AN INVESTIGATION OF THE VARIABLE OF LIKING IN THERAPY: ITS RELATION TO THE VARIABLES OF OUTCOME, EMPATHY, AND THERAPIST EXPERIENCE

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Norman Abeles
Major professor

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By

John Andrew Mullen

AN ABSTRACT OF A THESIS

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ABSTRACT

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By John Andrew Mullen

Much of the research and thought in recent years on therapy process variables has stressed the importance of the emotional reaction of the therapist to the client. Within this realm, the condition of high liking for a client, if combined with a condition of high level of empathy, was thought to be a basic prerequisite of successful therapy. An effort was made to determine the relation of high level conditions of empathy and liking to outcome of therapy, and to experience level of therapists. The extent of the contribution of different therapeutic conditions to outcome is important in attempts to understand what factors regularly lead to change as a result of therapy. Findings on these conditions in relation to therapist experience have implications for selection and training of therapists as well as implications for the conduct of therapy.

Generally, hypotheses were that high level conditions of liking and empathy would facilitate accurate prediction of success. It was expected that level of empathy would remain consistent for a given therapist throughout the therapy. The level of liking, however, was considered to be changeable, so long as high level conditions of empathy existed in the therapeutic situation. It was hypothesized, then, that some clients experiencing a high

level of empathy would experience change in the direction of increased liking from their therapist, as therapy progressed. It was also predicted that experienced therapists will initially communicate less liking as they allow therapy to develop. Experienced therapists were also expected to be more consistent in level of empathy established, as well as to be most successful in avoiding conditions of low empathy.

Therapists used in this study included twelve Ph.D. psychologists, five second year interns, twelve first year interns, and seven practicum students at the Michigan State University Counseling Center. All therapists in the study worked with an individual client.

The level of liking was measured using the Nonpossessive Warmth Scale presented by Truax and Carkhuff (1967). Level of empathy was measured using the Accurate Empathy Scale of Truax and Carkhuff. Tapes analyzed were composite tapes from random samples of each therapy hour for each case. Tapes were scored by two advanced graduate students following a training period during which they established the ability to use the scales on a reliable basis. Outcome measure was limited to change on the clinical scales of the MMPI. Cases were sorted into categories of "successful" and "unsuccessful" on the basis of increase or decrease on a majority of the clinical scales. All data were obtained from the therapy tape library established at the Michigan State University Counseling Center.

Results revealed an inability to accurately predict change

on MMPI scores from measure of therapeutic conditions of liking and empathy. This was discussed as possibly relating to: (1) the confounding effects on the NPW scale of social liking and general expression of nurturant needs, as well as an insensitivity of the scale to react to subtle differences which seem to characterize such a variable; and (2) the effect of a relatively homogeneous sample of therapists in this study who are generally nurturant, warm, empathic people. The possibility that the effect of high levels of the conditions did lead to change which the MMPI was not sensitive to was considered. This seemed to be especially possible, in view of the finding that the clients in this study could be classified into a disturbed and a normal group, rather than two equally disturbed groups. It was considered that the disturbed group had more potential for changes such as symptom alleviation, which the MMPI is more sensitive to.

Findings regarding the relationship of empathy to experience were in keeping with expectations. This was discussed as relating to the ability of experienced therapists to attain higher levels of empathy, and to avoid therapeutic conditions of extremely low levels of empathy. This has implications for training in empathy, and supports other work indicating that empathy can be trained. The effect of greater empathic ability of experienced therapists on their greater skill in becoming aware of "likeableness" in a client was discussed.

It was generally concluded that the therapeutic conditions of high levels of liking and empathy are necessary to establish

potential for change as a result of therapy. Low level conditions do not permit the development of trust in a therapeutic relationship that will be necessary for exploration of intensive conflict.

Post-hoc analysis of data was undertaken to further understanding of the results in this study and examine possibilities for future work. The post-hoc analysis supported previous conclusions of the importance of empathy. Low level conditions of empathy for all stages of therapy was clearly related to lack of client change. Empathy alone did have a statistically significant relationship to ability to predict outcome. These post-hoc findings are considered to further emphasize the need for high level conditions as a prerequisite to establish the potential for change as a result of therapy.

Approved: Norman Abeles
Committee Chairman

Date: May 21 1969

Thesis Committee:

Norman Abeles, Ph.D., Chairman

Lucy R. Ferguson, Ph.D.

Bill L. Kell, Ph.D.

William J. Mueller, Ph.D.

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DEDICATION

To Nancy, who worked and waited, so I might learn,

and

to David.

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CHAPTER I

INTRODUCTION

Research in the large and complex sphere of psychotherapy has realized substantial increase in the past few years. The increase in research has received some strong support (as well as criticism) by many involved in the practice and study of psychotherapy.

