in their preference for this kind of distant, personally aloof relationship, the Psychoanalytic-General group was next highest, and the remaining two, similar to one another, least preferred this kind of relationship (Wallach & Strupp, 1964). These findings were also consistent with those obtained by previous studies (Fey, 1958; Fiedler, 1950b, Strupp, 1955) on those aspects in which the studies were comparable. And in contrast to Fiedler's (1950b) often quoted conclusion that therapists of different orientations do not differ in how they actually behave in therapy, a study of the actual therapy behavior of highly experienced Client-Centered and Analytic therapists by Cartwright (1966) found extreme differences between therapists of the two schools in their proportional use of various therapeutic responses such as encouragement, reflection, clarification, and interpretation.

Thus, the evidence cited suggests that therapist attitudes and views regarding the client-therapist relationship differ as a function of orientation and not as a function of experience level, and this difference consists of the degree to which therapists of diverse orientations prefer an impersonal, aloof relationship with the client.

As noted earlier, since the importance of the client's feelings regarding the therapist is universally recognized and accepted by therapists, including those who prefer an impersonal, aloof relationship as well as by those who prefer a personal, intimate relationship, therapists would not be expected to differ on the extent to which they respond to therapist-relevant client statements as a function of their orientation or the degree of personal distance they prefer to maintain in the relationship.

However, it has been suggested that the therapist may prefer an impersonal, distant relationship because of his own neurotic conflicts about intimate contact with others. Bugental (1964), for example, has proposed that one of the major neurotic conflicts of therapists consists of a great need for and a concomitant fear of intimacy with others. The therapist with this neurotic conflict strives to establish a one-way intimacy with the client in which he holds himself and his feelings aloof from the client and thus, to some extent, gratifies his need for intimate contact, and at the same time, avoids the anxiety that would result from his permitting the client to become close to or intimate with him. Since the therapist cannot tolerate the anxiety associated with the closeness of another, efforts made by the client to reach out toward the therapist are met with anxiety and some form of rejection, avoidance, or resistance from the therapist. One manifestation of this resistance may be indicated by Hobb's (1962) suggestion that

interpreting, as opposed to reacting to, the client's transference behavior may be tantamount to negative reinforcement of the client's attempts to reach out toward the therapist. Marcondes (1960) has emphatically proposed that this type of neurotic one-way gratification which prevents the therapist from responding positively and adequately to the client's feelings about the therapist is exemplified by the impersonal, objective type of relationship typically established by psychoanalytic therapists.

Therefore, in view of the evidence suggesting that the therapist's orientation, but not his experience level, is related to the degree to which the therapist prefers a therapeutic relationship characterized by his maintenance of personal distance from the client, and the proposals by Bugental (1964), Hobbs (1962), and Marcondes (1960) suggestive of a relationship between a preference for maintaining personal distance and the therapist's inability or reluctance to accept and deal with the client's feelings about the therapist, the following predictions are made in this study regarding the relationship between the extent to which the therapist responds to therapist-relevant client statements and his orientation and experience level.

1. Therapists are ordered on the basis of their IRS scores according to orientation as follows--Relationship, Eclectic, Client-Centered, and Analytic.

2. Relationship therapists have significantly higher IRS scores than Eclectic, Client-Centered, or Analytically oriented therapists.

3. No significant differences in IRS scores occur between high and low experience level therapists within any of the four orientation groups of therapists.

Client Depth of Self-Exploration

A mass of research has accumulated which indicates that the client's self-exploratory behavior and attempts to understand and define his own beliefs, values, motives, and actions play an important role in the outcome of psychotherapy (Truax & Carkhuff, 1967). Much of this research has been based on the 9-stage Depth of Self-Exploration Scale (DX) developed by Truax (1962b) and subsequently condensed into five stages by Carkhuff (Carkhuff, 1964). These DX scales define along a continuum the extent to which clients engage in self-exploration, ranging from no demonstrable intrapersonal exploration to a very high level of self-probing and exploration. At the lowest level of the scale there is no discussion of personally relevant material by the client and no opportunity for it to be discussed. Personally relevant material includes self-descriptions by the client intended to reveal his innermost feelings and thoughts to the therapist, and communications of his personal values, perceptions of his relationships to others, his personal role and self-worth in life, as well as

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communications indicating emotional turmoil and expressions of specific feelings such as anger, affection, etc. At the middle level the client introduces discussion of personally relevant material but does so in a mechanical manner, without spontaneity or emotional proximity and without an inward probing to newly discover feelings and experiences. At the highest level the client actively and spontaneously engages in an inward probing to discover or rediscover feelings or experiences about himself, his relations with others, and his world.

A number of studies using the DX scale with a variety of client populations and outcome measures have reported that successful clients show more self-exploration during psychotherapy than do unsuccessful clients (Truax, 1966; Truax & Wargo, 1966; Truax, Wargo, & Carkhuff, 1966) and that this outcome was predictable even in the initial stages of therapy (Truax & Carkhuff, 1963, 1965). There is also a great deal of evidence indicating that the level of the therapeutic core conditions is positively related to the degree of client self-exploration (Truax, 1966; Truax & Carkhuff, 1967; Carkhuff & Berenson, 1967; Carkhuff, 1969c).

Cross cultural validating evidence from West Germany has recently become available for both the Truax DX and Accurate Empathy scales. In a replication of an experimental manipulation study by Truax and Carkhuff (1965), Sander, Tausch, Bastine and Nagel (1968) reported that when therapist level of empathy was lowered there was a

corresponding lowering of client self-exploration and when therapist level of empathy was raised there was a concomitant rise in client self-exploration. In addition, Tausch, Eppel, Fittkau and Minsel (1969) related therapist level of empathy to both client depth of self-exploration and client improvement and obtained results similar to those reported by Truax and his associates (Truax & Carkhuff, 1967; Truax & Mitchell, 1968, 1970): the higher the therapist level of empathy, the higher the client level of self-exploration and the greater the degree of client improvement.

In contrast to the bulk of evidence which indicates that client depth of self-exploration is positively related to constructive client change and improvement, Truax and Wargo (1966) found that depth of self-exploration was unrelated to some and negatively related to other measures of client outcome in a large sample of male juvenile delinquents in group psychotherapy. In explanation of this unexpected finding, the authors suggested that engaging in high levels of self-exploration may constitute "unmanly" behavior for juvenile delinquents.

In addition to the evidence derived from the body of research based upon the DX scale, similar measures of similar constructs have received extensive support in the literature of counseling and psychotherapy (Blau, 1953; Braaten, 1961; Kirtner & Cartwright, 1958; Peres, 1947; Seeman, 1949; Tomlinson & Hart, 1962; van der Veen, 1967).

Thus, the depth of self-exploration variable has been empirically demonstrated to be a reliable measure of client in-therapy behavior and to differentiate among clients who improve and those who fail to improve in therapy. Moreover, the self-exploration variable appears to be relevant to the IRS variable in view of the fact that high levels of self-exploration include the client's discovery and experience of new aspects of himself and new feelings in his relationships with others. The therapist's responses to therapist-relevant client statements in which the therapist attempts to focus directly on the client's feelings about the therapist and their immediate relationship would have the anticipated effect of enhancing the client's exploration of himself in relation to the therapist and, further, frequently in relation to other significant persons. As Gendlin et al. (1960) have observed, the client's feelings about the therapist and their relationship is frequently representative of one of the client's central problems, particularly problems in his relationships with others, and the client's exploration of his feelings in relation to the therapist is often a new experience constituting the initial step in his overcoming of the problem. Consequently, in this study prediction of a significant positive relationship between the IRS and DX variables is made.

Inpatient and Outpatient Status

In an attempt to reduce the heterogeneity within the sample, the IRS variable is investigated for inpatient and outpatient therapists separately. Since the IRS variable is conceptualized as being determined primarily by the therapist, it is predicted that the IRS variable does not differentiate between therapists of inpatients and therapists of outpatients, and no alternative predictions are made regarding client status.

Investigation of the IRS variable in relation to the foregoing specified variables is carried out by means of two separate psychotherapy studies. The first is a process study in which the IRS variable is investigated in relation to the therapists' core conditions, orientation and experience level as well as the clients' depth of self-exploration and status as inpatient or outpatient. The second is an outcome study in which the IRS variable is again investigated in relation to the therapeutic core conditions and in relation to measures of client improvement or outcome. The following specific hypotheses of each study are to be tested.

Study I--Process Study

Hypothesis I. There is a significant positive relationship between the therapists' core condition and IRS scores.

Hypothesis II. The group of outpatient therapists and the group of inpatient therapists do not differ significantly on mean IRS scores.

Hypothesis III. There is a significant positive relationship between the therapists' IRS scores and the clients' DX scores.

Hypothesis IV. Three specific hypotheses are used to test the general hypothesis that IRS responses significantly differentiate therapists on the orientation variable but do not significantly differentiate on the experience level variable.

A. Orientation to psychotherapy is ordered on the basis of IRS scores from highest to lowest in the following way: Relationship, Eclectic, Client-Centered, and Analytic.

B. Relationship therapists have significantly higher IRS scores than Eclectic, Client-Centered, or Analytically oriented therapists.

C. No significant differences in IRS scores occur between the group of high experience level therapists and the group of low experience level therapists within any of the four orientation groups.

Study II--Outcome Study

Hypothesis I. There is a significant positive relationship between the therapists' core condition and IRS scores.

Hypothesis II. The higher the therapists' IRS scores the greater the improvement (outcome score indicating better adjustment) the clients show, and the lower the therapists' IRS scores the less improvement the clients show on each of five different outcome measures, regardless of the therapists' core condition scores, i.e., with the effect of the core conditions on the outcome measures controlled statistically.

METHOD

Study I--Process Study

Tape recordings of the first psychotherapy session of 56 different therapist-client dyads were used in this study. The tape recordings were borrowed on the basis of availability from various researchers at institutions across the country, including the Universities of Kentucky, Massachusetts, Maryland, Arkansas, and Wisconsin.

The therapists represented a variety of settings, disciplines, theoretical orientations, and a wide sample of psychotherapy experience ranging from advanced level graduate students in Clinical and Counseling Psychology, to therapists with more than 15 years of post-doctoral psychotherapy experience.

Clients ranged from minimally disturbed college students to hospitalized chronic schizophrenics. Of the 56 clients, 23 were seen in university counseling centers and 33 were seen in hospital settings: 21 were female, and 35 were male. Formal diagnoses were not available for the students, but on the basis of the tape recordings, most appeared to be mildly to moderately disturbed although several seemed more severely disturbed and would best be

described as ranging from character disorders to ambulatory schizophrenics. The hospitalized clients were either acute or chronic schizophrenics with the exception of approximately five who were diagnosed at the time of hospitalization as sociopathic personalities with alcohol or drug addictions as primary symptoms.

Table 2 provides demographic information describing the therapists by discipline, orientation, setting, experience, sex, and type of client.

Information regarding the therapists' psychotherapy experience was obtained from therapists' self-reports and was available for only 39 of the 56 therapists. The criteria employed by Strupp (1960) was used to classify therapists as less (0-5 years) and more (6-15 years) experienced and resulted in dichotomization of therapists into graduate students and post-graduate therapists. The more experienced group thus consisted of the 22 therapists who had completed their training, with an average of 7.5 years of post-graduate psychotherapy experience. The less experienced group consisted of the 17 therapists who were graduate students in Clinical or Counseling Psychology, with an average of 2.5 years of supervised psychotherapy experience.

Therapists' orientation was also available for these 39 therapists and was determined by two colleagues who were well-acquainted with the way in which the therapists conceptualized and conducted psychotherapy. Four

Table 2. Summary of Therapists' Characteristics

<u>Discipline</u>	<u>n</u>
Clinical Psychology	14
Counseling Psychology	6
Psychiatry	12
Social Work	7
Clinical Psychology Students	7
Counseling Psychology Students	10
 <u>Orientation</u> ^a	
Analytically-Oriented	9
Client-Centered	7
Eclectic	11
Relationship	12
 <u>Setting</u>	
Counseling Center	23
Hospital	
 <u>Experience</u> ^a	
Low Experience Level	17
High Experience Level	22
 <u>Sex</u>	
Female	6
Male	50

^aAvailable for only 39 therapists.

classifications of orientations were used: Relationship, Eclectic, Analytic, and Client-Centered. Therapists were classified as Analytic on the basis of their relative emphasis on Freudian concepts such as unconscious processes, Oedipal conflict, transference neurosis, resistance, and use of the techniques of free association and interpretation; as Client-Centered on the basis of relative emphasis on Rogerian concepts such as client self-actualization, communication of therapist congruence, empathic understanding, and an attitude of unconditional acceptance toward the client, and the use of non-directive techniques such as reflection and restatement; as Relationship on the basis of emphasis on conceptualization of client maladaptive behavior in terms of problems in relating to others, emphasis on the client-therapist relationship as a major focal point of therapy, and use of extensive exploration of the therapeutic relationship to delimit and work through client conflicts and problems in relationships with others in addition to the therapist; and as Eclectic on the basis of utilization of a combination of concepts and techniques derived from a variety of theories.

The Immediate Relationship, Depth of Self-Exploration (Carkhuff, 1964), Empathy (Berenson, Carkhuff, & Southworth, 1964), Warmth (Carkhuff, Southworth, & Berenson, 1964), and Genuineness (Carkhuff, 1964a) scales were each rated on the same five 3-minute segments selected randomly with the restriction that no segments overlapped.

Copies of the Carkhuff scales appear in Appendices B through E.

Ratings on the E, W, G, and DX scales were made in connection with previous studies (Berenson, Mitchell, & Laney, 1968; Berneson, Mitchell, & Moravec, 1968). Two experienced clinicians with eight and four years of post-doctoral psychotherapy experience, respectively, made independent ratings on the E, W, and G scales. Ratings on the DX scale were made independently by two colleagues of the senior researchers who had previously had considerable experience in rating this scale. Ratings on the IRS scale were made independently by two advanced level graduate students in Clinical Psychology and by this writer, who had previously trained the two raters in the use of the IRS scale on tape recordings of therapy sessions not used in the present research. Each rater subsequently made a second set of ratings on approximately one-third or 19 of the 56 tapes after an interval of at least six weeks.

Study II--Outcome Study

The data for this study were based upon the tape recorded psychotherapy sessions of 40 clients seen in individual psychotherapy at the Henry Phipps Psychiatric Outpatient Department of The Johns Hopkins Hospital by four therapists who were randomly assigned ten clients each. The recordings were initially collected in connection with studies carried out at Johns Hopkins University

(Hoehn-Saric, Frank, Imber, Nash, Stone, & Battle, 1965; Nash, Hoehn-Saric, Battle, Stone, Imber, & Frank, 1965) and were subsequently used in studies by Truax (Truax, Wargo, Frank, Imber, Battle, Hoehn-Saric, Nash, & Stone, 1966a, 1966b).

The initial study for which the tape recordings were collected (Hoehn-Saric et al., 1965) was an investigation of the effect of client instruction regarding psychotherapy processes and typical therapist and client in-therapy behavior, designated as Role Induction, on client outcome following brief psychotherapy which lasted four months. The design consisted of a screening interview conducted by one of two research psychiatrists followed by weekly psychotherapy sessions over a period of four months. At the time of the screening interview a personal history was taken on each client, information relevant to outcome measures was obtained, clients were randomly assigned to either a Role Induction (RI) or a No Role Induction (NRI) group, and those clients assigned to the RI group were given the Role Induction instructions based on the Anticipatory Socialization Interview of Orne (Orne & Wender, 1968). This instruction, emphasizing the analytic model of therapy, covered four aspects: 1) a general exposition of psychotherapy, 2) a description and explanation of expected client and therapist behavior, 3) preparation for certain typical phenomena in the course of therapy such as resistance, and 4) the induction of a realistic expectation for improvement

within four months of therapy. Clients in the NRI group did not receive this instruction. Immediately following the screening interview the research psychiatrist designated each client as being either an Attractive (ATT) or Unattractive (UATT) candidate for psychotherapy. This designation was a global rating based on client characteristics of age, education, general appearance, psychopathology, warmth, and ability to relate easily with others. An equal assignment of ATT and UATT therapy clients was made to the four therapists and to the RI and NRI groups. Within these restrictions clients were assigned randomly. Thus, each therapist saw ten clients: three ATT RI, three ATT NRI, two UATT RI, and two UATT NRI. Additional client outcome data was obtained four months after the beginning of treatment or at the time of termination for clients who discontinued treatment earlier. No statistically significant differences existed between clients in the RI and NRI groups with respect to age, education, sex, race, or ratings by the research psychiatrists of severity of illness, prognosis, and difficulty in establishing a therapeutic relationship.

The sample of 40 neurotic clients excluded those with a history of alcoholism, brain damage, or mental deficiency and those having prior psychotherapy or theoretical knowledge of the therapeutic process. A total of 58 clients was given a screening interview; of the 12 who were excluded from the sample, eight were excluded because of prior psychotherapy experience or theoretical knowledge

of the therapeutic process, two were pregnant and would have delivered within the projected four-month treatment period, one was psychotic, and one refused therapy. Of these 46 clients, six clients began treatment but dropped out before the third therapy session. The remaining 40 clients, composed of 17 males and 23 females ranging between the ages of 18 and 55 and having a mean education of 11 years, constituted the research sample.

The four therapists, three males and one female, were psychiatric residents at The Johns Hopkins University and were predominantly Analytically oriented. Three were in their second year of residency and one in his fourth. The therapists were unaware of the design and nature of the research and were told only that the researchers were interested in the effects of brief psychotherapy and preferred that treatment be terminated after four months. Therapists were also given the client's case history notes. Therapists met with clients at least once a week for one-hour sessions. Specific therapeutic techniques, scheduling of sessions, and further treatment following the four-month period were left to the therapists' discretion.

Five predictor measures obtained on each client as part of the initial study conducted at The Johns Hopkins University (Hoehn-Saric et al., 1965) were used in the present study in the analyses of the five outcome measures:

- 1) The total number of therapy sessions received by each client (No. Sess.).
- 2) The Initial Adjustment score (IAS),

with higher scores representing a greater degree of maladjustment. The IAS was the score obtained on the Discomfort Scale administered prior to therapy. The Discomfort outcome measure, in distinction, was the change score on the Discomfort Scale from pre-therapy to post-therapy administration of the scale (see Appendix J). 3) A Relationship (REL) score which consisted of the post-therapy rating made by the therapist on a five point scale indicating the degree of difficulty encountered in establishing and maintaining a satisfactory therapeutic relationship with the client. The degree of difficulty was rated in terms of extreme, marked, moderate, slight, and not at all difficult, with a higher rating indicating a greater degree of difficulty. 4) The Patient Attractiveness condition (PA) which consisted of the client's pre-therapy designation by a research psychiatrist as either an Attractive (ATT) or an Unattractive (UATT) client for psychotherapy. 5) The Role Induction condition which consisted of the client's pre-therapy random assignment to either the Role Induction (RI) or the No Role Induction (NRI) group.

Five measures of client outcome were available from the initial study conducted at The Johns Hopkins University (Hoehn-Saric et al., 1965). Two were global measures of overall improvement: Patient Statement and Therapist Statement. Three were more specific measures of client outcome developed by Frank and his associates and used in a series of studies: Target Symptom (Battle, Imber,

Hoehn-Saric, Stone, Nash, & Frank, 1966), Discomfort (Frank, Gliedman, Imber, Nash, & Stone, 1957; Parloff, Kelman, & Frank, 1954; Stone, Frank, Nash, & Imber, 1961), and Social Ineffectiveness (Frank et al., 1957; Imber, Frank, Nash, Stone, & Gliedman, 1957; Parloff et al., 1954; Stone et al., 1961).

The Discomfort outcome measure consisted of the change score on the Discomfort Scale, which was filled out by each client just prior to the screening interview and again at the time of termination. The Discomfort Scale consists of 50 items describing symptoms of anxiety, depression, and somatic complaints. The client completed the scale by indicating the extent to which he had been bothered during the previous seven days by each of the 50 symptoms by checking one of the following alternatives: 0) not at all, 1) just a little, 2) pretty much, 3) very much. These alternative responses were assigned numerical values from zero through three, respectively, and were summed over the 50 symptoms to obtain the Discomfort Scale score. The algebraic change in this score between the pre- and post-therapy administrations of the scale constituted the Discomfort Outcome score (see Appendix J).

The Patient Statement of global improvement consisted of the client's post-therapy rating of the degree of his global or overall improvement in therapy on a 5-point scale. The five points of the scale were 1) worse, 2) same,

3) slightly better, 4) some better, 5) a lot better (see Appendix L).

The Therapist Statement of client global improvement consisted of the therapist's post-therapy rating of the degree of the client's global improvement in therapy on a 5-point scale. The five points of the scale were 1) worse, 2) no change, 3) slight, 4) moderate, and 5) marked (see Appendix M).

The Target Symptom outcome measure consisted of the client's rating of the amount of improvement in the three complaints or symptoms that he initially most wanted changed by therapy. Each client was asked to state three target symptoms during the screening interview. At the time of termination the client rated the amount of improvement of each target symptom on a 5-point scale. The five points were 1) a lot better, 2) some better, 3) slightly better, 4) the same, or 5) worse. The average of the ratings of improvement for the three symptoms constituted the Target Symptom outcome score (see Appendix K).