Hunt (1952) stressed the need for increased research in psychotherapy. He cited the increased use of professionals in aiding those with personal problems and the resulting need to understand the process of therapy. Strupp (1959) also argued for more attention to therapy research. He made a strong statement on this:

> We are as yet grossly ignorant of the factors in the therapist or the patient-therapist interaction which lead to one kind of change in one case and to another kind of change in another case. (Strupp, 1959, p. 46)

Rogers (1963), discussing the state of therapy, emphasized the need for comprehensive programs of research and especially cited the need for clearer communication regarding therapy among clinicians and researchers. He noted that for years he had believed therapists of other persuasions were really talking about the same experience and merely using differing "lingo" to describe

them. He further said that it was with great surprise, after observing others and being observed doing therapy, that he realized that what he experienced as "important" moments of "real" therapy, others viewed as non-therapeutic, or possibly even anti-therapeutic and vice versa. What happens in those moments of "real" therapy comes out of the complex interaction between therapist and client in their relationship (Kell and Mueller, 1966).

This study will take the view which many have espoused, that with increasing clarity we see that what is "meaningful" in therapy has to do more with emotions of both client and therapist, their interaction and effects on each other and less with cognitive constructs used by a "scientist-therapist," with emphasis limited to insight and intellectual understanding. This is not to deny the importance of understanding what one does as a therapist, but rather to put that in appropriate perspective with other aspects of therapy.

Quite often inexperienced therapists may have a tendency to bring with them into therapy what Martin (1955) has described as an "ultrascientific" attitude. This attitude is associated with a consequent lack of involvement of these therapists as people. The present study is concerned with the therapist's reaction to the client as a person, who can be liked or not, and the expression of this in therapy with possible consequences for clients attaining change. It is suggested here that true liking for the client is

of primary therapeutic importance as a response of the therapist to the client. This is to be distinguished from expressing liking for the client as a "technique" or because (based on misuse of certain theories), "it is good for him." Again, Martin (1955) quotes from the May 11, 1954 issue of Reporter, to draw attention to attitudes which he views as a product of the "ultra-scientific" approach. He feels these attitudes may be especially true of the young student of therapy and maintains their effect can be devastating. Martin quotes from the Reporter:

> The truly symbolic photograph of our time is not of the mushroom but of the crying Chinese baby. You have seen this famous photograph. It dates back to the Japanese attack on China, but it reappears periodically in war-relief drives and in the camera anthologies. Very simply and dramatically the crying Chinese baby photograph shows an infant sitting amid the ruins of a railway station. Bombs are still falling, the baby is stained with dirt and blood, and its face is so contorted that you can almost hear its cry competing with the roar of the bombing plane.
>
> But the point of the picture is not what it shows before the lens, but what it shows of civilization on our side of the lens. Some photographer surmounted his primal fear to go to work through that bombing, and he held his camera steady. And long before the bombing he had learned that the news, the picture, the flash, the story was the important thing. The picture of the emotion is everything; the emotion is secondary. So he did not do as men in ages past would have done. He did not do what men in ages to come, if man survives the era that produced his technique, may do. He did not rush to pick up the baby and take it out of danger. He first took its picture.
>
> This is the triumph and tragedy of our age, and we see it everywhere. (Martin, 1955, p. 4)

Martin then emphasizes that type of thing as one of the tragedies of much of "modern" therapy. He emphasizes, "I think there are

many instances where, in the keenness to get the picture, we even forget to pick up the baby" (Martin, 1955, p. 4). Martin proposes the corrective for this situation in therapy is not to deceive oneself about being "objective" and "detached" as a therpist, but rather admit to the interpersonal involvement with a client and further study the "nature and extent" of the involvement.

Gendlin (1962) refers to a trend in therapy toward emotional affective and interpersonal experiencing and away from past emphasis on cognitive exploring, insight, and verbal analysis. Reflecting on this, Gendlin states, "Increasingly we hear it said that it does not help the individual merely to understand the intricacies of why and what is wrong, and that he does not change due to conceptual insights. Rather, the felt, immediate experienced events during therapeutic interaction, these constitute concrete events within him, and thereby he may change therapeutically" (Gendlin, 1962, p. 40). Kovacs (1965) also stresses the importance of emotional encounter if one is seeking change through therapy, and relates most of the problems of people to their conflicts (approach-avoidance) over involvement with the "other" in a relationship.

This writer would submit that this involvement would include various emotional reactions of the therapist toward the client in their relationship such as those designated as counter-transference (Menninger, 1958; Whitaker and Malone, 1953; Searles, 1959), positive regard, empathy, genuineness and liking (Rogers, 1961; Truax

et al., 1966; Chassick, 1965; Wallach and Strupp, 1960; Mills and Abeles, 1965; Abeles, 1967). This study will be primarily concerned with the variable of liking for clients as defined by Mills (1964) and more specifically with its communication during therapy by inexperienced versus experienced therapists as well as the presence (or lack) of liking for a client in relation to the outcome of therapy.

CHAPTER II

REVIEW OF THE LITERATURE

Counter-transference:

Menninger (1958) points out that while at first counter-transference was regarded as a troublesome phenomenon which had to be "corrected for," later it was recognized as an integral part of the relationship between therapist and client. In fact many analytically oriented workers came to regard it as a regularly occurring phenomenon and a prerequisite of psychotherapy. The appropriate "use" of counter-transference is proposed by Menninger in the following:

> One must be constantly alert to the existence of counter-transference: but not intimidated by it, recognizing both its pitfalls and its uses. It may alert the analyst to unverbalized themes and impulses in his patient. But although it may be useful and though it may be inevitable, let us not assume that the more of it the better. Think about it from time to time; reflect on it. In this one might well take a page out of the book of some religious orders. For counter-transference is dangerous only when it is forgotten about (Menninger, 1958, p. 90).

Whitaker and Malone (1953) discuss their efforts to both define counter-transference as they found it meaningful to what they saw happening in therapy and to determine its usefulness. These authors initially viewed it as referring completely to those "transference problems of the therapist that are specifically

related to and elicited by the transference problems of the patient" (Whitaker and Malone, 1953, p. 160). However, in regard to this, they became dissatisfied with such a definition and felt it was rather narrow and did not contribute sufficiently to understanding the therapeutic process. Later they developed a more complex definition related to "pathological" versus "mature" emotional reactions of the therapist toward the patient. They explained that ". . . the dynamics of therapy are determined primarily by the affective reactions of the therapist to the patient's transference needs. . . (and they further define their term) . . . We used the term 'mature counter-transference.' At this, some of our colleagues accused us rather humorously of using upside-down words. Nevertheless, spontaneously at least, it seemed a most appropriate term, since it referred to those feelings of the therapist which 'counter' or respond to the transference of the patient, though not in an inconsidered and infantile manner" (Whitaker and Malone, 1953, p. 160).

At least a "fair share" of these feeling reactions to patients will deal with feelings of "love" or caring for the person (patient). For example, Searles (1959) suggests that in spite of one's best intentions and/or training, one will have intense feelings of love or caring for some patients, including sexual and non-sexual feelings. Searles maintains the analytic orientation is too critical of the therapist's feelings toward the patient. He suggests that therapists have often been given

the message that they "couldn't" or "shouldn't" have certain feelings toward a patient. However, Searles also points out that many analytically oriented workers in recent years have stressed that much can be learned about the patient from the therapist's awareness of the client's impact. Furthermore, liking and caring for clients has become increasingly accepted as a "legitimate" and important part of treatment. Whitaker (1955) stresses these ideas:

> Most therapists agree that the degree of the patient's involvement in the interpersonal relationship is one measure of the effectiveness of the experience. We believe the depth of the patient's involvement is related to the depth of the involvement of the therapist as a person. Can we then postulate that the therapist's problem is: "How can I make this patient more significant to me?" Dare we say, "How can I increase my counter-transference?" (Whitaker, 1955, p. 19).

Whitaker does not consider counter-transference as intrinsically "good" or "bad." He considers it good if it leads to growth within the therapeutic relationship, and bad if it "becomes fantasy bound in a repetition compulsion which allows no interaction between the patient as a therapist and the therapist as a person" (Whitaker, 1955, p. 20). Whitaker proposes here that eventually in therapy, both client and therapist need to experience the reciprocal give and take of a constructive relationship. Finally, Whitaker seems to emphasize the importance of the therapist bringing and owning all of <u>himself</u>, including his weaknesses. He asks, "Is it possible that the patient does not really grow unless the therapist dares to push his own

growing edge?" (Whitaker, 1955, p. 211).

Therapy literature in recent years increasingly reflects the importance of the reciprocal emotional impact in the therapeutic relationship. (See Seguin, 1962; Whitaker, et al., 1961; Nacht, 1962; Kell and Mueller, 1966.) These reactions also contribute to a more meaningful understanding of the client by the therapist in a more complete way. Kell and Mueller (1966) suggest this when they view diagnosis as "an ongoing interpersonal process" (Kell and Mueller, 1966, p. 16).

Others (Whitaker et al., 1961) have also stressed the importance of the emotional reactions between therapist and client at all levels. This is considered necessary to achieve change in the client and an integrated understanding of the client by the therapist that will include rational and non-rational spheres of the client's makeup. Whitaker et al. (1961) feel that both of these aspects (i.e., rational and non-rational) need to be dealt with in therapy. Both are important parts of the client and influence the way he operates with people.