Each client was rated on the Social Ineffectiveness Scale by a member of the research staff who had no knowledge of the client's group assignments or performance during therapy. The ratings were based on a structured interview which focused on the client's day-to-day relationships with each significant individual in his life. The frequency and degree of the client's ineffective behavior with each significant individual was rated on a 6-point scale in each of

15 areas of social and interpersonal relations: overly-independent, overly-dependent, superficially-sociable, withdrawn, extrapunitive, intrapunitive, officious, irresponsible, impulsive, over-cautious, hyper-reactive, constrained, overly systematic, unsystematic, sexual maladjustment. A single 6-point rating was then assigned to each category by using the rating made in connection with each significant person as a guide and by taking into consideration the relative importance to the client of the persons with whom the ineffective behavior was shown as well as the number of persons to whom it was shown. Thus, ratings of ineffective behavior in each category were made on the basis of the frequency, degree, and importance to the client of that behavior. The Social Ineffectiveness score consisted of the sum of the numerical ratings given to each of the 15 categories (see Appendix N).

Ratings of E, W, G, and DX were subsequently made on the recorded psychotherapy sessions of these 40 clients by Truax et al. (1966) in a study investigating the relationship between the therapeutic core conditions and the five measures of client outcome and were used in the present study.

From the tape recorded therapy sessions of each of the 40 clients six 3-minute segments were excerpted for study, two segments from the first session, two from the tenth session, and two from the fifth interview before the final one. In each case, one segment was taken from the

middle third and one from the final third of the session in question. These segments were rerecorded onto small tape spools and randomly assigned code numbers. Each of these segments were rated on the E (Truax, 1961), W (Truax, 1962a), G (Truax, 1962c), DX (Truax, 1962b), and IRS scales (see Appendices F through I). Undergraduate college students who were naive with respect to psychotherapy theory were trained in the use of the E, W, G, and DX scales. A total of four different raters independently rated each of the scales after training. The coded segments were presented to each set of raters in a different sequence. Two Master's level research technicians employed at the Arkansas Rehabilitation Research and Training Center who had no prior familiarity with the IRS scale rated this scale after training in its use.

RESULTS

Study I--Process Study

Reliabilities of the E, W, G, and DX scales were determined in a previous study (Berenson et al., 1968). Pearson intercorrelations between two independent raters were as follows: E, .96; W, .96; G, .80; DX, .76. Pearson r rate-rerate reliabilities for two raters were as follows: E, .90, .88; W, .92, .89; G, .90, .85; DX, .90, .95. Pearson intercorrelations between three independent raters on the IRS were .83, .86, and .87. Pearson rate-rerate reliabilities for the three raters were .85, .88, and .91. Using Fisher's Z transformation for Pearson's r, the mean reliability between raters was .855, and the mean rate-rerate reliability was .880.

The following procedure was followed in obtaining a core condition score for each therapist. First, separate scores of E, W, and G were obtained for each therapist by computing the mean of the five ratings made on each of the three respective scales. Following this, a core condition score was determined for each therapist by computing the average of his E, W, and G scores. An IRS score was determined for each therapist by computing the average of the

five IRS ratings. Similarly, a DX score was determined for each therapist by computing the average of the five DX ratings. Whenever the raters disagreed on the rating to be given a particular segment on any of the scales, the average of the discrepant ratings was used.

Table 3 presents the Pearson intercorrelations among the E, W, G, and core condition scores for the sample of 56 therapists. All r 's reached at least the .001 level of significance.¹ Since core condition scores were highly and significantly related to each of the separate E, W, and G scores, and since the r 's among the E, W, and G scores were also high and significant, the core condition score, i.e., the mean of the E, W, and G scores, was subsequently utilized throughout the process study to represent each therapist's ratings on the E, W, and G scales.

Table 3. r 's among E, W, G, and Core Condition Scores

	E	W	G
W	.74 ^a		
G	.71 ^a	.76 ^a	
Core	.76 ^a	.79 ^a	.78 ^a

^a $p < .001$

Core condition scores were used to classify therapists into a high and a low core condition group. Those 28

¹All tests of statistical significance are two-tailed tests.

therapists whose core condition score fell above the median score of 1.65 for the entire sample were designated as high core condition therapists, and those 28 therapists whose score fell below the median were designated as low core condition therapists. This classification of therapists is the referent for subsequent references to high and low core condition, or simply core, groups of therapists.

Table 4 presents the means and standard deviations of the E, W, G, and core condition scores for the high and low core condition groups and the entire sample. Both the means and standard deviations of the E, W, G, and core condition scores were quite similar within the high and low core groups and the total sample, further indicating the appropriateness of the use of the single core condition score to represent E, W, and G scores. A t-test for independent measures indicated that the mean core condition score was significantly higher for the high core group than the low core group of therapists ($t = 9.17, p < .01$). Thus, this high and low core condition classification resulted in two groups of therapists which differed significantly on the relevant variable.

Hypothesis I

There is a significant positive relationship between the therapists' core condition scores and IRS scores.

Hypothesis I was tested directly by computing a Pearson r between IRS scores, i.e., the mean of the five IRS

Table 4. \bar{X} 's and S.D.'s of E, W, G, and Core Condition Scores for High and Low Core Therapists

Group	E			W			G			Core Condition		
	X	S.D.		X	S.D.		X	S.D.		X	S.D.	Range
High Core N = 28	2.57	.66		2.66	.71		2.66	.90		2.63	.73	1.67-3.96
Low Core N = 28	1.31	.29		1.33	.23		1.32	.19		1.30	.17	1.00-1.62
Total	1.94	.81		1.99	.84		1.99	.93		1.97	.85	1.00-3.96

ratings per therapist, and core condition scores of the entire sample. A significant positive relationship was obtained ($r = .65, p < .001$), thus confirming Hypothesis I.

r 's were also computed between IRS and core condition scores for the high and the low core groups and for the 56 therapists divided into quartiles on the basis of their core condition scores. A significant relationship was obtained within the high core group ($r = .60, p < .001$) but not within the low core group ($r = .15$). A significant positive relationship was also obtained within the first core quartile group of therapists ($r = .82, p < .001$), but no significant relationship was found within the second ($r = .21$), the third ($r = .02$), or the fourth ($r = .03$) quartiles. Thus, although IRS and core condition scores were significantly and positively related for the total sample, additional analyses indicated that this finding was primarily accounted for by the strong relationship between IRS and core scores which existed within the first quartile group.

Table 5 presents the means and standard deviations of the IRS scores, i.e., the average of the five IRS ratings per therapist, and core condition scores and the range of the core scores for the high and low core groups of therapists and for the therapists divided into core condition quartiles. A t-test for independent measures indicated that the high core group had a significantly higher mean IRS score than the low core group ($t = 3.76, p < .01$). A

Table 5. \bar{X} 's and S.D.'s of IRS and Core Scores for High and Low Core and Core Quartile Therapists

Group	IRS Scores		Core Condition Scores		
	Mean	S.D.	\bar{X}	S.D.	Range
Core Q ₁	3.52	1.25	3.27	.44	2.42-3.96
Core Q ₂	2.76	.78	1.98	.21	1.67-2.33
Core Q ₃	2.39	.58	1.46	.09	1.30-1.62
Core Q ₄	2.21	.49	1.15	.07	1.00-1.29
High Core	3.14	1.11	2.63	.73	1.67-3.96
Low Core	2.30	.54	1.30	.17	1.00-1.62
Total	2.72	.97	1.97	.85	1.00-3.96

one-way analysis of variance, used to evaluate differences in IRS scores among the quartile groups, revealed a significant difference among the quartile groups ($F = 4.96$, $p < .01$), and Duncan's New Multiple Range test indicated that the first quartile had a significantly higher mean IRS score than each of the three lower quartiles ($p < .05$), while the three lower quartiles did not differ significantly among themselves.

In addition to the analyses used in testing Hypothesis I, the frequency with which the IRS scores, the average of the five IRS ratings per therapist, of the 56 therapists occurred at each of the six stages of the IRS scale was also investigated. These frequencies are presented in Table 6 as the percent of IRS scores at each IRS stage within each of the core quartile groups of therapists. These percents could not be evaluated statistically because of the many cells which contained a zero. Inspection of this table, however, suggested that the second, third, and fourth quartiles were quite similar in the distribution of IRS scores among the stages and, at the same time, quite different from the distribution in the first quartile. Therefore, the three lower quartiles were combined, and the test for the difference between two independent proportions was used to evaluate the differences in IRS scores at each IRS stage between these 42 therapists and the 14 therapists in the first quartile. Significant differences were obtained at both stages 2 and 4, indicating that a

Table 6. Percent of IRS Scores at Each IRS Stage for Core Quartile Therapists

Group	IRS Stages					
	1	2	3	4	5	6
Core Q ₁	7.14	7.14	42.86	21.43	14.29	7.14
Core Q ₂	0	50.00	42.86	0	7.14	0
Core Q ₃	7.14	50.00	42.86	0	0	0
Core Q ₄	7.14	57.14	35.71	0	0	0
Core Q ₁ N=14	7.14	7.14	42.86	21.43	14.29	7.14
Core Q ₁ , Q ₃ , & Q ₄ N=42	4.76	52.38	40.48	0	2.38	0
Total	5.36	41.07	41.07	5.36	5.36	1.79

significantly greater proportion of first quartile therapists had an IRS score at stage 4 ($Z = 2.40$, $p < .01$) while significantly fewer had an IRS score at stage 2 ($Z = 2.68$, $p < .01$) than the remaining group of 42 therapists.

Table 6 shows that the IRS scores of 82.14% of the entire sample of therapists were divided evenly between stages 2 and 3, while the remaining scores were fairly evenly divided among the remaining stages. When the distribution of IRS scores among the stages within the first and within the combined three lower quartiles was considered separately, striking differences between the two groups were apparent. The IRS scores of approximately 41.00% of the therapists in both groups fell at stage 3. However, for the remaining therapists within the first quartile, three times as many of their IRS scores fell above stage 3 as fell below stage 3; in contrast, almost all of the IRS scores of the remaining therapists in the three lower quartiles fell at stage 2, and 92.86% of all the therapists within this group had IRS scores at either stage 2 or 3.

Since the IRS scores, the average of the five IRS ratings per therapist, tended to rather severely reduce the variability of the individual IRS ratings so that a consequent piling up of IRS scores occurred near the middle stages of the scale, the five individual IRS ratings made on each therapist were also investigated. The frequency of these ratings made at each IRS stage was tallied for the

high and low core groups, for each of the core quartile groups, and for the 56 therapists as a group (see Table 7).

There is no appropriate statistical test with which to evaluate the statistical significance of the difference in the frequency or proportion of ratings obtained by the groups of therapists at each stage of the IRS scale. This rating data violates the assumption of the independence of observations which is made for the statistical tests with which the rating data might otherwise be analyzed, e.g., chi square, the test for the difference between two independent proportions. The IRS ratings were not independent; i.e., there were five repeated ratings for each therapist and, moreover, it was possible for each therapist to have more than one rating at any particular stage. The only strictly appropriate way of analyzing the rating data would involve obtaining a single measure or score per therapist to represent his five IRS ratings similar to the procedure above where t-tests were used to evaluate group differences in IRS scores. However, since the distribution or pattern of ratings among the stages of the scale was also very much of interest, the use of such a single measure or score was not entirely satisfactory for all of the purposes of this study.

Since even a somewhat crude or approximate statistical evaluation of group differences in the proportion of ratings at each stage was considered preferable to reliance on inspection or intuition so long as the assumption

violation and the consequent approximate nature of the statistical analysis is fully noted, the test for the difference between two independent proportions, corrected for discontinuity (Edwards, 1962, pp. 51-57), was selected as the most appropriate and direct test with which to analyze these differences. A chi square test proved to be unfeasible because the IRS rating data consisted of too many cells which contained a zero or an expected frequency less than five. Thus, with the realization that this use of the proportion test should be considered to provide only an approximate statistical evaluation of the data and could produce errors of unknown magnitude and kind, the test for the difference between two independent proportions was subsequently used in Studies I and II for evaluating group differences in the proportion of IRS ratings which occurred at individual IRS stages. However, some justification for this use may be drawn from the theoretical statistical analyses regarding the problem of the statistical independence of observations done by Chassan and Bellak (1966, pp. 493-496). On the basis of their work, Chassan and Bellak have concluded that even with relatively high degrees of statistical dependence of observations standard tests such as the t-test, which is highly related to the test for the difference between two proportions, can be used as a reasonably accurate tool.

In addition, throughout Studies I and II the results of all tests for the difference between two proportions of

IRS ratings were reported whenever they reached at least the .05 level of significance so the reader could evaluate these differences for himself; however, because of the large number of such tests computed, only those differences reaching at least the .01 level were used as a basis for drawing conclusions.

With the foregoing in mind, then, the following significant differences in the proportion of IRS ratings at the individual IRS stages were obtained between the high and low core groups of therapists: the high core group gave fewer stage 2 responses ($Z = 2.88$, $p < .004$), more stage 6 responses ($Z = 4.48$, $p < .001$), and more stage 4 responses ($Z = 3.49$, $p < .006$) than did the low core group.

The response pattern or the distribution of ratings among the IRS stages for the high and low core therapists displayed some striking dissimilarities. While both groups of therapists gave approximately the same number of stage 3 responses, the group of low core therapists showed much less variability than the high core therapists in the kinds of IRS responses they made, with 82.86% of all responses in the low core group occurring at either stages 2 or 3.

The following significant differences in IRS ratings were obtained between the core quartile groups of therapists. At stage 2, fourth quartile therapists had a greater proportion of IRS ratings than the first quartile therapists ($Z = 3.30$, $p < .001$). At stage 6, the first quartile gave a greater proportion of responses than the second ($Z = 3.17$,

Table 7. Percent of IRS Ratings at Each IRS Stage for High and Low Core and Core Quartile Therapists

Group	IRS Stages					
	1	2	3	4	5	6
High Core	12.14	26.43	30.00	12.86	2.14	16.43
Low Core	15.00	43.57	39.29	1.43	0	.71
Core Q ₁	12.86	22.86	21.43	14.29	1.43	27.14
Core Q ₂	11.43	30.00	38.57	11.43	2.86	5.71
Core Q ₃	15.71	35.71	45.71	1.43	0	1.43
Core Q ₄	14.29	51.43	32.86	1.43	0	0
Total	13.57	35.00	34.64	7.14	1.07	8.60

$p < .0001$), or the fourth quartiles ($Z = 4.39$, $p < .0001$). At stage 3, the first quartile gave fewer responses than either the second ($Z = 2.03$, $p < .04$) or the third ($Z = 2.86$, $p < .004$) quartiles. Thus, the first quartile made significantly fewer stage 2 responses than the fourth quartile, significantly fewer stage 3 responses than the third quartile, and significantly more responses at stage 6 than each of the three lower quartiles. These results suggested that the differences found at stages 2, 3, and 6 were primarily a function of the first quartile group of therapists differing significantly from one or more of the lower quartile groups.

Description of the characteristic manner of responding on the IRS by therapists grouped into the core quartiles can be seen from Table 7. In comparison with the first quartile, second quartile therapists made fewer responses at stage 6 while simultaneously making more responses at both stages 2 and 3. In comparison with the second quartile, the third quartile made fewer responses at both stages 4 and 6 while making a greater number at stages 2 and 3. In contrast to the third quartile, the fourth quartile simultaneously made fewer stage 3 and more stage 2 responses. Thus, the pattern of IRS responses within each of the core quartiles displayed a general trend progressing from the first through the fourth quartiles: within each successive quartile there occurred both a decrease in the variability of responses and a decrease in the number of responses made

above stage 3 with a concomitant increase in the number of responses made at stage 2.

In summary, a significant positive relationship was found between core condition scores and IRS scores, i.e., the mean of the five IRS ratings per therapist, for the entire sample of therapists, and Hypothesis I was therefore confirmed. A significant positive relationship was also found within the high core group, but no significant relationship was found within the low core group. Moreover, in comparison with the low core group the high core group had a significantly higher mean IRS score and gave a significantly greater number of responses at both stages 6 and 4 and a significantly fewer number of responses at stage 2. Analyses of the core quartile groups indicated that within the first quartile IRS scores were significantly and positively related to core scores and, in addition, were significantly higher than the IRS scores of each of the three lower quartiles. Moreover, significant differences between the quartile groups in the proportion of IRS ratings at stages 2, 3, and 6 tended to differentiate the first quartile from the remaining quartiles. Thus, two distinct groups which differed on both IRS ratings and mean IRS scores as well as on the relationship between IRS and core condition scores emerged from the data: the group of 14 therapists having the highest core scores and the remaining 42 therapists having the lowest core scores.

Hypothesis II

The group of outpatient therapists and the group of inpatient therapists do not differ significantly on mean IRS scores.

Hypothesis II was tested directly by evaluating the difference between the mean IRS scores, the average of the five IRS ratings per therapist, of the 33 therapists of the inpatients and the 23 therapists of the outpatients with a t-test for independent measures. The obtained t indicated that the inpatient and outpatient therapists did not differ significantly on mean IRS scores ($t = .38$); therefore, Hypothesis II was confirmed. Means and standard deviations of IRS scores of inpatient and outpatient therapists are shown in Table 8.

On the basis of their IRS scores the 56 therapists were divided into a high and a low IRS group, using the median IRS score of 2.56, and subdivided into IRS quartile groups. t-tests for independent measures were used to evaluate the differences in mean IRS scores between the inpatient and outpatient therapists within each of these six IRS groups. The results indicated that mean IRS scores of the high IRS group did not differ significantly between inpatient and outpatient therapists ($t = .63$), but within the group of low IRS therapists those who saw outpatients had a significantly higher mean IRS score than those who saw inpatients ($t = 2.86, p < .05$). No significant differences were found between the inpatient and outpatient therapists

Table 8. \bar{X} 's and S.D.'s of IRS Scores for In- and Out-Patient and IRS Quartile Therapists

Group	Mean				S.D.		Range
	Inpatients Therapists	Outpatient Therapists	In- & Out- patient Therapists	Inpatient Therapists	Outpatient Therapists	In- & Out- patient Therapists Combined	
IRS Q ₁	4.21	3.73	4.00	1.07	.87	.98	3.00-6.00
IRS Q ₂	2.74	2.74	2.74	.20	.20	.17	2.60-3.00
IRS Q ₃	2.39	2.34	2.36	.10	.10	.10	2.20-2.53
IRS Q ₄	1.67	2.09	1.76	.32	.07	.33	1.00-2.13
High IRS N=28	3.47	3.24	3.37	1.06	.76	.94	2.60-6.00
Low IRS N=28	1.93	2.27	2.06	.45	.14	.39	1.00-2.53
Total	2.68	2.78	2.72	1.11	.76	.97	1.00-6.00

within any of the IRS quartile groups (t 's = 1.53, 0.00, .76, and 1.38, respectively) (see Table 8).

The distribution of the five IRS ratings per therapist at each IRS stage was also investigated for the groups of inpatient and outpatient therapists as well as for the inpatient and outpatient therapists within both the high and the low IRS therapist groups. Tests for the difference between two independent proportions indicated that the only significant differences occurred at stage 3 where the group of outpatient therapists had a greater proportion of responses than the inpatient group ($Z = 3.20$, $p < .001$), and within the group of low IRS therapists outpatient therapists had a significantly greater proportion of responses than inpatient therapists ($Z = 2.83$, $p < .005$) (see Table 9).

To further clarify the differential IRS responses made by inpatient and outpatient therapists at the individual IRS stages, the percent of the total number of IRS ratings at each stage for the entire sample occurring in the inpatient and outpatient groups of therapists was calculated. Table 10 shows that inpatient therapists gave 75.00% of the total number of stage 6 responses given by the entire sample, 73.68% of the total number of stage 1 responses, and 64.29% of the total number of stage 2 responses. Thus, more variable and extreme IRS responses were given by the inpatient therapists than by the outpatient therapists.

Table 9. Percent of IRS Ratings at Each Stage for In- and Out- Patient and High and Low IRS Therapists

Group	IRS Stages					
	1	2	3	4	5	6
33 Inpatient Therapists	16.97	38.18	26.67	5.45	1.82	10.91
23 Outpatient Therapists	8.70	30.43	46.09	9.57	0	5.22
High IRS						
16 Inpatient Therapists	7.50	16.25	41.25	8.75	3.75	22.50
12 Outpatient Therapists	5.00	11.67	56.67	16.67	0	10.00
Low IRS						
17 Inpatient Therapists	25.88	58.82	12.94	2.35	0	0
11 Outpatient Therapists	12.73	50.91	34.55	1.82	0	0
Total	13.57	35.00	34.64	7.14	1.07	8.60

Table 10. Percent of Total IRS Ratings at Each Stage for Inpatient and Outpatient Therapists

Group	IRS Stages					
	1	2	3	4	5	6
33 Inpatient Therapists	73.68	64.29	45.36	45.00	100.00	75.00
23 Outpatient Therapists	26.32	35.71	54.64	55.00	0	25.00
Total	100	100	100	100	100	100

In summary, there was no significant difference in mean IRS scores between the 33 inpatient therapists and the 23 outpatient therapists, and Hypothesis II was therefore confirmed. However, the group of outpatient therapists gave a significantly greater proportion of stage 3 responses than inpatient therapists. Additional analyses indicated that this difference at stage 3 was primarily attributable to the group of low IRS therapists who saw outpatients and who had both a significantly higher mean IRS score and a significantly greater proportion of stage 3 responses than the low IRS therapists who saw inpatients. High IRS therapists who saw inpatients and those who saw outpatients, on the other hand, were not differentiated by either mean IRS scores or by the proportion of IRS ratings at any of the individual stages.