Nacht (1962) professes agreement with the views presented above. He also discusses the essence of the therapeutic relationship as beyond the verbal level, and states that the exchanges between one unconscious and the other are what really form the strongest bond in the analytic relationship. Nacht points to an important area of the emotional reactions of therapist to

client, that of the presence or absence of liking or caring for a client. He emphasizes:

> No one can cure another if he has not a genuine desire to help him; and no one can have the desire to help unless he loves, in the deepest sense of the word . . . The analyst's attitude, when it is one of unconditional kindness, becomes then, and only then, that support and strength necessary to the patient to conquer the fear which bars the way to recovery (Nacht, 1962, p. 210).

It should be pointed out here that what Nacht stresses, is that while the therapist must be able to "like," "love," or "care" for the client to help him attain change, this is not the only aspect of the relationship dealt with or experienced by both participants in therapy. For example, at a given time, client and therapist may feel angry with each other, hurt, or convey a range of feelings. However, liking is viewed as a basic ongoing part of the total therapeutic relationship.

Client centered theory:

Rogers (1954) discusses the "psychological climate" the therapist ought to create to most productively "release" the capacity of the client to reorganize himself and attain maturity. The three crucial characteristics he cites are "congruence or genuineness in the relationship; acceptance or prizing of the client; and accurate empathic understanding of the client's phenomenal world" (Rogers, in Rogers and Dymond, eds., 1954, p. 95). Rogers explains the therapist's caring for the client as occurring in a non-possessive way and "prizing" the human potentialities

of the client. This indicates the relationship is based on an underlying caring for the client by the therapist. It does not exclude the experiencing of other emotions (e.g., anger) toward the client as they occur in the relationship. While Rogers also postulates several other conditions as important to personality change (see Rogers, 1957; Rogers, 1965; Rogers, 1961), he stresses positive regard as a "caring for the client in a non-possessive way. . ." (Rogers, 1957, p. 98). This latter is the emphasis of this study. Rogers (1961) cites research of Halkides (1958) and Barret-Lennard as supportive of the ideas that unconditional positive regard (which includes "liking"), therapist genuineness, and empathy correlated with success in therapy. Again in mentioning these, Rogers refers to the importance of ". . . a high degree of regard, respect, liking for the client by the therapist" (Rogers, 1961, p. 31). Finally with regard to his extensive work in this area, Rogers concludes:

> A relationship in which the client comes to feel a strong liking and respect for the counselor is the type of relationship most associated with progress in therapy. When the counselor develops similar feelings for the client or an attitude of caring which is not possessive or demanding, then success is likely (Rogers, Rogers and Dymond, eds., 1954, p. 425).

Rogers eventually summarizes that "the process of client-centered therapy, as caught in the factual evidence of these various studies, appears to be based on a warm relationship of mutual liking and respect" (Rogers, Rogers and Dymond, eds., 1954, p. 425).

Client likability:

Liking for clients does appear to have its place in both psychoanalytic theory and client-centered theory as has been seen in its discussion under counter-transference and unconditional positive regard, respectively. Liking as defined in this study will be considered as definite feelings of caring for or "loving" of an individual client by an individual therapist specifically within that dyadic relationship. The focus will be, then, on specific feelings of liking for a particular client by a particular therapist and its expression within the context of their therapeutic relationship. The study will not attempt to measure therapists' general tendency to like "all clients" or be "friendly" toward all clients but rather focus on the impact of the variable within specific therapy relationships and the outcome of these relationships.

Within the past ten years, work dealing with client likability and the way this variable of liking for clients influences therapy has increased. The acceptance by many clinicians and researchers of not only the importance of this variable but also the validity of studying its influence in therapy (process and outcome) is expressed concisely by Jourard (1959) where he emphasizes ". . . the essential factor in the psychotherapeutic situation is a loving, honest and spontaneous relationship between the therapist and patient" (Jourard, 1959, p. 174). Jourard

expresses agreement with studies of Rogers which he felt demonstrated sufficiently that it is not the technique or theroetical orientation which leads to personal growth in clients but rather the state of the therapist's "being" when with the client. By this he means honesty or "genuineness" in a relationship which Jourard describes as a "loving" one. The importance of distinguishing between a basic underlying liking for the client as separate from a technique itself is stressed:

> This loving relationship is a far cry from the impersonal administration of reflections, interpretations, or the equivalent of pellets. The loving therapist is quite free and spontaneous in his relationship: his responses are bound only by his ethics and judgement. He may laugh, scold, become angry, give advice, in short break most of the rules laid down in psychotherapy training manuals (Jourard, 1959, p. 177).

A further finding throwing light on the variable of liking as well as certain notions that a therapist must be a certain way to be "good" or effective is that of Abeles (1967). In discussing his findings in relation to liking for clients he points out that:

> Therapists who "like" their clients tend to show significantly more anxiety and hostility on this projective test. If one speculates that a therapist's anxiety and hostility tends to interfere with therapeutic progress (a speculation which may be open to question, particularly if there is but a moderate proportion of anxiety and hostility present) then "liking" would be associated with qualities undesirable for a therapeutic relationship (Abeles, 1967, p. 20).

It is conceivable that if a therapist comes to realize that with a given client he simply does not like him (with present emphasis on that feeling of the therapist, rather than why

he can't like the client), it may hamper his ability to be invested in the client attaining changes, his ability to empathize with the client and other important aspects of the therapeutic relationship. Reporting on work with the variable of client likability, Stoler (1963) notes, "The clients whose experience of psychotherapy is less successful may be the people who are much more difficult to like and it is this behavioral characteristic of degree of likability that may be related to the less successful outcome of therapy. It is possible that the therapist may be unable to provide effective therapy to a client he cannot like and the client who has had little experience in life in being liked may be unable to perceive that the therapist really cares for him" (Stoler, 1963, p. 178). Clients who are not aware of being cared for are dealt with in the present study via expression of liking by therapists of varying experience. Stoler (1963) reports results of a study in which ten clients were rated for likableness by ten raters. This was done by the raters listening to and rating recorded segments from actual therapy interviews. These clients had previously been grouped into more successful and less successful groups. Results indicated that client likability could be reliably rated and (tentatively) success in therapy was related to the variable. Stoler, in a later work (1966), also reported that for two outcome measures (percent of time out of the hospital and general rating on a test battery) that "liked" patients in both "experimental" (previous therapy) and "control"

(no previous therapy) were predicted to have better outcome by a group of psychiatric residents.

Mills and Abeles (1965) observe that much of the literature implies that counselor needs for nurturance and affiliation has important effects on positive outcomes and prognosis of psychotherapy. In close connection to this, Grater, Kell and Morse (1961) discuss the social service oriented person operating within the field who will have a strong nurturant need. They explain, "We think of the nurturant need among counselors as a well refined, carefully circumscribed, and professional expression of the need as described by Edwards"(1957, p. 14). (Grater et al., 1961, p. 9). One of the components Edwards (1957) mentions is "to show a great deal of affection toward others" (Edwards, 1957, p. 14). It would seem then to this writer that two of the strong aspects of the nurturant need might be: (1) "showing a great deal of affection toward others"; and (2) "to have others confide in them about personal problems" (Edwards, 1957, p. 14). The latter might reflect simply that the person is a therapist while the former could be indicative of the therapist's need to "like," i.e., have affection for his client. In an effort to "pin down" the above, Mills (1964) hypothesized that the nurturant need and the need for affilitation measured for a range of therapists possibly would have a significant and positive relation to liking for clients. His results only supported this for the most inexperienced therapists in the group

he studied (i.e., all were in the hypothesized direction but only the most inexperienced attained statistical significance). In discussing these results, Mills (1964) notes that with increasing experience the therapist is able to be more selective in the meeting of his own needs (e.g., to be nurturant to someone he likes). More experienced therapists stress the primary goal of attaining change in the client, over satisfaction of their needs. This is probably because they are more aware of the expression of their needs in therapy. This study will investigate expression of therapist's reactions to the client on a liking dimension. Based on Mills (1964) findings, it assumes experienced therapists will express caring for the client most clearly when it will have its greatest impact on the client with increased chance of contributing to change.

Bergin (in Arbuckle, 1967) discusses therapist characteristics that are related to productive client self-exploration and change. He suggests that "understanding, warmth, and genuineness are essential to good therapy, and their absence leads to negative change" (Bergin, in Arbuckle, 1967, p. 190). Bergin presents evidence that the "liking" variable is not limited to client-centered theory. He refers to the different researchers' convergence on this variable:

> It is of considerable interest that much of the data supporting this view have been gathered by non-Rogerians. Many studies concern the relevance of therapist warmth and liking of his client. Strupp, Wallach, and Wogan report on extensive study of chiefly analytically oriented therapy in which patients reported

> retrospectively that their therapist's attitude of warmth toward them was a great influence in perceived outcome of treatment (Bergin, in Arbuckle, 1967, p. 190).

Bergin concludes that it is important to note that "although many studies reveal this correlation between therapists' warmth and outcome, none of them proves that warmth is a sufficient condition in and of itself for therapeutic personality change" (Bergin, in Arbuckle, 1967, p. 191).