Hypothesis III

There is a significant positive relationship between the therapists' IRS scores and their clients' DX scores.

Hypothesis III was tested by computing a Pearson r between the IRS and DX scores of the entire sample of 56 therapists and their respective clients. A significant positive relationship was obtained ($r = .31$, $p < .05$); therefore, Hypothesis III was confirmed.

Further delineation of the relationship between DX and IRS scores was achieved by classifying therapists on the basis of their client's DX scores into a high and a low DX group, using the median DX score of 1.88, and into DX quartile groups. This classification of therapists and their respective clients thus made possible analysis of therapists' IRS scores and the proportion of IRS ratings at each IRS stage in relation to their clients' DX scores. See Table 11 for means and standard deviations of IRS and DX scores for these six DX groups.

Analyses of the IRS scores indicated that therapists in the high DX group had significantly higher ($t = 3.04$, $p < .01$) and significantly more variable ($F = 5.03$, $p < .01$) IRS scores than therapists in the low DX group. Duncan's New Multiple Range test, used to evaluate the differences in mean IRS scores among the DX quartile groups, further indicated that therapists of clients in both the first and second DX quartiles had significantly higher IRS scores than those in the fourth DX quartile ($p < .05$).

Table 11. \bar{X} 's and S.D.'s of IRS and DX Scores for High and Low DX and DX Quartile Groups

Group	IRS Scores		DX Scores		
	\bar{X}	S.D.	\bar{X}	S.D.	Range
DX Q ₁	3.05	1.04	2.89	.33	2.50 - 3.25
DX Q ₂	3.14	1.34	2.06	.17	1.88 - 2.38
DX Q ₃	2.41	.60	1.71	.10	1.62 - 1.88
DX Q ₄	2.30	.46	1.42	.14	1.12 - 1.50
High DX	3.10	1.18	2.48	.50	1.88 - 3.25
Low DX	2.36	.53	1.56	.20	1.12 - 1.88
Total	2.72	.97	2.02	.59	1.12 - 3.25

Analyses of the frequency of IRS ratings at each IRS stage for therapists who saw high DX clients and those who saw low DX clients indicated that therapists of high DX clients gave a significantly greater number of responses at both stage 4 ($Z = 3.06$, $p < .002$) and stage 6 ($Z = 3.63$, $p < .0003$) and, at the same time, gave significantly fewer responses at stage 2 ($Z = 3.40$, $p < .0007$) than therapists of low DX clients. With therapists divided into the DX quartile groups, differences were obtained at the same stages, stages 2, 4, and 6, at which differences were obtained between the high and low DX groups. At stage 6, both the first and second DX quartiles had a greater proportion of responses than the third ($Z = 2.10$, $p < .04$;

$Z = 2.31$, $p < .02$, respectively) or the fourth DX quartile ($Z = 2.50$, $p < .01$; $Z = 2.70$, $p < .007$, respectively). At stage 4, the first quartile had a greater proportion of responses than either the third ($Z = 2.10$, $p < .04$) or the fourth quartile ($Z = 2.50$, $p < .01$). Finally, at stage 2, the first quartile had fewer responses than either the third ($Z = 1.99$, $p < .05$) or the fourth quartile ($Z = 3.13$, $p < .002$) (see Table 12).

Table 12. Percent of IRS Ratings at Each Stage for High and Low DX and DX Quartile Groups

Group	IRS Stages					
	1	2	3	4	5	6
High DX	13.57	25.00	32.14	12.14	2.14	15.00
Low DX	13.57	45.00	37.14	2.14	0.00	2.14
DX Q ₁	17.14	22.86	30.00	14.29	1.43	14.29
DX Q ₂	10.00	27.14	34.29	10.00	2.86	15.71
DX Q ₃	14.29	40.00	40.00	2.86	0	2.86
DX Q ₄	12.86	50.00	34.29	1.43	0	1.43
Total	13.57	35.00	34.64	7.14	1.07	8.60

In summary, a significant positive relationship was found between IRS and DX scores within the entire sample, and Hypothesis III was consequently confirmed. With therapists divided into DX groups on the basis of their client's DX scores, IRS scores were significantly higher and

more variable for therapists of high DX clients than for therapists of low DX clients and, in addition, therapists in the first and second DX quartiles each had significantly higher mean IRS scores than therapists in the fourth DX quartile. Therapists whose clients had high DX scores were also found to give a significantly greater number of responses at both stages 4 and 6 while giving significantly fewer responses at stage 2 than therapists whose clients had low DX scores.

Hypothesis IV

Three specific hypotheses are used to test the general hypothesis that IRS responses significantly differentiate on the variable of orientation but do not significantly differentiate on the variable of experience level.

Hypothesis IVA

Orientations to psychotherapy are ordered on the basis of IRS scores from highest to lowest in the following way: Relationship, Eclectic, Client-Centered, and Analytic.

Hypothesis IVB

Relationship therapists have significantly higher IRS scores than Eclectic, Client-Centered, or Analytically oriented therapists.

Hypothesis IVC

No significant differences in IRS scores occur between the group of high experience level therapists and

the group of low experience level therapists within any of the four orientation groups.

Since information regarding orientation and experience level was available for only 39 of the 56 therapists, the following analyses were based on only those 39 therapists. Table 13 shows the number of inpatients and outpatients as well as the average number years of experience in conducting psychotherapy for the 39 therapists classified according to orientation and experience level.

The IRS scores, i.e., the average of the five IRS ratings per therapist, formed a 2 x 4 factorial design with classification of therapist experience level into high (above five years) and low (five years or less) and classification of therapist orientation into Relationship (RE), Eclectic (EC), Client-Centered (CC), and Analytic (AN). A square root transformation, using the formula $\sqrt{X + .5}$, was performed on the IRS scores because of the simultaneous occurrence of heterogeneity of variance and unequal n's in the cells. Table 14 presents the means and standard deviations of both the transformed and nontransformed IRS scores for the four orientation groups divided into high and low experience levels.

Table 14 shows that the means of the transformed IRS scores for the RE, EC, CC, and AN groups were 2.05, 1.77, 1.75, and 1.72, respectively. Thus, the means of the transformed IRS scores for the orientation groups demonstrated the predicted order; therefore, Hypothesis IVA was confirmed.

Table 13. \bar{X} Years of Experience and Number of Inpatients and Outpatients for Therapists Classified According to Orientation and Experience Level

Group	High Experience				Low Experience				Total Therapists
	\bar{X} yrs. exp.	In- patient	Out- patient	\bar{X} yrs. exp.	In- patient	Out- patient			
Relationship	7	4	3	1.8	2	3			12
Eclectic	7	5	0	1.7	3	3			11
Client Centered	7.3	2	1	3.5	2	2			7
Analytic	8.7	5	2	3	1	1			9
Total	7.5	16	6	2.5	8	9			39

Table 14. \bar{X} 's and S.D.'s of Both Transformed IRS Scores and IRS Scores Prior to Transformation for Therapists Classified According to Orientation and Experience Level

Group	Relationship		Eclectic		Client Centered		Analytic		Total 39 Therapists	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Transformed IRS Scores										
High Experience	1.92	.24	1.73	.14	1.71	.10	1.77	.14	1.80	.17
Low Experience	2.20	.34	1.81	.34	1.78	.10	1.55	.30	1.89	.36
Total	2.05	.97	1.77	.26	1.75	.10	1.72	.20	1.84	.87
IRS Scores Prior to Transformation										
High Experience	3.25	.90	2.51	.52	2.45	.32	2.66	.46	2.78	.68
Low Experience	4.44	1.40	2.89	1.32	2.67	.28	1.94	.94	3.18	1.37
Total	3.72	1.24	2.71	1.01	2.57	.30	2.50	.61	2.96	1.04

The 2 x 4 analysis of variance, performed on the transformed IRS scores and using the unweighted means method for unequal n's, indicated there was no significant difference in mean IRS scores between the high and low experience therapists and no significant Experience Level x Orientation interaction effect. This failure to obtain a significant interaction effect thus indicated that high and low experience therapists within each of the orientation groups did not differ significantly on mean IRS scores. Both of these findings were in agreement with Hypothesis IVC; therefore, Hypothesis IVC was confirmed. However, a significant orientation main effect ($F = 4.68, p < .05$) was obtained from the analysis of variance. Duncan's New Multiple Range test, used to evaluate the difference in mean IRS scores among the four orientation groups, indicated that the RE group had a significantly higher mean IRS score than the AN group ($p < .05$) but only tended to have a higher score than the CC ($p < .10$) and EC group ($p < .10$). Therefore, Hypothesis IVB was rejected. Table 15 summarizes the analysis of variance.

The frequency of the five IRS ratings per therapist at each IRS stage was also investigated for the high and low experience level groups of therapists, for the four orientation groups, and for the high and low experience therapists within each orientation.

Table 16 presents the percent of IRS ratings at each stage for the high and low experience therapists. Tests for

Table 15. Summary of Orientation X Experience Level AOV

Source	df	SS	MS	F
Experience Level	1	.041	.041	--
Orientation	3	.785	.262	4.68 ^a
Experience X Orientation	3	.207	.069	1.23 N.S.
Error	31	1.73	.056	
Total	38			

^a_p < .05

Table 16. Percent of IRS Ratings at Each Stage for Experience Level and Orientation Groups

Group	IRS Stages					
	1	2	3	4	5	6
High Exp.	8.18	31.82	41.82	11.82	0	6.36
Low Exp.	16.47	24.71	17.06	8.24	3.53	20.00
RE	3.33	25.00	21.67	18.33	1.67	30.00
EC	12.73	40.00	29.10	7.27	1.82	9.10
CC	14.29	40.00	31.43	8.57	2.86	2.86
AN	20.00	11.11	64.44	4.44	0	0
Total	11.79	28.72	35.38	10.26	1.54	12.31

the difference between two proportions indicated the following. At stage 6, low experience therapists gave a significantly greater proportion of responses than high experience therapists ($Z = 2.65$, $p < .008$). At stage 3, high experience therapists gave a greater proportion of responses than low experience therapists ($Z = 1.99$, $p < .05$). Thus, although no significant differences were found between the two experience groups on mean IRS scores, significant differences were obtained in the analyses of IRS ratings of these two groups.

Table 16 also shows the percent of IRS ratings at each stage for therapists in the four orientation groups. Tests for the difference between two proportions indicated the following. At stage 1, the AN group gave more responses than the RE group ($Z = 2.43$, $p < .02$). At stage 2, the AN group gave significantly fewer responses than either the CC ($Z = 2.75$, $p < .006$) or EC group ($Z = 3.03$, $p < .002$). At stage 3, the AN group gave significantly more responses than the CC ($Z = 2.69$, $p < .007$), the EC ($Z = 3.34$, $p < .001$), or the RE group ($Z = 4.22$, $p < .0001$). At stage 6, the RE group gave significantly more responses than the EC group ($Z = 2.57$, $p < .01$), the CC ($Z = 2.93$, $p < .003$), or the AN group ($Z = 3.78$, $p < .0002$). These findings are summarized in Table 17. The major differences, then, between the orientation groups in the proportion of responses at individual IRS stages occurred between the RE and AN group where the RE therapists gave a significantly fewer number of

Table 17. Significant Differences in Proportion of IRS Ratings at IRS Stages for Orientation and Experience Level Groups

	IRS Stages		
1	2	3	6
$AN^b < RE^a, p < .02.$	$AN > CC^d, p < .002.$	$AN < CC, p < .007.$	$RE < EC, p < .01.$
	$AN > EC^c, p < .006.$	$AN < EC, p < .001.$	$RE < CC, p < .003.$
	$RE \text{ High Exp. } < \text{ RE Low Exp., } p < .02.$	$AN < RE, p < .0001.$	$RE < AN, p < .0002.$
		High Exp. < Low Exp., $p < .05.$	Low Exp. < High Exp., $p < .008.$
		$AN \text{ High Exp. } < AN \text{ Low Exp., } p < .03.$	$RE \text{ Low Exp. } < RE \text{ High Exp., } p < .02.$

a_{RE} = Relationship
 b_{AN} = Analytic
 c_{EC} = Eclectic
 d_{CC} = Client Centered

responses at both stages 1 and 3 and, simultaneously, gave a significantly greater number at stage 6. The EC and CC groups were quite similar to one another in the number of responses at each stage, and both groups differed significantly from the AN group at stages 2 and 3 and from the RE group at stage 6. Comparison of the distribution of IRS responses among the stages within the AN and RE groups revealed striking differences between these two groups. Ninety-five percent of all responses given by the RE therapists were approximately evenly divided among stages 2, 3, 4, and 6. In contrast, approximately 65.00% of all responses given by the AN therapists were given at stage 3 alone, 20.00% at stage 1, and 11.00% at stage 2. Thus, the response pattern of the RE therapists was more variable and consisted of more responses at the extreme stages of the scale than that of the AN therapists. The response pattern of the EC and CC therapists fell about midway between the more extreme patterns of the RE and AN therapists.

Finally, the percent of ratings at each IRS stage was tabulated for the high and low experience therapists within each of the four orientations (see Table 18). Tests for the difference between two proportions were computed at each stage between the two experience groups within each orientation and indicated the following. High experience RE therapists gave more stage 2 ($Z = 2.26$, $p < .02$) and fewer stage 6 responses ($Z = 2.28$, $p < .02$) than low experience RE therapists. Within the AN orientation, high

Table 18. Percent of IRS Ratings at Each Stage for
Experience Levels Within Orientation Groups

Group	IRS Stages					
	1	2	3	4	5	6
Relationship						
High	2.86	37.14	17.14	25.71	0	17.14
Low	4.00	8.00	28.00	8.00	4.00	48.00
Eclectic						
High	8.00	48.00	36.00	4.00	0	4.00
Low	16.67	33.33	23.33	10.00	3.33	13.33
Client Centered						
High	6.67	53.33	33.33	6.67	0	0
Low	20.00	30.00	30.00	10.00	5.00	5.00
Analytic						
High	14.29	5.71	74.29	5.71	0	0
Low	40.00	30.00	30.00	0	0	0
Total						
	11.79	28.72	35.38	10.26	1.54	12.31

experience therapists gave more stage 3 responses ($Z = 2.20$, $p < .03$) than low experience therapists. All significant differences obtained in the proportion of ratings at each stage by therapists classified according to orientation and experience level are summarized in Table 17.

In summary, the four orientation groups were ordered from highest to lowest on the basis of mean IRS scores in the following manner: RE, EC, CC, and AN. Thus, Hypothesis IVA was confirmed. The RE therapists had a significantly higher mean IRS score than the AN therapists but only tended to have a higher score than the CC or EC groups, and Hypothesis IVB was therefore rejected. In addition, comparisons between the orientation groups on the total number of ratings at each IRS stage indicated that the RE therapists gave a significantly greater proportion of responses at stage 6 than each of the three other orientation groups and gave significantly fewer responses at both stages 1 and 3 than the AN therapists.

The 22 high and the 17 low experience therapists did not differ significantly on mean IRS scores nor did the high and low experience therapists within each of the four orientation groups differ significantly on mean IRS scores, and Hypothesis IVC was confirmed. However, the low experience therapists gave a significantly greater number of stage 6 responses and tended to give fewer stage 3 responses than the high experience therapists. Comparisons between high and low experience therapists within each of the

orientations indicated that this difference found between the two experience groups at stage 6 was primarily accounted for by the RE therapists, while the difference found at stage 3 was primarily due to the AN therapists.

Study II--Outcome Study

Separate scores were computed for the IRS, E, W, G, and DX scales for each of the 40 cases and for each of the four therapists. The design on the study called for six ratings to be made on each scale for each of the 40 cases: for each case the six ratings per scale consisted of one segment selected from the middle portion and an additional segment from the last third portions of the first, tenth, and fifth from final therapy sessions. The score on each scale for each of the 40 cases was obtained by computing the average of the six ratings per scale; the score on each scale for each of the therapists was obtained by computing the average of the scores on the respective scales of the ten cases randomly assigned to each therapist. In the cases where not all six ratings were available because of missing segments, the score consisted of the average of the available ratings. In addition, two measures of the core conditions, a Σ EWG score and a Σ EG score, were determined for each case and for each therapist. Each of the distributions of the 40 E, W, and G scores was converted into a standard Z distribution with a mean of zero and a standard deviation of one. The first core condition score, Σ EWG, was

then obtained by summing the E, W, and G Z-scores, and a second core condition score, Σ EG, was obtained by summing the E and G Z-scores for each case and for each therapist.

The reliability of the E, W, G, and DX scales was determined in the previous study by Truax et al. (1966). The reliability as measured by intraclass correlation for the combined four raters on the mean ratings per case was E, $r_{kk} = .63$; W, $r_{kk} = .59$; G, $r_{kk} = .60$; DX, $r_{kk} = .71$. The reliability of the mean IRS ratings per case for the two raters as measured by a Pearson correlation was .85.

Table 19 presents the means, standard deviations, and intercorrelations for the 12 predictor variables in the present study for the 40 cases.

The Pearson intercorrelations among the E, W, and G scores for the 40 cases were as follows: E and G ($r = .60$, $p < .001$), E and W ($r = .07$), and W and G ($r = -.11$). Thus, for the entire sample of cases E and G scores were significantly related, while W scores were not significantly related to either E or G scores, and moreover, a negative r was obtained between W and G scores. Truax (Truax et al., 1966) has suggested that whenever one of the three components of the core conditions is negatively related to the other two, client outcome is best predicted by the two conditions which are most highly related. For this reason, the Σ EG scores were included as an additional predictor variable in this study.

Table 19. \bar{X} 's, S.D.'s and r's for 12 Predictor Variables (N = 40)

	ΣEG	ΣEWG	No. Sess.	REL	E	G	W	IRS	DX	RI/ ^e NRI	ATT/ ^f UATT	\bar{X}	S.D.
IAS	.34 ^a	.45 ^c	-.03	-.10	.35 ^a	.21	.15	-.08	-.03	.11	.15	28.80	17.18
ΣEG		.62 ^d	.02	.02	.90 ^d	.87 ^d	-.02	.17	-.11	.08	.04	.03	1.86
ΣEWG			-.35 ^a	.14	.65 ^d	.40 ^b	.46 ^c	.07	-.13	.02	.07	.49	2.03
No Sess.				-.69 ^d	-.03	.07	-.45 ^c	-.06	.11	-.28	-.24	12.65	4.24
REL					.06	-.02	.27	.09	-.17	.26	.33 ^a	2.90	1.35
E						.60 ^d	.07	.27	-.13	-.04	.01	4.28	.37
G							-.11	.01	-.07	.20	.03	3.36	.23
W								-.26	-.09	.06	-.07	3.90	.31
IRS									.03	.11	-.17	3.05	.60
DX										-.05	-.18	4.88	.67
II/NRI											.00	6.00	1.01

^a p < .05

^b p < .02

^c p < .01

^d p < .001

^e designated as 5 & 7, respectively, on computer program

^f designated as 3 & 4, respectively, on computer program

Hypothesis I

There is a significant positive relationship between the core condition scores and IRS scores within the entire sample of 40 cases.

Hypothesis I was tested directly by computing Pearson r 's between the Σ EWG scores and the IRS scores, i.e., the average of all IRS ratings per case, and between the IRS and Σ EG scores of the entire sample of 40 cases. The results indicated that no significant relationship existed between IRS scores and either Σ EWG scores ($r = .08$) or Σ EG scores ($r = .18$); therefore, Hypothesis I was rejected.

The 40 cases were dichotomized into high and low core condition groups of therapists, each group consisting of two therapists and their 20 clients. Each of the separate Σ EWG, Σ EG, E, and G scores of the four therapists resulted in identical dichotomies of two high core and two low core condition therapists. t -tests for independent measures indicated that the high core group of therapists had significantly higher mean scores on E ($t = 3.82$, $p < .01$), G ($t = 3.44$, $p < .01$), Σ EG ($t = 4.26$, $p < .01$), and IRS ($t = 2.33$, $p < .02$) than the low core group. Table 20 presents the means and standard deviations of the E, W, G, Σ EWG, Σ EG, and IRS scores for each therapist and for the high and the low core condition groups of therapists.

Pearson intercorrelations were computed among the IRS, E, W, G, Σ EWG, and Σ EG scores for the high and low core groups of therapists and the entire sample and are

Table 20. X's and S.D.'s of E, W, G, Σ EWG, Σ EG and IRS Scores for Each Therapist and for Two High and Two Low Core Therapists

	E		W		G		Σ EWG		Σ EG		IRS	
	\bar{X}	S.D.	\bar{X}	S.D.	\bar{X}	S.D.	\bar{X}	S.D.	\bar{X}	S.D.	\bar{X}	S.D.
Therapist 1 N = 10	4.27	.48	4.05	.32	3.42	.09	.73	1.59	.22	.95	2.63	.48
Therapist 2 N = 10	4.43	.35	3.99	.35	3.46	.24	.97	1.37	.61	1.16	3.17	.39
Therapist 3 N = 10	3.91	.22	3.88	.17	3.07	.13	-.85	2.41	-2.28	.93	3.06	.43
Therapist 4 N = 10	4.52	.28	3.68	.21	3.48	.14	.89	.97	1.26	1.26	3.35	.74
High Core Therapists 2 & 4 N = 20	4.48	.32	3.84	.33	3.47	.19	.93	1.19	.93	1.26	3.26	.60
Low Core Therapists 1 & 3 N = 20	4.09	.31	3.97	.27	3.25	.20	-.06	2.19	-1.03	1.56	2.84	.50
Total N = 40	4.28	.37	3.90	.31	3.36	.23	.49	2.03	.03	1.86	3.05	.60

shown in Table 21. For the sample of 40 cases IRS scores tended to be positively related to E scores ($r = .27$, $p < .10$) and negatively related to W scores ($r = -.26$, $p < .11$) but unrelated to G scores ($r = .01$), Σ EWG scores ($r = .08$), or Σ EG scores ($r = .18$). The IRS scores had strikingly different patterns of relationships with E and G scores within the high and low core groups of therapists. In the high core group IRS scores had a significant positive relationship to E ($r = .45$, $p < .05$) and Σ EG scores ($r = .47$, $p < .05$), while in the low core group IRS scores had a significant negative relationship to G ($r = -.55$, $p < .05$) and Σ EG scores ($r = -.50$, $p < .05$). Consequently, the failure to find IRS scores significantly related to E, G, or Σ EG scores within the entire sample of 40 cases reflected these opposing relationships within the high and low core therapist groups which tended to mask or cancel one another in the entire sample. The lack of a significant relationship between IRS and Σ EWG scores within the entire sample, however, reflected primarily the positive relationship of IRS scores with E scores, the negative relationship with W scores, and the lack of relationship with G scores within the total sample.