Bergin then refers to the "powerful" combination of warmth in combination with empathy. He refers to the need for training in empathy contrasted with warmth which he does not view as "trainable." Chessick (1965) pursues the issue of empathy and its relation to what he describes as love. He maintains that empathy of the therapist for the patient will bring forth love by the patient for the therapist. The idea expressed is that in a healthy interpersonal situation experiencing prolonged sympathy will lead to feelings of love. Chessick stresses that the love of the therapist for the patient and his ability to empathize are both crucial in therapy and supportive of each other. Chessick reports that this ". . . has been effectively defined by Fromm as respect for awareness of the unique individuality of, and active concern for the life, growth, and unfolding of the beloved. It is assumed by the authors mentioned above that this is the kind of love felt by the mature psychotherapist for the patient" (Chessick, 1965, p. 213).

Differentiation of the variables of empathy and liking:

Empathy and liking can be treated as two separate variables, and will be in this study. As two separate variables, they should be able to be measured separately. Previous literature cited (e.g., Bergin, 1967) has indicated empathy can be trained. A trained therapist should be able to maintain a high degree of empathy with all clients, while the feeling of liking toward clients is more specific to each individual client-therapist relationship. The work of Truax (1963) throws additional light on the question of the operation of empathy and "liking" which he terms "nonpossessive warmth." While mentioning characteristics of therapist behavior which "cut across" several different theories, Truax cites the importance of "nonpossessive warmth" and the therapist's ability to be empathic. Truax designed a scale in 1962 to measure the degree of "non-conditional warmth" in taped interviews. He defined "unconditional positive regard" as a nonpossessive caring for the patient as a separate person with the inherent right and responsibility of self-determination. Truax (1963) suggests that "accurate empathy" and unconditional positive regard (or nonpossessive warmth) are interrelated in such a way that to reach a high level of accurate empathy there must first be a "minimally high level" of positive regard. (Truax does not define what the "minimally high level" would be.) He proposes that "to be deeply sensitive to the moment-to-moment 'being' of another person requires of us as

therapists that we first accept and to some degree unconditionally prize this other person" (Truax, 1963, p. 259). Truax presents some evidence from a study with 14 schizophrenics and 14 matched controls. Patients had been randomly assigned to therapy or control conditions and were given pre- and post-batteries of psychological tests. The batteries were examined for over-all change in psychological functioning. Therapy cases rated high on the variables of accurate empathy, unconditional positive regard, and therapist self-congruence were compared with therapy cases rated low on these conditions as well as with controls. The data indicated high conditions facilitate "constructive personality change" and very low conditions were associated with "negative personality change" (i.e., they got worse). A rather important observation of Truax's is that in many studies comparing therapy cases with no-therapy cases (controls) the authors found "no change" and thus concluded no effect of therapy. However, he indicates, it is possible that therapy involving high conditions was lumped with therapy involving low conditions. If this reasoning is correct it would be quite possible that in many studies because "high level" conditions and "low level" were not separated, positive change occurring via therapy were cancelled out arithmetically by negative ones, clouding understanding of what happened.

Truax (1966) in further study of the conditions (genuineness, empathy, and nonpossessive warmth) obtained results which were

interpreted as indicating that the levels of genuineness and accurate empathy but not nonpossessive warmth are under the immediate and direct control of the therapist. The level of nonpossessive warmth "offered" by the therapist, they feel, is established over time, but is initially influenced by the impact of the patient on the therapist and the continuing nature of the client. Findings of several researchers here, indicate that the variable of empathy is separate from the variable of liking, and can be measured as such.

Experience and therapist variables:

More experienced therapists (assuming roughly equivalent training) will be more able to avoid some of the pitfalls in exploring the problem areas of clients and helping them obtain change than less experienced therapists. Kell and Mueller (1966) present material indicating that a more experienced therapist may be able to "hold back" initial reactions to a client more, and thus let the client expand on the initial conflict he has presented. This affords the client more of a chance to react to the therapist in the way he has to important people in his past and the therapist can learn about this by remaining more vague (especially early in the therapeutic relationship). Kell and Mueller (1966) discuss the ability of clients to elicit responses from the counselor, some of which can reduce the counselor's effectiveness,,while others may be directed at getting the counselor

to be more helpful. They note this may relate to client anxiety and/or ambivalence over what he wants out of the relationship (i.e., expand the relationship and communication of conflict versus not touching threatening aspects). They give the following clarifying example applicable to the variables of liking (and counselor need to give affection) and experience of interest to this study:

> For instance, clients who present themselves as being lonely, in need of friends, and without ready source of emotional supplies are quite appealing to counselors. The feelings and eliciting behaviors associated with these problems more readily touch on the nurturant needs of counselors than do clients whose initial eliciting behaviors are more hostile, negative, or disruptive. We wish to point out, however, that emotionally appealing clients will often disappoint and hurt the naive counselor, even though the early portions of the relationship may be satisfying to both persons. Eventually the overtly "needy" client will react to his fears about the counselor's withdrawing and defending himself against the intensity of the early emotional relationship. Such an initially appealing client may even become quite distant, hostile, and destructive (Kell and Mueller, 1966, pp. 49-50).

Counselors can have a strong need that leads to inappropriate desire to nurture and give affection to clients. In these situations the counselor (especially the more inexperienced) is not always likely to be aware of this in himself and may even (unconsciously) fear the client maturing which would lead to their relationship terminating. Often a client may have unsatisfied needs for affection (i.e., liking) from earlier significant relationships. As he has grown up, expressions of these needs have become intermixed with expressions of other needs.

The client is no longer clearly differentiating among his various needs. Kell and Mueller (1966), for example, discuss female clients who sexualize many aspects of their interactions as they feel this is the only way to get any of their needs met by men.

Abeles (1962) has also presented evidence relating to therapists' ability to be aware of and respond to affect and needs in clients along a continuum of experience and training. His findings lend support to the idea he expresses that with increasing experience and training therapists become more able to be aware of their own feelings in reacting to clients as well as feelings of the clients. The therapists are then more able to use this awareness to appropriately clarify conflicts with the client through use of client-therapist interaction.

This issue of communication and timing of it in therapy is also explored by Strupp (in Bachrach, ed., 1962). Strupp notes that while non-verbal communication elements may be as important (or more) than verbal we are lacking in ways to measure non-verbal elements. He suggests that while waiting to develop measures much can still be learned by focusing on verbal aspects of therapist communications (such as are available on tapes of therapy). This will be the focus of the present study. This seems to be in keeping with what Kell and Mueller state (1966), when they point out that choice of content of verbal material presented by clients reflects the nature of the emotional interaction between client and therapist.

Strupp (1960) cites the question of experienced versus

inexperienced therapists as an important one in research with most therapy variables. He cites literature supporting the notion that experienced therapists are more alike (regardless of differing theoretical orientation) than inexperienced therapists are like experienced therapists within the same theoretical orientation (see also Fiedler, 1950). In combination with the importance of experience and the learning of skill in understanding client communications, Strupp (1960) views as basic the ability of the therapist to care for (like) the client, which he sees as giving the therapist the commitment to the client as a person, which will help the client carry through the task of therapy in spite of its more painful aspects.

Finally, Seeman (in Rogers and Dymond, eds., 1954) reports research where counselors rated therapy for beginning and end on several variables. The relationship variables of interest in this study were two items measuring variables of liking for counselor by client and vice versa. The authors report that "the two items which are rated highest at the end of therapy indicated that a high degree of mutual liking and respect between counselor and client is judged to be characteristics of the end phase of therapy" (Seeman, in Rogers and Dymond, eds., 1954, p. 104).

This does not mean that mutual liking <u>caused</u> any positive changes occurring as the result of therapy. However, in view of much of the literature cited it would seem plausible that a basic "ingredient" of successful therapy is the eventual ability of the

therapist to like or care about the client. If such a state of affairs does not exist in a relationship, it might be difficult for a client-therapist pair to accomplish understanding leading to change and growth in the client, if they maintained the relationship at all. The importance of sensitivity by the therapist in terms of being aware of his as well as the client's feelings and using this awareness constructively in the relationship is clear as evidenced by the work of Abeles cited earlier. Empathy as an important variable has also been noted.

In summary, the importance of the role of experience as affecting therapist variables has been explored. Findings in this area suggest that the experienced therapist tends to make "wiser" use of communication of his emotional reactions to the client and their meaning in the therapeutic relationship as well as the interpersonal conflicts the client typically becomes involved in. For example, even though early in a therapeutic relationship, the more experienced therapist has realized that he likes a client a great deal, he will not necessarily express it then. Instead he may wait until such a time that much of the client's conflict has become clear to the client at an emotional as well as an intellectual level and the client can then assimilate "being liked" at both intellectual and "gut" levels in an appropriate way, useful to his growth.

The focus of this study will be the variable of liking. This variable is considered here to "cut across" theories and is treated (as reviewed above) by several theories under such broader

constructs as counter-transference, and unconditional positive regard. The notion that liking for a client is "basic" in a therapy relationship will be explored. The level of empathy for clients who are "liked" or "disliked" will be measured and related to the ideas of authors on the relation of level of empathy to liking, presented previously in this paper. Finally, the verbal communication of liking among more experienced and less experienced therapists will be examined.