The frequency distribution of IRS scores, i.e., the average of all IRS ratings per case, at each stage of the IRS scale was tallied separately for the two high core therapists and the two low core therapists with their respective sets of 20 clients. Tests for the difference

Table 21. r 's Among IRS, E, W, G, Σ EWG, and Σ EG Scores for High and Low Core Therapists

		W	G	EWG	EG	IRS
<u>E</u>	High	.06	.28	.57 ^b	.65 ^c	.45 ^b
	Low	.40 ^a	.56 ^c	-.30	.89 ^c	-.30
	Total	.07	.60 ^c	.27 ^a	.84 ^c	.27 ^a
<u>W</u>	High		-.20	.43 ^a	-.33	-.25
	Low		.19	.65 ^c	.35	-.13
	Total		-.12	.44 ^c	-.11	-.26
<u>G</u>	High			.59 ^c	.78 ^c	.10
	Low			.17	.87 ^c	-.55 ^b
	Total			.39 ^b	.87 ^c	.01
<u>ΣEWG</u>	High				.62 ^c	.13
	Low				.46 ^b	-.12
	Total				.55 ^c	.08
<u>ΣEG</u>	High					.47 ^b
	Low					-.50 ^b
	Total					.18

^a_p < .10^b_p < .05^c_p < .01

between two independent proportions revealed no significant differences between the high and low core therapists in the proportion of IRS scores at any of the individual stages. Reference to Table 22 shows that 70.00% of the total number of IRS scores in both the high and low core groups fell at stage 3; however, in the high core group the remaining 30.00% fell at stages above stage 3 while in the low core group 20.00% fell at stage 2.

Table 22. Percent of IRS Scores at Each IRS Stage for the High and Low Core Therapists

Group	IRS Stages					
	1	2	3	4	5	6
High Core N = 20	0	0	70.00	25.00	5.00	0
Low Core N = 20	0	20.00	70.00	10.00	0	0
Total N = 40	0	10.00	70.00	17.50	2.50	0

In addition to the above frequency distribution of IRS scores, the frequency of the IRS ratings at each stage of the IRS scale was also tallied for the high and low core therapists. Tests for the difference between two independent proportions indicated that the greatest difference between the two groups occurred at stage 6, where the high core therapists had a higher proportion of responses than the low core therapists ($Z = 2.03$, $p < .04$). The ratings

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made at stages 4, 5, and 6 were then combined: 26.53% of the responses of the high core therapists and 8.33% of the responses of the low core therapists occurred at the combined stages 4, 5, and 6. This difference was significant ($Z = 3.00$, $p < .003$), thus indicating that the high core therapists made a significantly greater proportion of responses in which attempts were made to refer client statements to the immediate therapeutic relationship than did the low core therapists. Table 23 shows the percent of ratings at each stage for the high and low core therapists and for the entire sample.

Table 23. Percent of IRS Ratings at Each IRS Stage for the High and Low Core Therapists

Group	IRS Stages					
	1	2	3	4	5	6
High Core N = 98 Ratings	2.04	16.33	55.10	13.27	2.04	11.22
Low Core N = 84 Ratings	5.96	20.24	65.48	4.76	1.19	2.38
Total N = 182 Ratings	3.85	18.13	59.89	9.34	1.65	7.14

In summary, IRS scores were not significantly related to either measure of the core conditions, Σ EWG or Σ EG scores, within the total sample of cases, and Hypothesis I was therefore rejected. The nonsignificant relationships

between IRS scores and the two core condition measures reflected the opposing patterns of relationships between IRS scores and the individual E, W, and G scores within the high and low core groups and within the total group of cases. However, high core therapists had a significantly higher mean IRS score and gave significantly more IRS responses at the combined higher stages of the scale, stages 4, 5, and 6, than low core therapists.

IRS Responses on Middle and Last
Segments Selected from the First,
Tenth, and Fifth from Final
Therapy Sessions

Although no specific hypotheses were proposed regarding differential IRS scores as a function of time within an individual therapy session or as a function of time across the entire course of therapy, this information was of considerable interest and was consequently investigated insofar as was possible on the basis of the available data. Many of the middle and last segments designated for analysis in the design of the study, particularly those from the fifth from final session, were not available because of inaudible tape recordings, missed sessions, or fewer than six sessions. For the first therapy session, middle and last segments were available for 38 clients, 18 seen by low core and 20 by high core therapists. Segments for 20 clients, seven seen by low core and 13 by high core therapists, were available from the tenth therapy session, where the tenth session occurred prior to the fifth from final

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session, thus making the tenth session the second one to be sampled. In all but one case this reduction from the first to the tenth session in the number of clients for whom segments were available was a result of termination of therapy prior to the 14th session. Segments for 13 clients, three low core and ten high core cases, were available from the fifth from final session where the fifth from final session chronologically followed the tenth session. This fifth from final session for these 13 clients was, on the average, session 12.5. Altogether, a total of 19 clients terminated prior to the 14th session, and 30 terminated prior to the 16th session. Within the total sample of 40 clients the mean number of sessions was 12.7 and the number of sessions ranged from four to 19.

In order to make maximum use of all the available data, the IRS ratings obtained on the segments taken from the middle and last third portions of the first therapy session were analyzed for the group of 20 clients seen by the high core therapists and the group of 18 clients seen by the low core therapists. A 2 x 2 factorial design was used. The high and low core groups constituted one factor, and the middle and last segments constituted the second factor for which there were repeated measures. Results of the analysis revealed no significant differences in IRS ratings between either the high and low core therapists or between the middle and last segments and no significant Therapist x Segment interaction. The analysis of variance

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is summarized in Table 24, and the means and standard deviations of the IRS ratings are shown in Table 25.

IRS ratings were then analyzed for those 20 clients, seven in the low core group and 13 in the high core group, for whom the middle and last segments were available from both the first and tenth sessions. The data formed a $2 \times 2 \times 2$ factorial design with one factor consisting of high and low core therapists and with repeated measures on the two remaining factors, middle and last segments and first and tenth sessions. The only significant difference obtained from the analysis of variance consisted of a Segment \times Session interaction ($F = 8.30$, $p < .05$). t -tests for repeated measures indicated that the significant interaction consisted of a significantly higher mean IRS rating on the last segment of the tenth session than on either the middle segment of the tenth session ($t = 2.10$, $p < .05$) or the last segment of the first session ($t = 2.73$, $p < .02$). The analysis of variance is summarized in Table 26. IRS means and standard deviations are shown in Table 25.

A t -test for repeated measures indicated that no significant difference existed between mean IRS ratings on the middle and last segments selected from the fifth from final session for those 13 clients, ten seen by high core and three by low core therapists, for whom segments on all three sessions were available ($t = 1.01$). Therefore, these IRS ratings on the middle and last segments were averaged and analysis of variance for repeated measures was used to

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Table 24. Summary of 2 x 2 AOV on IRS Ratings of Middle and Last Segments Selected from First Therapy Session for High and Low Core Therapists

Source	df	SS	MS	F
<u>Between Ss</u>	37	19.23		
High vs. Low Core Therapists	1	.61	.61	1.17 N.S.
Error	36	18.62	.52	
<u>Within Ss</u>	38			
Middle vs. Last Segments	1	.03	.03	--
Therapists x Segments	1	1.16	1.16	4.14 N.S.
Error	36	9.93	.28	
Total	75			

TABLE 25. S.M. and R.D.M. or Available 124 Scores on Segments Selected from First and Tenth Sessions for High and Low Core Therapists

Group	First Therapy Session			Tenth Therapy Session		
	Middle		Last	Middle		Last

Table 25. \bar{X} 's and S.D.'s of Available IRS Scores on Segments Selected From First and Tenth Sessions for High and Low Core Therapists

Group	First Therapy Session			Tenth Therapy Session		
	\bar{X}	S.D.	Last	\bar{X}	S.D.	Last
High Core N = 20	3.15	.52	2.88	.69		
Low Core N = 18	2.73	.60	2.94	.71		
Total ^a N = 38	2.95	.59	2.91	.69		
High Core N = 13	3.12	.58	2.73	.78	2.88	1.56
Low Core N = 7	2.50	.76	2.64	.48	2.43	.79
Total ^b	2.90	.70	2.70	.68	2.73	1.33

^aN = 38 clients for whom middle and last segments from first therapy session were available.

^bN = 20 clients for whom middle and last segments were available from both first and tenth sessions.

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$p < .05$

Table 26. Summary of 2 x 2 x 2 AOV on Available IRS Ratings on Segments Selected from the Middle and Last Thirds of the First and Tenth Therapy Sessions for High and Low Core Therapists

Source	df	SS	MS	F
<u>Between Ss</u>	19	35.93		
High vs. Low Core Therapists	1	6.14	6.14	3.70
Error	18	29.79	1.66	
<u>Within Ss</u>	60	47.94		
Middle vs. Last Segments	1	1.13	1.13	1.20
First vs. Tenth Sessions	1	1.38	1.38	1.82
Therapists x Segments	1	.03	.03	.07
Therapists x Sessions	1	.96	.96	1.26
Segments x Sessions	1	3.82	3.82	8.30 ^a
Therapists x Segments x Sessions	1	1.75	1.75	3.80
Error ₁	18	16.91	.94	
Error ₂	18	13.69	.76	
Error ₃	18	8.27	.46	
Total	79			

^a_p < .05

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evaluate the differences in mean IRS ratings on the first, tenth, and fifth from final sessions for these 13 clients. Although the mean IRS ratings showed a progressive increase on each successive session, 2.90, 3.13, and 3.38, respectively, this trend was not significant ($F = 1.50$). The analysis of variance is summarized in Table 27.

Table 27. Summary of AOV on IRS Scores Obtained on First, Tenth, and Fifth from Final Sessions for Therapists of 13 Clients for Whom Data was Available

Source	df	SS	MS	F
Three Therapy Sessions	2	1.50	.75	1.50
Subjects	12	22.72	1.89	3.78
Sessions x Subjects	24	12.00	.50	
Total	38			

In summary, IRS scores of neither the high nor the low core therapists differed significantly on the first and tenth sessions, nor did IRS scores of the combined four therapists differ significantly on the first, tenth, and fifth from final sessions. There was no significant difference in IRS ratings on middle and last segments selected from the first, the tenth, or the fifth from final sessions. However, the four therapists as a group had significantly higher IRS ratings on the last segment of the tenth session than on either the middle segment of the tenth session or the last segment of the first session.

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Hypothesis II

The higher the IRS score of the clients' therapists, the better the clients' outcome on each of the five outcome measures, regardless of the therapists' level of core conditions, i.e., with the effect of the core conditions on the outcome measures controlled statistically.

Hypothesis II was tested and the results reported separately for each of the five different outcome measures.

The Pearson intercorrelations between the five outcome measures and the means and standard deviations of each outcome measure are presented in Table 28 for the 34 cases on which all outcome measures were available. On both the Target and Ineffectiveness measures a lower score indicated a greater degree of improvement. All of the outcome measures were significantly interrelated with the exception of the Discomfort measure, which only tended to be related to Ineffectiveness ($r = -.32$, $p < .10$) and had no significant relationship with Therapist Statement ($r = .28$).

A computerized step-wise regression analysis was employed in testing Hypothesis II (Efroymson, 1960).² This analysis was selected because it provided a direct and comprehensive evaluation of the relational prediction stated in Hypothesis II in which independent sources of variance

²BMDX2R--Stepwise Regression--Version of January 10, 1966

Health Sciences Computing Facility, UCLA
Modified for Texas Tech Computer Center, September 10, 1966

Table 28. X's, S.D.'s, and r's for Five Outcome Measures for 34 Cases

	Discomfort	Patient Statement	Therapist Statement	Target	Ineffectiveness
Discomfort		.41 ^b	.28	-.43 ^b	-.32 ^a
Patient Statement			.69 ^d	-.69 ^d	-.42 ^b
Therapist Statement				-.61 ^d	-.44 ^b
Target					.66 ^d
Mean	7.14	3.60	3.20	2.25	19.38
S.D.	16.96	1.25	1.11	.99	8.54

^ap < .10

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associated with each outcome measure could be determined. The extent to which each of the 12 predictor variables predicted each of the five outcome measures was determined by means of a separate run of the program for each outcome measure. The operations of the step-wise regression program and the resulting tests of significance which can be made are summarized as follows. A Pearson r , also referred to as a zero order r , is first computed between each of the 12 predictor variables and the outcome measure. The variable having the highest zero order r with the outcome measure is selected out and entered into a regression equation, and the significance of the zero order r is tested. Partial correlations are then computed between each of the remaining 11 predictor variables and the outcome measure with the effect of the variance of the first selected variable, i.e., the variable which had the highest zero order r with the outcome measure, partialled out. The second variable, the variable having the highest partial correlation with the outcome measure, is then selected out and entered into the multiple regression equation together with the first selected variable, and the partial regression coefficient for each of the two variables is tested for significance with a t -test, with df equal to the number of subjects, minus the number of predictor variables, minus 1. The significance of the partial r is tested using an F ratio for which the df is reduced by one for each variable held constant. A multiple R is computed between the first two

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The procedure of selecting from the remaining predictor variables the one having the highest partial r with the outcome measure while the effect of all previously selected variables are held constant, testing the significance of this partial r , entering the selected variable into the multiple regression equation with all those previously selected and testing the significance of the partial regression coefficient for each of the variables in the equation, and finally, computing a multiple R for the selected variable and all those previously selected with the outcome measure, is repeated until all the orthogonally related variables have been selected for inclusion in the multiple regression equation.

Since the large number of missing segments made the use of ratings on the individual segments for predicting outcome measures unfeasible, each client's scores, i.e., the average of his ratings, were used in all analyses of the outcome measures. In addition, each of the step-wise regression analyses computed on the total sample of cases employed an n of 40, although four of the outcome measures were available on only 34 clients. Since the six clients who did not return for the post-therapy collection of outcome data could not be assumed to be randomly selected from the entire sample of clients, the mean of the outcome scores of the 34 clients who returned was assigned as the outcome

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values for these six clients. This was done in order to avoid the possible biasing of the sample which might have resulted from the exclusion of these cases. Use of the outcome scores did not mathematically alter the outcome data but did permit the use of all the available data related to these six clients, e.g., IRS and core condition scores. Of the six clients who did not return for the post-therapy evaluation, four were seen by low core condition therapists and were rated by their therapists as either having shown no improvement or deterioration, and the remaining two clients were seen by one high core therapist and were rated as having slightly and markedly improved, respectively.

Table 29 presents the Pearson zero order r 's between each of the 12 predictor variables and each of the five outcome measures for the 40 cases.

Discomfort Outcome Measure. Only Initial Adjustment scores (IAS) ($r = .50, p < .01$), and IRS scores with IAS scores held constant ($r = -.31, p < .05$), significantly predicted Discomfort scores as each predictor variable was in turn entered into the multiple regression equation. Moreover, the partial r 's between IRS and Discomfort scores, with Σ EWG scores ($r = -.31, p < .05$) and Σ EG scores ($r = -.34, p < .05$) separately held constant, indicated that IRS scores significantly predicted Discomfort scores with the effect of the core condition scores, as measured by either Σ EWG or Σ EG scores, controlled statistically.

TABLE 200. 100 OF 1000000 VARIATION WITH FIVE OUTCOME MEASURES (N = 40)

	Discomfort	Patient Statement	Therapist Statement	Target	Ineffectiveness
IRS	-.31 ^a	.06	-.04	.11	.06

Table 29. r's of 12 Predictor Variables with Five Outcome Measures (N = 40)

	Discomfort	Patient Statement	Therapist Statement	Target	Ineffectiveness
IRS	-.31 ^a	.06	-.04	.11	.06
ΣEWG	.33 ^b	.37 ^b	.04	-.36	-.21
ΣEG	.03	.27	.14	-.12	.07
E	.05	.33 ^b	.19	-.17	.00
G	-.04	.12	.04	-.02	.17
W	.21	-.06	-.24	-.24	-.27
IAS	.50 ^c	.19	.07	.02	.19
No. Sess.	.12	.15	.54 ^d	-.24	-.08
REL	-.25	-.39	-.70 ^d	.33 ^b	.16
DX	-.07	-.03	-.15	.02	.07
RI/NRI	.07	-.09	-.27	.33 ^b	.25
ATT/UATT	.06	-.15	-.15	.16	.05

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The relationship of Discomfort with IAS was positive while the relationship with IRS scores was negative. Consequently, the more improvement a client showed on the Discomfort outcome measure, the greater his degree of pre-therapy maladjustment on IAS and the lower his therapist's IRS score. Thus, although IRS scores significantly predicted Discomfort scores, in contradiction to the prediction made in Hypothesis II, lower rather than higher IRS scores were associated with client improvement; therefore, Hypothesis II was rejected for the Discomfort outcome measure.

See Table 30 for a summary of the significant findings reported for each outcome measure.

Patient Statement Outcome Measure. Only Relationship (REL) scores ($r = -.39$, $p < .05$), and Σ EWG scores with REL scores held constant ($r = .46$, $p < .01$), significantly predicted Patient Statement scores, indicating that the more improvement a client showed on the Patient Statement outcome measure, the less difficult his therapist rated establishing and maintaining a satisfactory therapeutic relationship and the higher his therapist's Σ EWG score. Therefore, Hypothesis II was rejected for this outcome measure.

Therapist Statement Outcome Measure. Only REL scores ($r = -.70$, $p < .01$), and DX scores with REL scores held constant ($r = -.38$, $p < .05$), made significant predictions of Therapist Statement scores, indicating that the more a client improved on the Therapist Statement outcome

Table 10. Summary of Significant Predictions of Each Outcome Measure Obtained from Step-Wise Regression Analyses

Outcome Measure	Predictor Variable	r Between Predictor & Outcome	R of Cumulative Predictors with Outcome	R ²	Increase in R ²	Variables Held
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Table 30. Summary of Significant Predictions of Each Outcome Measure Obtained from Step-Wise Regression Analyses

Outcome Measure	Predictor Variable	r Between Predictor & Outcome	R of Cumulative Predictors with Outcome	R ²	Increase in R ²	Variables Held Constant
Discomfort	IAS	.50 ^b	.50 ^b	.2487	.2487	None
	IRS	-.31 ^a	.57 ^b	.3218	.0731	IAS
Patient Statement	REL	-.39 ^a	.39 ^a	.1547	.1547	None
	ΣEWG	.46 ^b	.58 ^b	.3354	.1807	REL
Therapist Statement	REL	-.70 ^b	.70 ^b	.4898	.4898	None
	DX	-.38 ^a	.75 ^b	.5620	.0722	REL
Target	ΣEWG	-.36 ^a	.36 ^a	.1268	.1268	None
	No. Sess.	-.42 ^b	.53 ^b	.2803	.1536	ΣEWG
Ineffectiveness	None					

^ap < .05

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measure, the less difficult his therapist rated establishing and maintaining a satisfactory therapeutic relationship and the lower the client's DX score. Therefore, Hypothesis II was rejected for this outcome measure.

Target Outcome Measure. Only Σ EWG scores ($r = -.36$, $p < .05$), and the Number of Therapy Sessions (No. Sess.) with Σ EWG scores held constant ($r = -.42$, $p < .01$), significantly predicted Target scores, indicating that the more improvement shown by clients on the Target outcome measure, the higher the therapist's Σ EWG score and the greater the client's number of therapy sessions. Therefore, Hypothesis II was rejected for this outcome measure.

Ineffectiveness Outcome Measure. Warmth scores had the highest zero order r ($r = .27$) with Ineffectiveness scores, but this r did not reach significance; moreover, none of the predictions of Ineffectiveness scores made by the systematic selection of each variable reached significance. Therefore, Hypothesis II was rejected for this outcome measure.

The significant findings reported for each of the outcome measures are summarized in Table 30. This table also presents the R for the significant predictor variables of each outcome measure as well as R^2 , the percent of outcome measure variance accounted for by the best single predictor and the percent accounted for by the combination of the significant predictor variables. The "Increase in R^2 " column shows the amount of outcome score variance

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accounted for by the initial or best single predictor and the amount of additional outcome variance accounted for by the addition of a second predictor to the initial predictor, i.e., the increase in the amount of predicted outcome variance resulting from the combination of predictor variables over that predicted by the initial variable alone. For example, reference to Table 30 shows that the combination of IAS and IRS scores accounted for 32.18% of the variance of the Discomfort scores, that IAS alone accounted for 24.87% of the Discomfort score variance, and that the addition of IRS scores to IAS scores accounted for an additional 7.31% of Discomfort score variance.

In summary, IRS scores were found to significantly predict only one outcome measure, Discomfort, and contrary to the prediction made in Hypothesis II, clients whose therapists had lower IRS scores rather than those whose therapists had higher IRS scores, showed greater improvement on this outcome measure. Consequently, Hypothesis II was rejected for each of the five outcome measures.

Five of the eleven predictor variables, excluding the IRS variable, made significant predictions for either one or two of the outcome measures. While the IRS variable significantly predicted only the one outcome measure, the well-established variable of the core conditions, as reflected in the Σ EWG scores, significantly predicted only two of the outcome measures, Patient Statement and Target, with higher core condition scores associated with more

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improvement on both outcome measures. The Relationship variable also significantly predicted two of the outcome measures, Patient and Therapist Statements, with greater ease in establishing and maintaining a satisfactory relationship associated with more improvement on both measures. In addition, the Initial Adjustment variable predicted the Discomfort outcome measure, with better pre-therapy adjustment associated with lesser degrees of improvement. A greater number of therapy sessions was associated with improvement on the Target measure. And contrary to expectation, while the DX variable significantly predicted one measure, Therapist Statement, lower rather than higher DX scores were associated with more improvement.

Outcome Measures as a Joint Function of IRS and Σ EG Scores

Although no hypothesis was stated regarding the effect that the core condition context in which IRS scores occurred may have on the prediction of client outcome from IRS scores, the earlier findings that high and low core therapists differed significantly on IRS scores and ratings suggested that IRS scores in differing core condition contexts may be differentially related to outcome scores. Consequently, the extent to which IRS responses simultaneously accompanied by low core conditions and IRS responses accompanied by high core conditions predicted each of the outcome measures was investigated. The 40 cases were divided into 19 high core condition cases and 21 low core

condition cases, using the mean Σ EG score of the 40 cases as the dividing score. Table 31 presents the means and standard deviations of the predictor variables and the outcome measures for the high and low Σ EG groups, and Table 32 presents the Pearson intercorrelations among the predictor variables within the high and low Σ EG groups.

Step-wise regression analyses were again used to determine the extent to which each of the predictor variables predicted each of the five outcome measures within the high and the low Σ EG groups separately. In each of these ten regression analyses one additional predictor variable, the Four Individual Therapists, which consisted of the scores on each of the 12 predictor variables obtained by each therapist and his respective set of ten clients, was included along with the previous 12 predictors. Since the high and low Σ EG groups were classified only on the basis of Σ EG scores, these groups were not balanced for Role Induction or Patient Attractiveness conditions or for the individual therapists of the clients composing each group. Consequently, by including the scores associated with each of the four therapists as a variable in predicting outcome scores in the step-wise regression analyses, it could be determined whether or not there was a significant difference in the predictions of any of the outcome measures for either the high or low Σ EG group associated with the individual therapists. The finding of a significant prediction made by the Four Therapist variable would indicate a significant

Table 31. X's and S.D.'s of Predictor Variables and Outcome Measures for the High and Low Σ EG Groups

	19 High Σ EG Cases		21 Low Σ EG Cases	
	\bar{X}	S.D.	\bar{X}	S.D.
Discomfort	6.81	17.69	7.43	16.70
Patient Statement	4.05	.97	3.18	1.34
Therapist Statement	3.42	1.12	3.00	1.10
Target	2.22	.88	2.29	1.06
Ineffectiveness	20.84	9.06	18.05	8.02
IAS	33.89	17.54	24.19	15.87
Σ EG	1.58	1.06	-1.37	1.17
Σ EWG	1.51	1.56	-.44	1.99
No. Sess.	12.37	4.41	12.90	4.17
REL	2.79	1.44	3.00	1.30
E	4.56	.30	4.03	.22
G	3.53	..16	3.21	.18
W	3.87	.36	3.93	.26
IRS	3.18	.73	2.93	.43
DX	4.95	.79	4.82	.54
4th's	2.63	1.26	2.38	1.02
RI/NRI	6.16	1.01	5.86	1.01
ATT/UATT	3.37	.50	3.43	.51

Table 32. Pearson r 's Among Predictor Variables for the High and Low ΣEG Groups

	ΣEG		ΣEWG		No. Sess.		REL		E		G	
	Hi	Lo	Hi	Lo	Hi	Lo	Hi	Lo	Hi	Lo	Hi	Lo
IAS	.48 ^b	-.07	.48 ^b	.31	-.21	.19	.19	-.37 ^a	.43 ^a	-.07	.16	-.10
ΣEG			.66 ^c	.30	-.14	.35	.16	.11	.77 ^d	.82 ^d	.53 ^b	.88 ^d
ΣEWG					-.63 ^c	-.18	.36	.08	.66 ^c	.36	.15	.08
No. Sess.							-.85 ^d	-.54 ^b	-.19	.30	.02	.28
REL									.25	.08	-.06	.15
E											-.14	.46 ^b
G												
W												
IRS												
DX												
4th's												
RI/NRI												

Table 32 (cont'd.)

	W		IRS		DX		4th's		RI/NRI		ATT/UATT	
	H1	Lo	H1	Lo	H1	Lo	H1	Lo	H1	Lo	H1	Lo
IAS	.18	.20	-.05	-.33	-.33	.33	-.09	-.20	.23	-.09	.37	-.01
ΣEG	-.02	.26	.20	-.29	-.44 ^a	-.21	.18	-.50 ^b	.13	-.24	.34	-.01
ΣEWG	.74 ^d	.50 ^b	-.09	.01	-.35	-.07	-.22	-.10	.20	-.25	.12	.12
No. Sess.	-.73 ^d	-.12	.25	-.54 ^b	.23	-.03	.44 ^a	-.17	-.18	-.36	-.27	-.22
REL	.35	.14	-.12	.51 ^b	-.20	-.10	-.35	-.11	.18	.38 ^a	.43 ^a	.23
E	.20	.23	.32	-.13	-.42 ^a	-.07	.17	-.32	-.08	-.38 ^a	.23	-.09
G	-.28	.20	-.12	-.31	-.13	-.28	.03	-.50 ^b	.32	-.01	.21	.03
W			-.28	-.16	-.04	-.15	-.44 ^a	-.47 ^b	.12	.03	-.14	.01
IRS					-.09	.23	.52 ^b	.12	.02	.17	-.21	-.10
DX							-.45 ^a	-.30	-.36	.33	-.33	.01
4th's									.18	-.23	-.04	.06
RI/NRI											-.01	.03

^a p < .10^c p < .01^b p < .05^d p < .001

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amount of confounding in that particular group for that particular outcome measure, not only of the individual therapists but possibly also of the Role Induction and Patient Attractiveness conditions since both these conditions had been initially balanced across the four therapists; however, in the instances in which a significant confounding of the four therapists occurred, the effect of the Four Therapist variable on the remaining variables would then be held constant within that group, thus statistically eliminating the effect of this confounding.

Pearson zero order r 's between each of the 13 predictor variables and each of the outcome measure scores within the high and low Σ EG groups are shown in Table 33.

Results of the step-wise regression analyses indicated that within the high core group IRS scores did not significantly predict any of the five outcome measures (Discomfort, $r = -.26$; Patient Statement, $r = .19$; Therapist Statement, $r = .01$; Target, $r = -.05$; Ineffectiveness, $r = .05$); moreover, within the high core group only one outcome measure, Therapist Statement, was significantly predicted by any of the predictor variables. However, within the low core condition group IRS scores significantly predicted three of the five outcome measures: Discomfort, Target, and Therapist Statement. Within the low core group on the Discomfort outcome measure, IRS scores had a significant zero order r with Discomfort scores ($r = -.47$, $p < .05$), and with the variance of the two best predictors of

Table 33. Zero Order r 's Between Each Predictor Variable and Each Outcome Measure Within the High and Low Σ EG Groups

	Discomfort		Patient Statement		Therapist Statement		Target		Ineffective-ness	
	Hi	Lo	Hi	Lo	Hi	Lo	Hi	Lo	Hi	Lo
IRS	-.23	-.47 ^b	.24	-.31	.26	-.62 ^c	-.06	.37 ^a	-.07	.20
Σ EWG	.14	.58 ^c	-.13	.43 ^b	-.22	.05	.10	-.66 ^c	-.17	-.49 ^b
Σ EG	.03	.11	-.20	.08	.02	-.05	.21	-.39 ^a	-.05	-.16
E	.08	.11	-.13	.34	-.02	.19	.14	-.57 ^c	-.09	-.31
G	-.06	-.01	-.13	-.22	.03	-.27	.16	-.08	.06	.08
W	.15	.29	.03	-.07	-.30	-.14	-.09	-.42 ^a	-.20	-.34
IAS	.42 ^a	.64 ^c	-.17	.29	-.18	.22	.35	-.23	.30	-.03
No. Sess.	.04	.21	.24	.15	.59 ^c	.55 ^c	-.21	-.27	.09	-.25
REL	-.13	-.39 ^a	-.39	-.41 ^a	-.70 ^d	-.70 ^d	.37	.31	.08	.28
DX	-.18	.09	-.10	-.05	-.18	-.18	-.16	.21	.03	.10
RI/NRI	.24	-.08	.16	-.35	-.16	-.45 ^b	.16	.48 ^b	.15	.30
ATT/UATT	.09	.03	-.27	-.05	-.30	.00	.26	.10	.04	.08
4th's	.02	-.18	.43 ^a	.38 ^a	-.59 ^c	.31	-.16	.03	-.32	-.13

^a $p < .10$; ^b $p < .05$; ^c $p < .01$; ^d $p < .001$.



Discomfort scores held constant, IAS and Σ EWG scores, IRS scores also then had a significant partial r with Discomfort scores ($r = -.50$, $p < .05$). Thus, although a previous finding indicated that IRS scores significantly predicted Discomfort scores within the entire sample of 40 cases, these results of the analyses of the high and low Σ EG groups indicated that the relationship between IRS and Discomfort scores was much stronger in the low Σ EG group than in the high Σ EG group. Within the low core group on the Target outcome measure, IRS scores had a zero order r with Target scores of $.37$ ($p < .10$), and with the effect of the best predictor of Target scores held constant, Σ EWG scores, the IRS scores was the only other variable that significantly predicted Target scores ($r = .48$, $p < .05$). Within the low core group on the Therapist Statement outcome measure, IRS scores had a significant zero order r with Therapist Statement scores ($r = -.62$, $p < .01$), and with the effect of the best overall predictor held constant, Relationship scores, IRS scores then had a partial r of $-.42$ ($p < .10$) with Therapist Statement scores. The significant findings of each predictor variable for each outcome measure obtained on the step-wise regression analyses of the high and low core groups are summarized in Table 34.

Thus, IRS scores made a significant prediction of outcome scores for three of the five outcome measures for the low Σ EG group; moreover, these predictions were also significant when the effect of the core conditions, measured

Table 34. Summary of Significant Predictions of Each Outcome Measure Obtained from Step-Wise Regression Analyses of the High and Low Σ EG Groups

	Predictor Variable	r Between Predictor and Outcome Measure	R of Cumulative Predictors with Outcome Scores	R ²	Increase in R ²	Variables Held Constant
<u>Discomfort</u>						
Low Σ EG Group	IAS	.64 ^c	.64 ^c	.4041	.4041	None
	Σ EWG	.53 ^b	.75 ^c	.5691	.1650	IAS
	IRS	-.50 ^b	.82 ^c	.6774	.1084	IAS, Σ EWG
<u>Patient Statement</u>						
Low Σ EG	REL	-.49 ^b	.61 ^b	.3779	.1966	Σ EWG
	4th's	.48 ^b	.72 ^c	.5183	.1404	Σ EWG, REL
	E	.51 ^b	.80 ^c	.6460	.1276	Σ EWG, REL, 4th's
<u>Therapist Statement</u>						
High Σ EG Group	REL	-.70 ^c	.70 ^c	.4908	.4908	None
	4th's	.51 ^c	.79 ^c	.6244	.1336	REL
Low Σ EG Group	REL	-.70 ^c	.70 ^c	.4902	.4902	None
	IRS	-.42 ^a	.76 ^c	.5817	.0915	REL
	G	-.53 ^b	.84 ^c	.6974	.1157	REL, IRS
	E	.66 ^c	.91 ^c	.8287	.1313	REL, IRS, G
	DX	-.56 ^b	.94 ^c	.8816	.0530	REL, IRS, G, E
	W	-.54 ^b	.96 ^c	.9160	.0344	REL, IRS, G, E, DX
	Σ EG	-.64 ^b	.99 ^c	.9757	.0169	REL, IRS, G, E, DX, PA, No. Sess, RI/NRI, Σ EWG

Table 34 (cont'd.)

Predictor Variable	r Between Predictor and Outcome Measure	R of Cumulative Predictors with Outcome Scores	R ²	Increase in R ²	Variables Held Constant
<u>Target</u>					
Low Σ EG					
Σ EWG	-.66 ^c	.66 ^c	.4355	.4355	None
IRS	.48 ^b	.75 ^c	.5625	.1270	Σ EWG
<u>Ineffectiveness</u>					
Low Σ EG					
Group	-.49 ^b	.49 ^c	.2388	.2388	None

^a p < .10^b p < .05^c p < .01

by both Σ EWG and Σ EG scores, was controlled statistically. On the Discomfort measure, significant partial r 's between IRS and Discomfort scores were obtained with Σ EWG scores ($r = -.57$, $p < .01$) and with Σ EG scores ($r = -.46$, $p < .05$) separately held constant. On the Therapist Statement outcome measure, significant partial r 's between IRS and Therapist Statement scores were obtained with Σ EWG scores ($r = -.62$, $p < .01$) and with Σ EG scores ($r = -.65$, $p < .01$) separately held constant. On the Target outcome measure, a significant partial r between IRS and Target scores was obtained with Σ EWG scores ($r = .48$, $p < .05$) held constant but not with Σ EG scores held constant ($r = .29$). However, this failure of IRS scores to significantly predict Target scores with Σ EG scores held constant represented a small and nonsignificant decrease of 5.25% ($F = 2.31$) (Baggaley, 1964) in the Target score variance predicted by IRS scores; consequently, the IRS prediction made with Σ EG scores held constant did not differ significantly from that made with the effect of Σ EG scores included. Thus, the significant predictions of the three outcome measures for the low core group made by IRS scores were not attributable to the relationship of IRS scores with core condition scores.

These findings indicated that knowledge of the core condition context of IRS scores when that context was high, i.e., an average Σ EG Z score of 1.58 or raw score of 8.08, was of little or no use in predicting any of the outcome measures, whereas knowledge of the core condition context

of IRS scores when that context was low, i.e., an average Σ EG Z score of -1.37 or raw score of 7.24, was useful in significantly predicting three of the five outcome measures. The relationship between IRS and Σ EG scores within the high core group was positive ($r = .20$) while the relationship within the low core group was negative ($r = -.29$). Since within the low core group higher, rather than lower, IRS scores were associated with both less client improvement and lower therapist Σ EG scores, this suggested that greater client improvement was associated with lower IRS responses in a lower core condition context.

A more precise description of the relationship between the IRS scores in their Σ EG score context and the three outcome measures for which IRS scores made significant predictions was obtained by investigation of client outcome scores as a joint function of their therapist's IRS and Σ EG scores. The IRS scores and the Σ EG scores of the 34 cases for which all of the outcome data was available were each divided into equal thirds, i.e., into high, moderate, and low levels of both IRS and Σ EG scores, and the Discomfort, Target, and Therapist Statement outcome scores of each client were classified as a joint function of his therapist's high, moderate, or low level on both IRS and Σ EG scores. Table 35 shows the means and standard deviations of the IRS, Σ EG, and outcome scores for these groups of clients. The Σ EG scores in Table 35 were transformed into

Table 35. \bar{X} 's and S.D.'s of IRS, Σ EG, and Outcome Scores for 34 Cases Classified According to High, Moderate, or Low Levels of IRS and Σ EG Scores

	High Σ EG		Moderate Σ EG		Low Σ EG		Total	
	\bar{X}	S.D.	\bar{X}	S.D.	\bar{X}	S.D.	\bar{X}	S.D.
High IRS								
N ^a = 5								
Discomfort	1.40	22.15	.33	3.51	- 3.67	9.61	- .27	15.20
Target	2.30	.50	2.00	1.00	3.83	.30	2.64	.96
Ineffective	22.20	5.37	15.67	10.40	24.00	7.81	20.91	7.57
Th. St.	4.00	.71	3.33	1.53	2.33	.58	3.36	1.12
Pt. St.	4.00	1.00	3.33	1.16	2.33	.58	3.36	1.12
Σ EG	8.28	.28	7.77	.20	7.11	.24	7.82	.56
IRS	3.53	.17	3.43	.50	3.39	.24	3.47	.24
Moderate IRS								
N = 6								
Discomfort	28.50	26.16	5.00	9.43	6.75	15.39	9.50	15.71
Target	2.65	.49	1.75	.96	2.00	1.41	1.98	1.05
Ineffective	20.00	5.66	15.33	9.03	15.75	11.32	16.25	8.83
Th. St.	3.50	.71	3.33	1.21	3.25	.96	3.33	1.44
Pt. St.	4.50	.71	4.00	1.26	3.75	1.50	4.00	1.20
Σ EG	8.10	.01	7.99	.51	7.22	.28	7.75	.55
IRS	3.04	.10	2.98	.08	2.93	.26	2.97	.08
Low IRS								
N = 4								
Discomfort	28.50	26.16	5.00	9.43	6.75	15.39	9.50	15.71
Target	2.65	.49	1.75	.96	2.00	1.41	1.98	1.05
Ineffective	20.00	5.66	15.33	9.03	15.75	11.32	16.25	8.83
Th. St.	3.50	.71	3.33	1.21	3.25	.96	3.33	1.44
Pt. St.	4.50	.71	4.00	1.26	3.75	1.50	4.00	1.20
Σ EG	8.10	.01	7.99	.51	7.22	.28	7.75	.55
IRS	3.04	.10	2.98	.08	2.93	.26	2.97	.08

Table 35 (cont'd.)

	High Σ EG		Moderate Σ EG		Low Σ EG		Total	
	\bar{X}	S.D.	\bar{X}	S.D.	\bar{X}	S.D.	\bar{X}	S.D.
Low IRS								
	N = 3		N = 4		N = 4		N = 11	
Discomfort	6.67	13.64	16.25	30.05	10.50	25.87	11.55	22.92
Target	1.93	1.21	2.08	1.35	2.48	1.33	2.18	1.20
Ineffective	19.33	11.02	26.00	13.49	23.25	28.41	23.18	12.92
Th. St.	3.67	.58	2.75	1.71	3.50	.57	3.27	1.10
Pt. St.	4.00	1.00	3.25	2.06	3.00	1.82	3.36	1.63
Σ EG	8.13	.17	7.68	.14	6.86	.26	7.50	.57
IRS	2.46	.32	2.25	.44	2.68	.05	2.46	.35
Total								
	N = 10		N = 13		N = 11		N = 34	
Discomfort	8.40	21.52	7.38	17.50	5.27	18.06	7.00	18.40
Target	2.26	.73	1.91	1.01	2.67	1.32	2.26	1.08
Ineffective	19.00	8.97	18.69	11.09	20.73	12.12	20.00	10.13
Th. St.	3.80	.63	3.15	1.35	3.09	.83	3.32	1.03
Pt. St.	3.73	1.49	3.62	1.45	3.09	1.45	3.59	1.34
Σ EG	8.20	.22	7.84	.37	7.06	.28	7.69	.56
IRS	3.11	.53	2.86	.56	2.96	.32	2.97	.48

^aN = number of clients

raw scores so that the levels of Σ EG may be more readily interpreted.

Since the outcome scores of each client were classified solely on the basis of the joint levels of his therapist's IRS and Σ EG scores, the resulting groups of clients were only partially balanced for the Patient Attractiveness and Role Induction conditions. Consequently, before attempting to evaluate differences in outcome scores as a function of the joint levels of IRS and Σ EG scores, it was necessary to determine whether the Role Induction or Patient Attractiveness conditions significantly altered or affected the relationship between either IRS scores or Σ EG scores and each of the outcome measure scores. Therefore, R's were computed between each of the outcome measure scores and Role Induction conditions and IRS scores. F tests were used to assess whether the correlation of outcome scores with the combination of IRS and Role Induction scores (and the combination of IRS and Patient Attractiveness scores) differed significantly from the correlation of outcome scores with IRS or Role Induction scores alone (and with IRS or Patient Attractiveness scores alone). This same procedure was also carried out with Σ EG scores. For example, IRS and Discomfort scores had an r of $-.31$, while Role Induction and Discomfort scores had an r of $.07$; the R of $.33$ between IRS, Role Induction, and Discomfort scores reflected a nonsignificant increase of 1.28% ($F = .42$) in the amount of Discomfort score variance accounted for by the

three sets of scores over that accounted for by the IRS scores alone. Thus, the correlation of IRS and Discomfort scores was not significantly affected by the Role Induction/No Role Induction condition.

The results indicated that the r 's between IRS and outcome scores were not significantly altered by either the Role Induction conditions or by the Patient Attractiveness conditions, respectively, for any of the outcome measures: Discomfort ($F = .42$; $F = .42$), Therapist Statement ($F = 0.00$; $F = 0.00$), Patient Statement ($F = .07$; $F = .38$), Target ($F = 0.00$; $F = .78$), and Ineffectiveness ($F = .40$; $F = .19$). Similarly, the r 's between Σ EG and outcome scores were not significantly altered by the Role Induction conditions or by the Patient Attractiveness conditions, respectively, on any of the outcome measures: Discomfort ($F = .04$; $F = .05$), Therapist Statement ($F = .96$; $F = .77$), Patient Statement ($F = .40$; $F = 1.23$), Target ($F = .85$; $F = .39$), and Ineffectiveness ($F = .40$; $F = .19$). Since neither the relationship of IRS scores with each outcome measure nor the relationship of Σ EG scores with each outcome measure was significantly altered by either the Role Induction or Patient Attractiveness conditions, analyses of the outcome scores as a joint function of the levels of IRS and Σ EG scores were carried out even though the cells were not completely balanced for these two conditions.

Table 35, based on the 34 cases, reveals a similar pattern of client improvement for each of the three outcome

measures: the least amount of improvement, or actual deterioration in the instance of the Discomfort measure, occurred within the group of clients that received high levels of IRS scores in the context of low levels of Σ EG scores. Within the context of low Σ EG scores, high IRS scores were associated with less improvement than moderate and low IRS scores on all three outcome measures, and this trend reached at least the .10 level of significance on two of the outcome measures: the group of clients whose therapists had high IRS scores in a context of low Σ EG scores had a higher mean Target score ($t = 2.04$, $p < .10$), representing less improvement, and a lower mean Therapist Statement score ($t = 2.27$, $p < .05$) than the group of clients whose therapists had moderate or low IRS scores in the context of low Σ EG scores. In contrast, the groups of clients who received high, moderate, or low levels of IRS scores in contexts of either high or moderate Σ EG contexts did not differ significantly on improvement on any of the outcome measures.

It can be seen from Table 35 that high level IRS scores were associated with differing degrees of client improvement depending upon the high, moderate, or low level of the accompanying Σ EG scores, and to a lesser extent, that the amount of improvement associated with moderate IRS scores was also affected by the Σ EG context, whereas low level IRS scores were relatively unaffected by the Σ EG context. Differences in outcome scores between the high, moderate, and low Σ EG score contexts of high IRS scores were

significant for both the Target and Therapist Statement outcome measures: the mean Therapist Statement score was significantly higher for the group of clients whose therapists had high levels of IRS scores in the context of high Σ EG scores than for the clients that had high IRS scores in the context of low Σ EG scores ($t = 3.43$, $p < .02$). Mean Target scores were significantly higher, representing less improvement, for the group of clients whose therapists had high IRS scores in the context of low Σ EG scores than for the group which had high IRS scores in the contexts of either high ($t = 4.78$, $p < .01$) or moderate ($t = 3.05$, $p < .05$) Σ EG scores. Moderate levels of IRS scores in the contexts of high and moderate Σ EG scores tended to be associated with differential amounts of improvement on both the Target and Discomfort outcome measures: for moderate levels of IRS scores, the context of moderate Σ EG scores was associated with greater improvement on the Target measure ($t = 1.94$, $p < .10$) but with less improvement on the Discomfort outcome measure ($t = 2.09$, $p < .10$) than the context of high Σ EG scores.

In addition to the three outcome measures for which IRS scores made significant predictions within the low core group, means and standard deviations of the Ineffectiveness and Patient Statement outcome scores of clients classified according to their therapist's levels of IRS and Σ EG scores are also shown in Table 35 for comparative purposes, although no significant predictions were obtained from IRS

scores for either of these two outcome measures. Reference to Table 35 indicates that the pattern of Patient Statement scores was similar to that of the Target and Therapist Statement scores, but the only significant difference in improvement on this measure between the different Σ EG contexts of IRS scores consisted of significantly greater improvement for the group of clients who received high IRS scores in a high Σ EG context rather than in a low Σ EG context ($t = 2.61$, $p < .05$). On the Ineffectiveness measure one quite interesting trend occurred which differed from that of the other four outcome measures. The group of clients that received high and moderate IRS scores in a moderate Σ EG context was judged after termination of therapy as being the most effective in interpersonal relationships, while the group that received low IRS scores in a moderate Σ EG context was judged as being the least effective; however, the difference between the clients who had therapists with high and moderate IRS scores and those who had therapists with low IRS scores in the moderate Σ EG context was only suggestive since the obtained t of 1.72 reached only the .11 level of significance. Since the Ineffectiveness measure was the only outcome measure which specifically attempted to assess the quality of the client's interpersonal relationships, this finding very tentatively suggested that dealing with the therapeutic relationship in a manner reflected by the higher stages of the IRS scale may be related to the client's effectiveness in his

significant relationships after therapy. Subsequent research, however, is needed to assess the possibility that the existence of such a trend simply reflects a differential pretherapy predisposition for the most effective and least effective groups of clients to explore the therapeutic relationship.

DISCUSSION

The present research has demonstrated the IRS scale to be a reliable instrument capable of making significant and meaningful discriminations among therapists. Moreover, each of the individual stages of the scale, with the exception of stage 5, proved to be useful in discriminating among therapists on at least one of the following variables: core conditions, orientation, experience, DX, patient status. Discriminations on the greatest number of variables occurred at stages 3 and 6, while the fewest occurred at stage 1. In addition to significant differences obtained in the proportion of IRS responses at individual stages, trends consistent with the predictions frequently occurred. For example, at stage 2 the percent of IRS ratings obtained by the core quartile groups was 22.9, 30.0, 35.7, and 51.4, respectively: only the difference between the first and fourth quartiles reached significance, but the progressive increase through the four quartiles was consistent with Hypothesis I.

Since the IRS scale was used for the first time in the present research, detailed description and analyses of differences in IRS ratings at each stage for the high and low IRS therapists and IRS quartiles in each study are

presented in Appendix O. Systematic differentiations among therapists in the IRS quartiles were made at each stage, with the exceptions of stage 5 in both studies and stage 1 in Study II. The discriminations at each stage formed a consistent pattern in which successively higher stages of the scale differentiated between therapists with successively higher IRS scores. Although this pattern was more pronounced in Study I where there was a greater variability and a greater number of IRS ratings, it was also clearly evident in Study II. Thus, for example in Study I, stage 6 differentiated the 14 therapists with the highest IRS scores from the remaining therapists, while in direct contrast, stage 1 differentiated the 14 therapists with the lowest IRS scores from the remaining therapists.

The failure of stage 1 to differentiate among different levels of IRS scores in Study II appears to be a result of the very few responses, 3.85%, which occurred at this stage. No discriminations were made at stage 5 in either study, and only six of the entire ratings made in both studies occurred at this stage. Either the discriminations required in making a rating at stage 5 were too difficult or the therapists simply did not make stage 5 responses. Since this stage was not useful in either study, it appears that stage 5 should be eliminated from the scale in subsequent research.

All hypotheses in Study I were confirmed with the exception of Hypothesis IVB, which predicted differences

among Orientations. However, all three findings used to evaluate Hypothesis IVB were in the predicted direction, with one finding reaching the .05 level of significance and the remaining two reaching the .10 level for two-tailed tests. Thus, for the total sample of therapists in Study I IRS scores were: 1) positively related to both core condition scores and DX scores; 2) did not differentiate between inpatient and outpatient therapists or between high and low experience level therapists within any of the four orientations, 3) ordered therapists according to Orientation from higher to lower as Relationship, Eclectic, Client-Centered, and Analytic, respectively; and 4) differentiated Relationship therapists from Analytic therapists and tended also to differentiate them from Eclectic and Client-Centered therapists.

Since the statistical tests used to evaluate differences in IRS ratings yielded findings which were approximations, only the results of statistical tests used to evaluate differences in IRS scores were used in testing the hypotheses. However, a great deal of information that was not available from the IRS scores was provided by the IRS ratings, and this additional information was considered to justify their conservative and cautious interpretation. In addition to eliminating the regression toward the mean which occurred for the IRS scores, the IRS ratings were valuable in determining the more precise nature of the differences between therapists who were found to differ on IRS scores by

indicating the distribution of responses among all the stages and the particular stages at which therapists differed.

For example, although therapists of in- and out-patients were not differentiated by IRS scores, IRS ratings revealed that therapists who saw outpatients gave more stage 3 responses, constituting almost half of all their responses, than inpatient therapists. Moreover, the distribution of IRS ratings indicated that unlike the high IRS therapists who did not respond differentially with in- and out-patients, the low IRS therapists, who almost never focused on the relationship and gave only 2% of their IRS responses at the combined stages 4, 5, and 6, avoided references made to themselves by inpatients to a greater extent than those made by outpatients.

Hypothesis I in each study, which predicted a positive relationship between IRS and core condition scores within the total sample of therapists, was confirmed in Study I but rejected in Study II. However, classification of therapists according to relatively high and low functioning on the core conditions revealed dramatically different relationships between IRS and core scores within these groups in both studies and clarified the failure to find a relationship in Study II. The significant positive relationship between IRS and empathy for the high core therapists and the significant negative relationship between IRS and genuineness for the low core therapists was obscured or

masked when these two homogeneous groups were combined in the total sample. Moreover, IRS scores as well as the combined ratings at stages 4, 5, and 6 were also significantly higher for the high functioning than for the low functioning therapists. Consequently, although hypothesis I was rejected in Study II, a definite pattern of relationship was nevertheless clearly demonstrated in which the two high functioning therapists, who on the average were relatively more empathic and genuine, focused on the relationship to a greater extent in those interactions with clients in which they were more empathic; in contrast, the two low functioning therapists focused on the relationship more with those clients with whom they were less genuine.

Similarly, classification of therapists into relatively high and low functioning therapists revealed striking differences in Study I. High functioning therapists focused on the relationship significantly more often and avoided client's direct and indirect references to themselves significantly less often than the low functioning therapists. Moreover, the more empathic, warm and genuine the high functioning therapists were, the greater the extent to which they focused on the relationship, but within the low functioning group of therapists there was no correspondence between their empathy, warmth, and genuineness and the extent to which they focused on or avoided the relationship.

Thus, in both studies the high functioning therapists related client statements to themselves to a



significantly greater extent and avoided client references to a lesser extent than the low functioning therapists. However, these differences, particularly the extent to which client references were avoided, were greater in Study I than in Study II and reflected the fact that both high and low functioning therapists in Study II gave approximately half as many responses at stages 1 and 2 combined but gave roughly twice as many at stage 3 than those in Study I. In both studies slightly more than a fourth of the responses of the high functioning therapists related client statements to themselves, while fewer than 10% of the responses of the low functioning therapists related client statements to themselves.

Moreover, therapists in Study II consistently offered higher and less variable levels of the core conditions than those in Study I, but this differential functioning on the core conditions was more pronounced for the low functioning than for the high functioning therapists. Thus, the difference in therapist-offered conditions between the high and low functioning therapists was considerably greater in Study I than in Study II. In Study I the high functioning therapists frequently communicated understanding of the client's surface feelings, although they failed to understand most of his deeper feelings, and related to the client in an ingenuine or "professional" manner only infrequently, while the low functioning therapists communicated no understanding of the client's deeper feelings and frequently

failed to understand even his surface feelings, and most of the time related to the client in a rigid, nonspontaneous, professional manner. In Study II, in contrast, although the high functioning therapists offered statistically significantly higher levels of empathy and genuineness than the low functioning therapists, the actual difference between the levels of therapeutic functioning of the two groups of therapists was so small as to be relatively inconsequential in a practical sense. The two high functioning therapists responded accurately to almost all of the client's more surface feelings as well as to many of his less evident feelings and only rarely related to the client in a professional or phony manner. The two low functioning therapists offered only slightly lower levels of empathy and genuineness to their clients, with differences consisting of less than half a stage on the 9-stage Empathy scale and less than a quarter of a stage on the 5-stage Genuineness scale. Thus, the fact that the levels of empathy and genuineness offered by the relatively high and low functioning therapists in Study II did not differ sufficiently to indicate a practical or meaningful difference appears to at least in part account for the smaller overall variability in IRS responses and the fewer differences in IRS responses obtained between the high and low functioning therapists in Study II in comparison with Study I.

Not only was the sample of therapists in Study II, which consisted of four low experience, predominantly

analytically oriented therapists each of whom saw 10 outpatients, more homogeneous with respect to their IRS responses and their functioning on the core conditions, they were also more homogeneous with respect to Orientation, Experience, and Client Status. Since only four cases in Study I exactly matched this description of the therapists in Study II, such a direct comparison of the IRS responses could not be made. However, when the distributions of IRS ratings of therapists who saw outpatients in each study were compared, the distributions were much more similar, with the differences between the two studies at stages 2 and 3 each reduced to approximately only 13%.

The two studies also differed with respect to the scales and raters used to measure E, W, G, and DX. In Study II the original scales devised by Truax were each rated by four different undergraduate college students who were relatively naive regarding psychotherapy theory and processes, and moderate reliabilities were obtained on each of the scales. In Study I the Truax E, W, and G scales revised and condensed by Carkhuff and his associates were rated by two experienced post-doctoral therapists, and the DX scale was rated by two research technicians, and very high reliabilities were obtained on each of the scales.

These differences may at least partially account for some of the differences obtained between the two studies. For example, the high interrelationships among E, W, and G in Study I and the lack of relationship between W

and both E and G in Study II may be a reflection of one or more of several relevant factors. The ratings on the three scales in Study II may have been more independent than those in Study I as a result of different sets of raters being used to rate each scale. In addition, the scales used in Study I, which had been revised specifically in order to make them more clear, concise, and reliable, were rated by experienced, psychologically sophisticated raters, and higher reliabilities were obtained. However, from listening to the tapes, it appeared that the lack of relationship in Study II between therapists' warmth and their empathy and genuineness was an accurate reflection of the psychotherapy of these therapists: the Analytically oriented psychiatric residents who composed the sample in Study II tended to give a considerable amount of direct advice to clients, and much of this advice-giving, perhaps consistent with the therapists' medical training and orientation, appeared at times to constitute an imposition upon the client and thus to communicate a low level of nonpossessive warmth toward the client.

The IRS responses of therapists who differed in Orientation were relatively consistent with the prediction that therapists who prefer a more intimate relationship would relate client references to themselves and focus on the relationship to a greater extent than therapists who prefer a more personal, distant relationship. Although the Relationship therapists tended to focus on the relationship

to a greater extent than the Eclectic and Client-Centered therapists, they differed dramatically from the Analytic therapists. The Relationship therapists related client statements to themselves in half of their responses, ignored almost no client statements directly related to themselves, and failure to respond to indirect and opaque references to themselves each accounted for approximately a fourth of their responses. In contrast, in spite of the fact that the cornerstone of an Analytic orientation consists of the working through with the client of his transference feelings (Wolman, 1967), Analytic therapists never directly related client statements to themselves or attempted to explore the client's feelings about themselves. They actually ignored direct statements about themselves in 20% of their responses, and in a majority of their responses, 65%, responded literally to the manifest content seemingly unrelated to themselves or the therapy situation. These findings thus indicate that the Relationship therapists actually behaved in therapy in a manner consistent with the tenets of their orientation, that is, they focused to a considerable extent in therapy on the client-therapist relationship. The findings regarding the Analytic therapists, however, seem to be consistent with a more passive approach to therapy in which the therapist is relatively uninvolved personally, quite content oriented, and regardless of the theoretically deleterious effect on the client,

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does not encourage the client to explore his feelings about the therapist.

Although the high and low experience level therapists did not differ on IRS scores, the high experience therapists gave more responses at stage 3 and fewer at stage 6 than the low experience therapists. This difference at stage 3, however, was primarily due to the Analytic therapists. Approximately 75% of the responses of the high experience Analytic therapists consisted of responses to the manifest content of client statements apparently unrelated to the therapist in contrast to 30% of such responses for the low experience Analytic therapists. The difference at stage 6, however, was primarily accounted for by the Relationship therapists. The high experience Relationship therapists focused directly on the relationship less often and, at the same time, more frequently ignored indirect client references to the therapist than did the low experience Relationship therapists. These differences between the high and low experience therapists of the Relationship and Analytic orientations may reflect the tendency for therapists who are still in training to experiment more within the limits of their theoretical orientations and, conversely, for therapists with considerable post-graduate therapeutic experience to become more cautious and conservative in their responses over time.

The findings regarding client depth of self-exploration were quite different in Studies I and II. The

clients in Study I explored themselves more deeply as their therapists focused to a greater extent on the relationship. More specifically, deeper levels of self-exploration were achieved by clients of those therapists who relatively more frequently interpreted client references to themselves and, at the same time, relatively less frequently ignored their client's indirect references. However, clients' depth of self-exploration in Study II was unrelated to the extent to which their therapists focused on the relationship. Thus, while Hypothesis III of Study I was confirmed, the findings were not replicated in Study II.

Although somewhat different scales were used to measure client self-exploration in the two studies, this does not appear to account for the dissimilar relationships between IRS and DX scores obtained in the two studies. The revised DX scale used in Study I is simply a condensed version of the Truax DX scale used in Study II. Moreover, contradictory to the great majority of the evidence cited by Truax and Carkhuff (1967), in the Johns Hopkins study Truax et al. (1966) found that clients' level of self-exploration was unrelated to their therapists' level of empathy, genuineness, or warmth and, more surprisingly, was unrelated to any of the measures of the clients' degree of improvement at the time of termination.³

Clearly, the findings regarding client DX generated in Study II are atypical and run counter not only to the

³Personal communication

findings in Study I but to the bulk of the research reported by Truax and his associates (Truax & Carkhuff, 1967) and Berenson (1967).

Hypothesis II of Study II which predicted greater degrees of improvement for clients whose therapists functioned at higher levels on the IRS, independent of the therapist's functioning on the core conditions, was rejected for each of the five outcome measures. However, additional, more precise analyses were suggested by the findings in both studies which indicated that therapists functioning at relatively higher and lower levels on the core conditions responded very differently to client references to themselves and differed greatly in the extent to which they focused on the relationship. These findings were thus consistent with previous research (Truax & Mitchell, 1970) which has indicated that failure to take into account the therapeutic level of functioning on the core conditions constitutes a critical instance of adherence to the fallacious Therapist Uniformity Myth (Kiesler, 1966) and frequently results in misleading findings and conclusions. In other words, analyses of the relationship between IRS and client outcome, without taking into account the fact that the clients in Study II received different levels of the core conditions, resulted in masking the differential relationship of IRS with client outcome. These additional analyses, which took into account the fact that therapists functioning at relatively high and low levels on the core

conditions cannot be assumed to constitute a homogeneous group with respect to a variety of process and outcome variables (Truax & Mitchell, 1970), in turn provided further evidence that uniformity or homogeneity of therapists who differ with respect to the core conditions is indeed a myth.

The results of these additional analyses were consistent with differential conceptualizations of the general nature of the IRS and core condition variables. The core conditions may best be regarded as reflecting rather broad and relatively permanent personal characteristics or attributes of the therapist which are not specific to the therapeutic situation or the therapist-client relationship. Indeed, ample evidence has been cited indicating that high levels of the core condition characteristics facilitate growth in areas other than psychotherapy, e.g., teacher-student relations and parent-child relations. In fact, it is quite likely that the core conditions lent themselves readily to early measurement precisely because they reflect broad, easily discerned, and generally effective personal characteristics of helpful persons who are effective in a number of disparate situations. In contrast, the IRS variable may be regarded as reflecting a particular class of therapist behavior that is more specific to the psychotherapy situation but which is not uniformly effective in psychotherapy. That is, a particular therapist response to client references to the therapist, e.g., a therapist response which explicitly relates the client reference to

himself or a therapist response which ignores the reference, is not necessarily more effective than another. A particular IRS response can have very different consequences in the hands of different therapists, in this case a therapist who is empathic and genuine with a client in comparison to a therapist who is unempathic and ingenuine with a client. Thus, the effectiveness of a therapist's IRS responses is dependent upon the accompanying level of his empathy and genuineness and, consequently, should be evaluated in conjunction with or in the context of his level of functioning on the core conditions.

The major implications of the present research regarding the effectiveness of IRS responses of predominantly Analytically oriented, psychiatric resident therapists in relatively short-term therapy with outpatients can be briefly summarized as follows. The extent to which a therapist focuses on the relationship in the context of the therapist's deep understanding and genuine responses to the client is relatively unrelated to client improvement. However, the extent to which a therapist focuses on the relationship is related to client lack of improvement and even deterioration when the context is that of minimal understanding and a lack of spontaneity and genuineness. Furthermore, the more unempathic and ingenuine the therapeutic context, the more harmful the therapist's attempts to focus on the relationship become in relation to the client, i.e., the less improvement or even deterioration

the client shows. More precisely, responses which relate a client's statement to the immediate therapeutic relationship when made by an unempathic, ingenuine therapist are adversely related to the client's subsequent improvement; moreover, for such an unempathic, ingenuine therapist either ignoring the client's references to the therapeutic situation or simply responding literally to the client's manifest content may be more appropriate since these therapist responses are associated with approximately average levels of client improvement. For relatively highly empathic, genuine therapists whether the therapist relates the client's statements to the immediate relationship or simply responds to the literal content and ignores references to himself has little relationship to the client's subsequent level of improvement: Unlike the low core condition therapist, attempts by an understanding and genuine therapist to relate client statements to himself are not associated with client unimprovement or deterioration.

The major significance of the IRS variable in relation to therapeutic effectiveness thus lies in the lack of client improvement associated with an unempathic and ingenuine therapist's attempts to relate client statements to himself or to focus on the immediate therapeutic relationship. The particular way in which an empathic, genuine therapist responds to client references to himself, e.g., whether he avoids or directly approaches and interprets such references, is relatively unrelated to the client's

improvement. And more surprisingly, consistently ignoring or avoiding a client's references to the therapist is relatively inconsequential to his improvement, regardless of whether the therapist who avoids these references is relatively highly empathic and genuine or unempathic and ingenuine with the client.

Thus, the most important and far-reaching implication of the present research is that the manner in which a therapist responds to his client's references to himself bears relatively little relation to client improvement except in those destructive instances in which a therapist who fails to accurately understand most of the client's feelings and responds to the client in an ingenuine, professionally stereotyped, defensive manner attempts to interpret these references in relation to himself and their immediate relationship. Such instances are destructive in that they are related to client failure to improve or even deterioration. It is not simply that frequent and direct interpretation of client statements in relation to the therapist in and of itself is destructive to the client. The critical element is that these interpretations are made by an unempathic, ingenuine therapist, and the destructiveness is associated with the inaccurate interpretation of the client's statements and feelings in question and the ingenuine, phony manner in which the therapist offers the interpretation.

In speculation of what may actually occur in psychotherapy with an unempathic, ingenuine therapist that could perhaps account for this destructiveness, two factors seem plausible. A therapist's relatively frequent and consistently inaccurate interpretations of the client's statements in relation to himself may be experienced to some degree by the client as attempts by the therapist to impose his own distorted perceptions and reality, and even worse, an unwarranted closeness, on the client, somewhat analogously to the experience of schizophrenics described by Powdermaker (1952), Searles (1965), and Stierlin (1959). Moreover, when a client is encouraged to focus on and to freely and spontaneously express his innermost feelings about the therapist by a therapist who, at the same time, hides his own feelings from the client behind a professionally stereotyped, defensive facade, the client may very likely experience a double-bind situation somewhat analogous to that proposed by Bateson, Jackson and Weakland (1956). Such a therapist, while seeming to encourage client exploration of feelings about the therapist may in fact be subverting such exploration as well as a close, open therapeutic relationship. Thus, in these respects the destructiveness of this type of therapist behavior appears to resemble that frequently found in mothers of schizophrenics. In any event, it seems likely that clients of such therapists would at least feel confused and somewhat distrustful of the therapist's motives and ability to be helpful: these or similar feelings of client

dissatisfaction may have been reflected in the fact that the more these unempathic, ingenuine therapists focused on the relationship, the earlier the client terminated therapy.

Subsequent outcome research is called for which employs a larger sample of therapists who are more heterogeneous with respect to level of functioning on the core conditions, orientation and experience. One of the limitations of the present research is that the relationship between IRS responses and client outcome was based on the therapy of four relatively inexperienced therapists. Inasmuch as the four therapists each saw 10 clients, the specific relationships between therapist IRS responses and diverse measures of client outcome would appear to be reliable. Nevertheless, confirmation of the findings should be attempted with a larger sample of therapists. In addition, the investigation of such complex variables as therapists' level of functioning on the core conditions and their IRS responses and client outcome requires a sample of therapists large and heterogeneous enough to permit detailed study of first and second order interaction effects.

SUMMARY

The present research was an investigation of the frequency and explicitness with which therapists interpret client statements in relation to themselves or the immediate therapeutic relationship and thereby focus on the client-therapist relationship. All client statements are assumed to be related to the therapist to some extent or with varying degrees of directness or overtness. The Immediate Relationship Scale (IRS) was constructed to measure the explicitness with which therapists respond to client references to the therapist of varying degrees of overtness. In view of the consensus among therapists regarding the critical role in psychotherapy of the client's feelings about the therapist and the importance attached to the therapist's encouragement of client expression and explorations of such feelings, a positive relationship between therapists' IRS scores and client improvement was hypothesized. In addition, therapists' IRS scores were hypothesized to be related to their functioning on the core conditions, Orientation but not level of experience, and their clients' depth of self-exploration but not to client status as inpatient or outpatient.

Two separate studies using tape recordings of actual psychotherapy sessions were conducted. The data for Study I, a process study, was based on tape recordings of first therapy sessions of 56 different therapist-client dyads, which included both inpatient and outpatient clients and therapists heterogeneous with respect to setting, discipline, orientation, experience level, and sex. Ratings on the IRS and the E, W, G, and DX scales by Carkhuff and his associates were obtained on five 3-minute segments excerpted from each of the 56 tapes.

The results of Study I indicated that for the total sample of therapists, IRS scores were 1) positively related to the therapists' core condition scores and clients' DX scores, 2) ordered therapists according to Orientation from higher to lower as Relationship, Eclectic, Client-Centered, and Analytic, respectively, 3) differentiated Relationship therapists from Analytic therapists and tended to also differentiate Relationship therapists from Eclectic and Client-Centered therapists and 4) did not differentiate between inpatient and outpatient therapists or between high and low experience level therapists within any of the four orientations. All hypotheses in Study I were confirmed with the exception of the hypothesis predicting the Relationship therapists to be differentiated from each of the other orientation groups of therapists.

The data in Study II, an outcome study, was based on tape recorded psychotherapy sessions of 40 outpatients seen

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by four psychiatric residents at Johns Hopkins University. Ratings on the IRS and the E, W, and G scales by Truax were obtained on six 3-minute segments excerpted from the recordings of each client's sessions: one segment was excerpted from the middle and another from the last third portions of the first, tenth, and fifth from final sessions. Five measures of client outcome were used: global improvement ratings by clients and therapists, Discomfort, Target, and Social Ineffectiveness.

The results indicated that although for the total sample of therapists IRS scores and core condition scores were unrelated, thus rejecting the hypothesis predicting a positive relationship, IRS scores were positively related to the core condition scores for the high functioning therapists but negatively related for the low functioning therapists. Moreover, the high functioning therapists also functioned at higher levels on the IRS than the low functioning therapists. These findings, in addition to the finding that high and low functioning therapists in Study I also responded differentially on the IRS, were interpreted as providing further evidence that therapist uniformity is indeed a myth with respect to high and low functioning therapists and that failure to take into account therapists' level of functioning on the core conditions can result in misleading and even erroneous conclusions.

The importance of the therapeutic level of functioning received further emphasis from the analyses relating IRS

scores to client outcome measures. The hypothesis predicting a positive relationship between the degree of clients' improvement and therapists' IRS scores for the entire sample was rejected for each of the five outcome measures; indeed, step-wise regression analyses indicated that higher IRS scores were actually predictive of lesser degrees of client improvement on one outcome measure, Discomfort. However, additional analyses, which took into account the core condition context of IRS scores, indicated that higher IRS scores in a context of relatively low levels of therapist offered empathy and genuineness were related to lesser degrees of client improvement on three of the outcome measures: Discomfort, Therapist Statement, and Target. In contrast, IRS scores in a context of relatively high levels of therapist offered empathy and genuineness were unrelated to client improvement on any of the outcome measures. These findings were interpreted as indicating that in the context of a therapist's deep understanding and genuine responses to the client the particular way in which a therapist responds to client statements or references to himself, e.g., whether he ignores or explicitly interprets such references, is relatively inconsequential to the client's improvement. But when a therapist interprets client statements in relation to himself and thus attempts to focus on the relationship in the context of the therapist's failure to respond genuinely and to accurately understand the client's feelings, the client fails to improve or even

deteriorates. Thus, the effectiveness of a therapist's IRS responses is dependent upon the accompanying level of his empathy and genuineness and, consequently, should be evaluated in conjunction with or in the context of his level of functioning on the core conditions.

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APPENDICES

APPENDIX A

IMMEDIATE RELATIONSHIP SCALE

Stage 1

The client clearly and explicitly talks about or makes a direct, overt reference to the therapist or the therapeutic situation, but the therapist completely ignores the explicit statements related to himself or the therapeutic situation by remaining silent or by responding as if the client had said nothing or had referred to some person or situation other than the therapist or the therapeutic situation. The therapist responds as if he had not heard that part of the client's statements regarding himself (the therapist).

Examples:

Cl: I had to wait for you a long time today. I guess the secretary forgot to tell you that I was here. . .

T: Silence, or Mmmmm, or Where shall we begin today? At the end of the last session I believe we were talking about your brother. . .

Cl: I just can't seem to ask a girl for a date. I get all nervous and scared. What do you do in that case? Did you ever have that trouble?

T: Sounds like you're afraid she might turn you down.

Stage 2

Implicit in the client's statements is an indirect reference to the therapist or the therapeutic situation. Regardless of the client's specific statements, and in addition to the overt message, the statements contain an indirect or covert reference to the therapist and reflect some of the client's feelings or attitudes about the therapist or the therapeutic situation. The therapist ignores the indirect reference to himself or the therapeutic situation and makes no attempt to relate the statements to himself. Also rated at this stage is a therapist's response which fails to relate to himself or the therapeutic situation a client's clear and overt statements about physicians, psychologists, social workers or other helping personnel, other than the therapist himself. The following are examples of topics likely to occur at this stage: authority figures such as doctors, bosses, teachers, ministers, and nosy people, people who just sit there and don't say or do anything, people who feel or act superior to others, people who evaluate and judge others, people who won't let others be dependent/independent, demanding people, people who are too objective and professional, seductive people, people who don't understand others, and people who can read others' minds.

Examples:

Cl: I've been to three doctors so far and no one has told me what's wrong with me.

T: What do you think is wrong with yourself?

Cl: I just can't stand people who are always so nosy, always asking questions. . . always trying to mind other people's business. I used to have a friend that always wanted to know all about my business but he'd never tell me anything about himself. He always wanted to know what I thought or felt about something. . . .

T: It sounds like you really were angry with your friend.

Stage 3

The client's statements contain no clearly discernible reference to the therapist or the therapeutic situation, and the therapist makes no attempt whatsoever to relate the client's statements to himself, the therapeutic situation, or to a class of persons, relationships, or situations in which the therapist could be included, e.g., doctors, helping personnel. In other words, in the absence of discernible client references to the therapist, the therapist responds to the client's statements quite specifically and literally and does not encourage the client to generalize his statements toward the therapeutic relationship.

Examples:

Cl: Well, I've always had problems with guys over me like my boss at the office.

T: He really gets to you. . . . is that it?

Cl: My brother always seemed to get his own way.

T: You must have resented that. . . How about your sister? Did she get her own way, too?

Stage 4

The client's statements contain either indirect or indiscernible references, but not overt references, to the therapist or the therapeutic situation, and the therapist's response indicates or suggests that the client's statements could be related, applied, or generalized to unspecified persons or situations other than those named by the client. The therapist's response is open-ended in that it does not refer to a specific person or situation but is structured in such a way that the client could rather readily relate or apply the statement to the therapist or the therapeutic situation.

Examples:

T: Does that remind you of anyone else besides your boss?

T: Who else does that sound like to you?

T: Are there any other situations in which you feel that way, or in which something similar happens?

T: Why do you bring that up at this particular time? What made you think of that right now?

Stage 5

The client's statements contain direct, indirect, or indiscernible references to the therapist or the therapeutic situation, and the therapist tentatively, indirectly, or cautiously attempts to relate the client's statements to himself or the therapeutic situation. The therapist's response is more direct than his response at stage 4, but less direct than his response at stage 6.

Examples:

Cl: I've always found that most doctors kind of think they're up on a pedestal all the time.

T: Do you include therapists in that observation?

Cl: Well that's just it . . . you go to class for three or four months before you find out how you're doing. She never got the grades out on time. You never knew how you stood with her, how she thought you were doing.

T: I wonder . . . Sometimes . . . maybe not all the time but at times maybe you feel a little frustrated about . . . or maybe . . . possibly . . . a little worried about . . . how things are going in here.

Stage 6

The client's statements contain direct, indirect, or indiscernible references to the therapist or the therapeutic situation, and the therapist clearly, directly, and explicitly relates the client's statements to himself or to what is going on between them, i.e., to their immediate relationship.

Examples:

Cl: Christ! I'll be glad to get out of this hospital.

T: And away from me, too!

Cl: It's always been like that . . . first my mother . . . then . . . I don't know . . . I never got . . .

T: Sure, even me, even me. You feel like I'm not really helping you either. Right?

Summary of Stages

- Stage 1. Therapist ignores client's direct statements about therapist.
- Stage 2. Therapist ignores client's indirect references to therapist.
- Stage 3. Therapist responds literally to client's statements, which contain no discernible references to therapist.
- Stage 4. Therapist's open-ended response sets stage for client to relate to the therapist his statements, which contain indirect or indiscernible references.
- Stage 5. Therapist tentatively and/or indirectly relates to himself the client's statements, which contain direct, indirect, or indiscernible references.
- Stage 6. Therapist directly and explicitly relates to himself client's statements, which contain direct, indirect, or indiscernible references.

APPENDIX B

EMPATHIC UNDERSTANDING IN INTERPERSONAL PROCESSES

A Scale for Measurement¹

Bernard G. Berenson, Robert R. Carkhuff, J. Alfred Southworth

Level 1

The first person appears completely unaware or ignorant of even the most conspicuous surface feelings of the other person(s).

Example: The first person may be bored or disinterested or simply operating from a preconceived frame of reference which totally excludes that of the other person(s).

In summary, the first person does everything but listen, understand or be sensitive to even the surface feelings of the other person(s).

Level 2

The first person responds to the surface feelings of the other person(s) only infrequently. The first person continues to ignore the deeper feelings of the other person(s).

Example: The first person may respond to some surface feelings but tends to assume feelings which are not there. He may have his own ideas of what may be going on in the other person(s) but these do not appear to correspond with those of the other person(s).

In summary, the first person tends to respond to things other than what the other person(s) appears to be expressing or indicating.

Level 3

The first person almost always responds with minimal understanding to the surface feelings of the other person(s) but, although making an effort to understand the other person's deeper feelings almost always misses their import.

Example: The first person has some understanding of the surface aspects of the messages of the other person(s) but often misinterprets the deeper feelings.

In summary, the first person is responding but not aware of who that other person really is or of what that other person is really like underneath. Level 3 constitutes the minimal level of facilitative interpersonal functioning.

Level 4

The facilitator almost always responds with understanding to the surface feelings of the other person(s) and sometimes but not often responds with empathic understanding to the deeper feelings.

Example: The facilitator makes some tentative efforts to understand the deeper feelings of the other person(s).

In summary, the facilitator is responding, however infrequently, with some degree of empathic understanding of the deeper feelings of the other person(s).

Level 5

The facilitator almost always responds with accurate empathic understanding to all of the other person's deeper feelings as well as surface feelings.

Example: The facilitator is "together" with the other person(s) or "tuned in" on the other person's wavelength. The facilitator and the other person(s) might proceed together to explore previously unexplored areas of human living and human relationships.

The facilitator is responding with full awareness of the other person(s) and a comprehensive and accurate empathic understanding of his most deep feelings.

¹The present scale "Empathic Understanding in Interpersonal Processes" has been derived in part from "A scale for the measurement of accurate empathy" by Truax which has been validated in extensive process and outcome research on counseling and psychotherapy. In addition, similar measures of similar constructs have received extensive support in the literature of counseling and therapy. The present scales were written to apply to all interpersonal processes and have already received research support.

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

APPENDIX C

RESPECT OR POSITIVE REGARD IN INTERPERSONAL PROCESSES

A Scale for Measurement¹

Robert R. Carkhuff, Alfred J. Southworth, Bernard G. Berenson

Level 1

The first person is communicating clear negative regard for the second person.

Example: The first person may be actively offering advice or telling the second person what would be "best" for him.

In summary, in many ways the first person acts in such a way as to make himself the focus of evaluation and sees himself as responsible for the second person.

Level 2

The first person responds to the second person in such a way as to communicate little positive regard.

Example: The first person responds mechanically or passively or ignores the feelings of the second person.

In summary, in many ways the first person displays a lack of concern or interest for the second person.

Level 3

The first person communicates a positive caring for the second person but there is a conditionality to the caring.

Example: The first person communicates that certain kinds of actions on the part of the second person will reward or hurt the first person.

In summary, the first person communicates that what the second person does or does not do matters to the first person. Level 3 constitutes the minimal level of facilitative interpersonal functioning.

Level 4

The facilitator clearly communicates a very deep interest and concern for the welfare of the second person.

Example: The facilitator enables the second person to feel free to be himself and to be valued as an individual except on occasion in areas of deep personal concern to the facilitator.

In summary, the facilitator sees himself as responsible to the second person.

Level 5

The facilitator communicates a very deep respect for the second person's worth as a person and his rights as a free individual.

Example: The facilitator cares very deeply for the human potentials of the second person.

In summary, the facilitator is committed to the value of the other person as a human being.

¹The present scale, "Respect or Positive Regard in Interpersonal Processes," has been derived in part from "A tentative scale for the measurement of unconditional positive regard" by Truax which has been validated in extensive process and outcome research on counseling and psychotherapy. In addition, similar measures of similar constructs have received extensive support in the literature of counseling and therapy and education. The present scales were written to apply to all interpersonal processes and have already received research support.

The present scale represents a systematic attempt to reduce the ambiguity and increase the reliability of the scale. In the process many important delineations and additions have been made. For comparative purposes, the levels of the present scale are approximately equal to the stages of the earlier scale, although the systematic emphasis upon the positive regard rather than upon unconditionality represents a pronounced divergence of emphasis.

APPENDIX D

FACILITATIVE GENUINENESS IN INTERPERSONAL PROCESSES

A Scale for Measurement¹

Robert H. Carkhuff

Level 1

The first person's verbalizations are clearly unrelated to what he is feeling at the moment, or his only genuine responses are negative in regard to the second person(s) and appear to have a totally destructive effect upon the second person.

Example: The first person may be defensive in his interaction with the second person(s) and this defensiveness may be demonstrated in the content of his words or his voice quality and where he is defensive he does not employ his reaction as a basis for potentially valuable inquiry into the relationship.

In summary, there is evidence of a considerable discrepancy between the first person's inner experiencing and his current verbalizations or where there is no discrepancy the first person's reactions are employed solely in a destructive fashion.

Level 2

The first person's verbalizations are slightly unrelated to what he is feeling at the moment or when his

responses are genuine they are negative in regard to the second person and the first person does not appear to know how to employ his negative reactions constructively as a basis for inquiry into the relationship.

Example: The first person may respond to the second person(s) in a "professional" manner that has a rehearsed quality or a quality concerning the way a helper "should" respond in that situation.

In summary, the first person is usually responding according to his prescribed "role" rather than expressing what he personally feels or means, and when he is genuine his responses are negative and he is unable to employ them as a basis for further inquiry.

Level 3

The first person provides no "negative" cues between what he says and what he feels, but he provides no positive cues to indicate a really genuine response to the second person(s).

Example: The first person may listen and follow the second person(s) but commits nothing of himself.

In summary, the first person appears to make appropriate responses which do not seem insincere but which do not reflect any real involvement either. Level 3 constitutes the minimal level of facilitative interpersonal functioning.

Level 4

The facilitator presents some positive cases indicating a genuine response (whether positive or negative) in a non-destructive manner to the second person(s).



Example: The facilitator's expressions are congruent with his feelings although he may be somewhat hesitant about expressing them fully.

In summary, the facilitator responds with many of his own feelings and there is no doubt as to whether he really means what he says and he is able to employ his responses, whatever their emotional content, as a basis for further inquiry into the relationship.

Level 5

The facilitator is freely and deeply himself in a non-exploitative relationship with the second person(s).

Example: The facilitator is completely spontaneous in his interaction and open to experiences of all types, both pleasant and fearful, and in the event of hurtful responses, the facilitator's comments are employed constructively to open further areas of inquiry for both the facilitator and the second person.

In summary, the facilitator is clearly being himself and yet employing his own genuine responses constructively.

¹The present scale, "Facilitative Genuineness in Interpersonal Processes" has been derived in part from "A tentative scale for the measurement of therapist genuineness or self-congruence" by Truax which has been validated in extensive process and outcome research on counseling and psychotherapy and education. The present scale represents a systematic attempt to reduce the ambiguity and increase the reliability of the scale. In the process, many important delineations and additions have been made. For comparative purposes, the levels of the present scale are approximately equal to the stages of the earlier scale, although the systematic emphasis upon the constructive employment of negative reactions represents a pronounced divergence of emphasis.

APPENDIX E

SELF-EXPLORATION IN INTERPERSONAL PROCESSES

A Scale for Measurement¹

Robert R. Carkhuff

Level 1

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

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

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

Level 2

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

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

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

Level 3

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

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

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

Level 4

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

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

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

Level 5

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

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

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

¹The present scale "Self-exploration in interpersonal processes" has been derived in part from "The measurement of depth of intrapersonal exploration" by Truax which has been validated in extensive process and outcome research on counseling and psychotherapy. In addition, similar measures of similar constructs have received extensive support in the literature of counseling and therapy.

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

APPENDIX F

A TENTATIVE SCALE FOR THE MEASUREMENT OF ACCURATE EMPATHY

Charles B. Truax

Stage 1

Therapist seems completely unaware of even the most conspicuous of the client's feelings; his responses are not appropriate to the mood and content of the client's statements. There is no determinable quality of empathy, and hence no accuracy whatsoever. The therapist may be bored and disinterested or actively offering advice, but he is not communicating an awareness of the client's current feelings.

Stage 2

Therapist shows an almost negligible degree of accuracy in his responses, and that only toward the client's most obvious feelings. Any emotions which are not clearly defined he tends to ignore altogether. He may be correctly sensitive to obvious feelings and yet misunderstand much of what the client is really trying to say. By his response he may block off or may misdirect the patient. Stage 2 is distinguishable from Stage 3 in that the therapist ignores feelings rather than displaying an inability to understand them.

Stage 3

Therapist often responds accurately to client's more exposed feelings. He also displays concern for the deeper, more hidden feelings, which he seems to sense must be present, though he does not understand their nature or sense their meaning to the patient.

Stage 4

Therapist usually responds accurately to the client's more obvious feelings and occasionally recognizes some that are less apparent. In the process of this tentative probing, however, he may misinterpret some present feelings and anticipate some which are not current. Sensitivity and awareness do exist in the therapist, but he is not entirely "with" the patient in the current situation or experience. The desire and effort to understand are both present, but his accuracy is low. This stage is distinguishable from Stage 3 in that the therapist does occasionally recognize less apparent feelings. He also may seem to have a theory about the patient and may even know how or why the patient feels a particular way, but he is definitely not "with" the patient. In short, the therapist may be diagnostically accurate, but not emphatically accurate in his sensitivity to the patient's current feelings.

Stage 5

Therapist accurately responds to all of the client's more readily discernible feelings. He also shows awareness

of many less evident feelings and experiences, but he tends to be somewhat inaccurate in his understanding of these. However, when he does not understand completely, this lack of complete understanding is communicated without an anticipatory or jarring note. His misunderstandings are not disruptive by their tentative nature. Sometimes in Stage 5 the therapist simply communicates his awareness of the problem of understanding another person's inner world. This stage is the midpoint of the continuum of accurate empathy.

Stage 6

Therapist recognizes most of the client's present feelings, including those which are not readily apparent. Although he understands their content, he sometimes tends to misjudge the intensity of these veiled feelings, so that his responses are not always accurately suited to the exact mood of the client. The therapist does deal directly with feelings the patient is currently experiencing although he may misjudge the intensity of those less apparent. Although sensing the feelings, he often is unable to communicate meaning to them. In contrast to Stage 7, the therapist's statements contain an almost static quality in the sense that he handles those feelings that the patient offers but does not bring new elements to life. He is "with" the client but doesn't encourage exploration. His manner of communicating his understanding is such that he makes of it a finished thing.

Stage 7

Therapist responds accurately to most of the client's present feelings and shows awareness of the precise intensity of most of the underlying emotions. However, his responses move only slightly beyond the client's own awareness, so that feelings may be present which neither the client nor therapist recognizes. The therapist initiates moves toward more emotionally laden material, and may communicate simply that he and the patient are moving towards more emotionally significant material. Stage 7 is distinguishable from Stage 6 in that often the therapist's response is a kind of precise pointing of the finger toward emotionally significant material.

Stage 8

Therapist accurately interprets all the client's present, acknowledged feelings. He also uncovers the most deeply shrouded of the client's feelings, voicing meanings in the client's experience of which the client is scarcely aware. Since the therapist must necessarily utilize a method of trial and error in the new uncharted areas, there are minor flaws in the accuracy of his understanding, but these inaccuracies are held tentatively. With sensitivity and accuracy he moves into feelings and experiences that the client has only hinted at. The therapist offers specific explanations or additions to the patient's understanding so that underlying emotions are both pointed out and

specifically talked about. The content that comes to life may be new but it is not alien.

Although the therapist in Stage 8 makes mistakes, these mistakes are not jarring, because they are covered by the tentative character of the response. Also, this therapist is sensitive to his mistakes and quickly changes his response in midstream, indicating that he has recognized what is being talked about and what the patient is seeking in his own explorations. The therapist reflects a togetherness with the patient in tentative trial and error exploration. His voice tone reflects the seriousness and depth of his empathic grasp.

Stage 9

The therapist in this stage unerringly responds to the client's full range of feelings in their exact intensity. Without hesitation, he recognizes each emotional nuance and communicates an understanding of every deepest feeling. He is completely attuned to the client's shifting emotional content; he senses each of the client's feelings and reflects them in his words and voice. With sensitive accuracy, he expands the client's hints into a full-scale (though tentative) elaboration of feeling or experience. He shows precision both in understanding and in communication of this understanding, and expresses and experiences them without hesitancy.

APPENDIX G

A TENTATIVE SCALE FOR THE MEASUREMENT OF NONPOSSESSIVE WARMTH

Charles B. Truax

Stage 1

The therapist is actively offering advice or giving clear negative regard. He may be telling the patient what would be "best for him," or in other ways actively approving or disapproving of his behavior. The therapist's actions make himself the locus of evaluation; he sees himself as responsible for the patient.

Stage 2

The therapist responds mechanically to the client, indicating little positive regard and hence little nonpossessive warmth. He may ignore the patient or his feelings or display a lack of concern or interest. The therapist ignores client at times when a nonpossessively warm response would be expected; he shows a complete passivity that communicates almost unconditional lack of regard.

Stage 3

The therapist indicates a positive caring for the patient or client, but it is a semipossessive caring in the

sense that he communicates to the client that his behavior matters to him. That is, the therapist communicates such things as "It is not all right if you act immorally." "I want you to get along at work," or "It's important to me that you get along with the ward staff." The therapist sees himself as responsible for the client.

Stage 4

The therapist clearly communicates a very deep interest and concern for the welfare of the patient, showing a nonevaluative and unconditional warmth in almost all areas of his functioning. Although there remains some conditionality in the more personal and private areas, the patient is given freedom to be himself and to be liked as himself. There is little evaluation of thoughts and behaviors. In deeply personal areas, however, the therapist may be conditional and communicate the idea that the client may act in any way he wishes--except that it is important to the therapist that he be more mature or not regress in therapy or accept and like the therapist. In all other areas, however, nonpossessive warmth is communicated. The therapist sees himself as responsible to the client.

Stage 5

At stage 5, the therapist communicates warmth without restriction. There is a deep respect for the patient's worth as a person and his rights as a free individual. At this level the patient is free to be himself

even if this means that he is regressing, being defensive, or even disliking or rejecting the therapist himself. At this stage the therapist cares deeply for the patient as a person, but it does not matter to him how the patient chooses to behave. He genuinely cares for and deeply prizes the patient for his human potentials, apart from evaluations of his behavior or his thoughts. He is willing to share equally the patient's joys and aspirations or depressions and failures. The only channeling by the therapist may be the demand that the patient communicate personally relevant material.

APPENDIX H

A TENTATIVE SCALE FOR THE MEASUREMENT OF THERAPIST GENUINENESS OR SELF-CONGRUENCE

Charles B. Truax

Stage 1

The therapist is clearly defensive in the interaction, and there is explicit evidence of a very considerable discrepancy between what he says and what he experiences. There may be striking contradictions in the therapist's statements, the content of his verbalization may contradict the voice qualities or nonverbal cues (i.e., the upset therapist stating in a strained voice that he is "not bothered at all" by the patient's anger).

Stage 2

The therapist responds appropriately but in a professional rather than a personal manner, giving the impression that his responses are said because they sound good from a distance but do not express what he really feels or means. There is a somewhat contrived or rehearsed quality or air of professionalism present.

Stage 3

The therapist is implicitly either defensive or professional, although there is no explicit evidence.

Stage 4

There is neither implicit nor explicit evidence of defensiveness or the presence of a facade. The therapist shows no self-incongruence.

Stage 5

The therapist is freely and deeply himself in the relationship. He is open to experiences and feelings of all types--both pleasant and hurtful--without traces of defensiveness or retreat into professionalism. Although there may be contradictory feelings, these are accepted or recognized. The therapist is clearly being himself in all of his responses, whether they are personally meaningful or trite. At stage 5 the therapist need not express personal feelings, but whether he is giving advice, reflecting, interpreting, or sharing experiences, it is clear that he is being very much himself, so that his verbalizations match his inner experiences.

APPENDIX I

A TENTATIVE SCALE FOR THE MEASUREMENT OF DEPTH OF SELF-EXPLORATION

Charles B. Truax

Stage 0

No personnaly relevant material and no opportunity for it to be discussed. Personally relevant material refers to emotionally tinged experiences or feelings, or to feelings or experiences of significance to the self. This would include self-descriptions that are intended to reveal the self to the therapist, and communications of personal values, perceptions of one's relationships to others, one's personal role and self-worth in life, as well as communications indicating upsetness, emotional turmoil, or expressions of more specific feelings of anger, affection, etc.

Stage 1

The patient actively evades personally relevant material (by changing the subject, for instance, refusing to respond at all, etc.). Thus, personally relevant material is not discussed. The patient does not respond to personally relevant material even when the therapist speaks of it.

Stage 2

The patient does not volunteer personally relevant material but he does not actually evade responding to it when the therapist introduces it to the interpersonal situation.

Stage 3

The patient does not himself volunteer to share personally relevant material with the therapist, but he responds to personally relevant material introduced by the therapist. He may agree or disagree with the therapist's remarks and may freely make brief remarks, but he does not add significant new material.

Stage 4

Personally relevant material is discussed (volunteered in part or in whole). Such volunteer discussion is done (1) in a mechanical manner (noticeably lacking in spontaneity or as a "reporter" or "observer"); and (2) without demonstration of emotional feeling. In addition, there is simply discussion without movement by the patient toward further exploring the significance of meaning of the material or feeling in an effort to uncover related feelings or material. Both the emotional remoteness and the mechanical manner of the patient make his discussion often sound rehearsed.

Stage 5

This stage is similar to Stage 4 except that the material is discussed either with feeling indicating emotional proximity or with spontaneity, but not both. (Voice quality is the main cue.)

Stage 6

In Stage 6 the level of Stage 4 is achieved again, with the additional fact that the personally relevant material is discussed with both spontaneity and feeling. There is clear indication that the patient is speaking with feeling, and his communication is laden with emotion.

Stage 7

Tentative probing toward intrapersonal exploration. There is an inward probing to discover feelings or experiences anew. The patient is searching for discovery of new feelings which he struggles to reach and hold on to. The individual may speak with many private distinctions or with "personal" meanings to common words. He may recognize the value of this self-exploration but it must be clear that he is trying to explore himself and his world actively even though at the moment he does so perhaps fearfully and tentatively.

Stage 8

Active intrapersonal exploration. The patient is following a "connected" chain of thoughts in focusing upon

himself and actively exploring himself. He may be discovering new feelings, new aspects of himself. He is actively exploring his feelings, his values, his perceptions of others, his relationships, his fears, his turmoil, and his life-choices.

Stage 9

Stage 9 is an extension of the scale to be used in those rare moments when the patient is deeply exploring and being himself, or in those rare moments when he achieves a significant new perceptual base for his view of himself or the world. A rating at this stage is to be used at the judge's discretion.

APPENDIX J

DISCOMFORT SCALE

Listed below are 50 symptoms or problems that people sometimes have. The doctor will read each of the 50 items, one at a time, and you must decide whether you have had the complaint during the last seven days including today. For each complaint you have had, the doctor will ask how much it bothered you, that is--not at all, just a little, pretty much, or very much.

Symptoms or Complaints	No	Yes	How Much It Bothered You			
			Not at all	Just a little	Pretty much	Very much
1. Headaches						
2. Pains in the heart or chest						
3. Heart pounding or racing						
4. Trouble getting your breath						
5. Constipation						
6. Nausea or upset stomach						
7. Loose bowel movements						

Symptoms or Complaints	No	Yes	How Much It Bothered You			
			Not at all	Just a little	Pretty much	Very much
8. Twitching of the face or body						
9. Faintness or dizziness						
10. Hot or cold spells						
11. Itching or hives						
12. Frequent urination						
13. Pains in the lower part of your back						
14. Difficulty in swallowing						
15. Skin eruptions or rashes						
16. Soreness of your muscles						
17. Nervousness and shakiness under pressure						
18. Difficulty in falling asleep or staying asleep						
19. Sudden fright for no apparent reason						
20. Bad dreams						
21. Blaming yourself for things you did or failed to do						
22. Feeling generally worried or fretful						
23. Feeling blue						

Symptoms or Complaints	No	Yes	How Much It Bothered You			
			Not at all	Just a little	Pretty much	Very much
24. Being easily moved to tears						
25. A need to do things very slowly in order to be sure you were doing them right						
26. An uncontrollable need to repeat the same actions, e.g., touching, counting, hand-washing, etc.						
27. Unusual fears						
28. Objectionable thoughts or impulses which keep pushing themselves into your mind						
29. Your "feelings" being easily hurt						
30. Feeling that people were watching or talking about you						
31. Generally preferring to be alone						
32. Feeling lonely						
33. Feeling compelled to ask others what you should do						
34. People being unsympathetic with your need for help						
35. Feeling easily annoyed or irritated						

Symptoms or Complaints	No	Yes	How Much It Bothered You			
			Not at all	Just a Little	Pretty much	Very much
36. Severe temper outbursts						
37. Feeling critical of others						
38. Frequently took alcohol or medicine to make you feel better						
39. Difficulty in speaking when you were excited						
40. Feeling you were functioning below your capacities, i.e., feeling blocked or stymied in getting things done						
41. Having an impulse to commit a violent or destructive act, for example desire to set a fire, stab, beat or kill someone, mutilate an animal, etc.						
42. Feeling shy and uneasy with the opposite sex						
43. Unsatisfied with sexual partner						
44. Worried about sloppiness or carelessness						
45. Superstitions						
46. Having to check and double check what you do						
47. Sex dreams						

Symptoms or Complaints	No	Yes	How Much It Bothered You			
			Not at all	Just a little	Pretty much	Very much
48. Seeing anything on a wall that is not hanging straight						
49. Difficulty in carrying out normal sex relations						
50. Poor appetite						

APPENDIX K

TARGET SYMPTOM SCALE

Completed by Patient

TARGET OUTCOME MEASURE

Clients rated the improvement in each Target Symptom as follows:

1. Target Symptom 1

- () 1. A lot Better
- () 2. Some Better
- () 3. Slightly Better
- () 4. The Same
- () 5. Worse

2. Target Symptom 2

- () 1. A lot Better
- () 2. Some Better
- () 3. Slightly Better
- () 4. The Same
- () 5. Worse

3. Target Symptom 3

(____) 1. A lot Better

(____) 2. Some Better

(____) 3. Slightly Better

(____) 4. The Same

(____) 5. Worse

APPENDIX L

PATIENT GLOBAL IMPROVEMENT SCALE

Completed by Patient

PATIENT STATEMENT OUTCOME MEASURE

Clients rated their overall or global improvement as one of the following:

- (____) 1. Worse
- (____) 2. Same
- (____) 3. Slightly Better
- (____) 4. Some Better
- (____) 5. A Lot Better

APPENDIX M

PATIENT GLOBAL IMPROVEMENT SCALE

Completed by Therapist

THERAPIST STATEMENT OUTCOME MEASURE

Therapist rated the overall or global improvement of each client as one of the following:

- (____) 1. Worse
- (____) 2. No Change
- (____) 3. Slight Improvement
- (____) 4. Moderate Improvement
- (____) 5. Marked Improvement

APPENDIX N

SOCIAL INEFFECTIVENESS SCALE

Each of the fifteen areas of functioning are scored according to the following procedure. Ratings are made on both the intensity of the behavior (closeness of agreement with the example) and the frequency of the behavior (how typical it is of him with how many people or in how many social situations).

- 1 = Behavior pattern is slightly true for him and then it is seldom
- 2 = Behavior pattern is slightly true for him and then it is often, or
Behavior pattern is moderately true for him and then it is seldom
- 3 = Behavior pattern is slightly true for him and then it is almost always, or
Behavior pattern is moderately true and then it is seldom
- 4 = Behavior pattern is very true for him and then it is seldom, or
Behavior pattern is moderately true for him and then it is often
- 5 = Behavior pattern is very true for him and then it is often, or
Behavior pattern is moderately true for him and then it is almost always
- 6 = Behavior pattern is very true for him and almost always

The following examples of the "Ineffectiveness Scale" items are to be scored.

- Score (___) 1. Overly-independent: Takes pride in self-sufficiency and competence; makes light of his troubles (as if he should be able to handle them without help), contemptuous of help seeking. N.B. Keep in mind that men are expected culturally to be more independent than women.
- Score (___) 2. Overly-dependent: Refuses to take initiative where he can although it is expected of him. Relies on others for help with problems beyond what observer believes he really needs. N.B. 1) Do not rate patients seeking help for problems which are objectively too much for him. 2) Keep in mind that women are permitted culturally to be more dependent than men.
- Score (___) 3. Superficially-sociable: Seeks many superficial acquaintanceships. Breaks off relationships before they become intimate and/or refuses to form close relationships. N.B. Does not apply to relationships forced on patient, e.g., family or necessities of occupation.
- Score (___) 4. Withdrawn: Has less contacts with others than is culturally expected. This includes own family. N.B. Certain patients may express withdrawal from others in terms of withdrawal from activities. Mere under-activity, unless it implies withdrawal from people, should not be scored.
- Score (___) 5. Extra-punitive: Tends to disparage or blame others for his difficulties, frustrations, or failures.
- Score (___) 6. Intra-punitive: Self-critical, tends to blame, criticize and hold himself responsible for his difficulties, frustrations, and failures. Over-apologetic.
- Score (___) 7. Officious: Volunteers his services where they are neither asked nor needed; meddlesome to others in the use of their skills and capacities; may be overprotective of children or other family members.

- Score (___) 8. Irresponsible: Tends to avoid his responsibilities and obligations as an adult; fails to provide culturally expected economic support for self, children, parents, etc. Yields to desires without considering the welfare of those dependent on him; e.g., gambling. N.B. Do not score sexual activity here but under 15 below.
- Score (___) 9. Impulsive: Acts or makes decisions without considering consequences; loses interest or becomes impatient if he cannot attain goals immediately. Takes unnecessary risks.
- Score (___) 10. Over-cautious: Tends to be timorous, indecisive. Plans too much for the future at the expense of the present. Refuses to take reasonable risks. N.B. Do not score guarded or evasive here.
- Score (___) 11. Hyper-reactive: Tends to overreact emotionally; behaves in an uncontrolled manner.
- Score (___) 12. Constrained: Tends to be unable to express feelings he experiences to their referent; expression of emotion inhibited.
- Score (___) 13. Overly systematic: Tends to be overly concerned with details and orderliness; needs to recheck his acts.
- Score (___) 14. Unsystematic: Tends to be disorganized and unsystematic in daily routine, managing money, etc. N.B. Do not score irresponsible, i.e., self-indulgent here.
- Score (___) 15. Sexual Maladjustment: Tends to be sexually inadequate or fearful of heterosexual relationships. If married has impotency or frigidity problems or is very restricted sexually. If not married has difficulty or is fearful in dating. Or tends to show overconcern with sexuality and is promiscuous in hetero or homosexual relationships. May have series of sex partners or dates. Sexual adjustment is unsatisfying.

APPENDIX O

Table 36. \bar{X} 's, S.D.'s, and Ranges of IRS Scores and Percent of IRS Ratings at Each Stage for High and Low IRS Groups and IRS Quartile Groups in Studies I & II

		IRS STAGE					
		1	2	3	4	5	6
Hi	I	6.43	14.29	47.86	12.14	2.14	17.14
IRS	II	2.22	12.22	51.11	16.67	3.33	14.44
Lo	I	20.71	55.71	21.43	2.14	0.00	0.00
IRS	II	5.43	23.91	68.48	2.17	0.00	0.00
Q ₁	I	4.28	10.00	31.43	20.00	4.28	30.00
	II	2.08	8.33	41.67	18.75	6.25	22.92
Q ₂	I	8.57	18.57	64.29	4.28	0.00	4.28
	II	2.38	16.67	61.90	14.29	0.00	4.76
Q ₃	I	7.14	54.29	34.29	4.28	0.00	0.00
	II	0.00	11.90	85.71	2.38	0.00	0.00
Q ₄	I	34.29	57.14	8.57	0.00	0.00	0.00
	II	10.00	34.00	54.00	2.00	0.00	0.00
Total	I	13.57	35.00	35.64	7.14	1.07	8.60
	II	3.85	18.13	59.89	9.34	1.65	7.14
Significant Differences at Each Stage Between High and Low IRS Groups							
	I	Lo<Hi ^a	Lo<Hi	Hi<Lo	Hi<Lo ^b	-----	Hi<Lo
	II	-----	-----	-----	Hi<Lo	-----	Hi<Lo
Significant Differences at Each Stage Between IRS Quartile Groups							
	I	4<1,2,3 ^d	3,4<1,2	4<1,3,2; 2<1,3	1<2,3,4	-----	1<2,3,4
	II	-----	4<1	3<1,4	1<3,4 ^c	-----	1<3,4

Table 36 (cont'd.)

		IRS SCORES		
		\bar{X}	S.D.	Range
Hi	I	3.37	.94	2.60 - 6.00
IRS	II	3.32	.35	3.00 - 4.00
Lo	I	2.06	.39	1.00 - 2.53
IRS	II	2.79	.69	1.83 - 3.00
Q ₁	I	4.00	.98	3.00 - 6.00
	II	3.79	.60	3.25 - 4.00
Q ₂	I	2.74	.98	2.60 - 3.00
	II	3.07	.10	3.00 - 3.17
Q ₃	I	2.36	.10	2.20 - 2.53
	II	2.92	.10	2.75 - 3.00
Q ₄	I	1.76	.33	1.00 - 2.13
	II	2.43	.33	1.83 - 2.75
Total	I	2.72	.97	1.00 - 6.00
	II	3.05	.60	1.83 - 4.00

^aAll p's < .01 unless otherwise specified.

^bThree stage 5 ratings included.

^cp's between .05 and .01.

^dnumbers represents IRS quartile groups.

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