CHAPTER III

HYPOTHESES

1. This study considers the variable of empathy as separate from the variable of liking for clients. (See Truax et al., 1966; Truax, 1963; Chessick, 1965; Bergin, 1967; discussed earlier in this paper.) However, the two variables are viewed most meaningfully as separate but interacting components of successful therapy. Generally, this study hypothesizes that both variables are necessary at a high level in an interaction if one is to attain highly "successful" therapy.

The following group of statements deal with empathy and liking as separate therapeutic conditions, which will interact to affect client change. The level of empathy provided by the therapist is considered constant for a given therapist, i.e., in his control (Truax, 1966); and is not expected to change radically during therapy. Thus, cases where the level of empathy provided by the therapist is low are expected on outcome measures to be in the "unsuccessful" category. This is expected to occur when empathy is consistently low, regardless of other therapeutic conditions.

On the other hand, the level of liking as a therapeutic condition, is considered to be changeable; therefore conditions of "Lo-liking" early in therapy may become conditions of "Hi-liking"

by the middle or late stages of therapy and then, if combined with conditions of "Hi-empathy" would be expected to lead to a "successful" outcome.

Because liking is expected to change (initially in therapy, liking is not in control of the therapist, but is affected by the client; see Truax, et al., 1966), a number of clients experiencing "Lo-liking-Hi-empathy" conditions for whom failure would be predicted are expected to shift to "Hi-liking-Hi-empathy" conditions by the middle or late stages of therapy and then success would be predicted for them. The reverse of this shift is not expected to occur (i.e., "Hi-Hi" to "Lo-Hi") as it is assumed that once a therapist comes to like a client he will continue to like him, although other emotions may get expressed by the therapist in the relationship at various times. This is to be expected to be reflected in the data, in the following ways:

Hypothesis I: Change in therapeutic conditions of liking will occur for clients initially experiencing a high level of empathy.

Specific predictions are:

Hypothesis I-a: The conditions of "Hi-liking-Hi-empathy" will increase through middle and late stages of therapy.

Hypothesis I-b: The conditions of "Lo-liking-Hi-empathy" will decrease through middle and late stages of therapy.

Hypothesis I-c: The conditions of "Lo-liking-Lo-empathy" and "Hi-liking-Lo-empathy" will not change.

The following hypotheses deal with the impact of the conditions of "Hi-liking-Hi-empathy" on the success of therapy. The relationship of "predicted successful" (based on the rationale of the influence of the variables of empathy and liking influencing therapy outcome through their interaction) to "actual successful" needs to be considered:

Because changes will occur in the "predicted successful" category (as changes occur in the conditions measured from therapy data) these are expected to be directly reflected in the "actual successful" category. Therapy will be predicted to be unsuccessful based on conditions of a high level of empathy but a low level of liking. As the level of liking increases during therapy for some of the people and the level of empathy remains high their predicted outcome will change from unsuccessful to successful.

Hypothesis II: Clients who are "predicted successes" in the early stage of therapy will be "actual successes" on outcome measure.

Hypothesis II-b: Clients who are "predicted successes" in the middle stage of therapy will be "actual successes" on outcome measure.

Hypothesis II-c: Clients who are "predicted successes" in the late stage of therapy will be "actual successes" on outcome measure.

Hypothesis II-d: Clients who experience therapeutic conditions of "Hi-liking-Hi-empathy" at any time up to and

including the last stage of therapy will be categorized on outcome as successes.

2. Abeles (1962), in his work with therapists' ability to be aware of their affective responses to clients and communicate it, has observed that as experience and training increase, therapists have more awareness of their emotional responses to clients and are more able to communicate it appropriately. In a similar way, Kell and Mueller (1966) pointed out that more naive therapists may initially "over-respond" to clients' needs to be liked and receive affection, as opposed to more experienced therapists who will also have a need to be nurturant and show affection to clients they like, but will do it at a time in therapy when the client can "make better use" of it.

Hypothesis III: Thus, experienced therapists will have a lower mean of "liking" (NPW scale) than inexperienced (naive) therapists, in the initial stage of therapy.

Hypothesis III-a: Experienced therapists will have a higher NPW scale mean in the late stage of therapy as contrasted to the early stage.

Hypothesis III-b: NPW mean will not differ in the late stage of therapy as compared to the early stage for inexperienced (naive) therapists.

Hypothesis IV: Experienced therapists will have smaller variance among empathy scale scores for clients than inexperienced therapists.

Generally inexperienced therapists are expected to be

more concerned with getting their needs met by doing therapy, than experienced therapists. They will be easier sidetracked from what the client is experiencing (i.e., less empathic) and more concerned with satisfying their own needs to be nurturant (e.g., by expressing "liking" for the client sometimes in contrast with needs the client is expressing). Thus, this should be reflected in their empathy scores (i.e., the inexperienced therapist will be more likely to be "not with" the client), and inexperienced therapists, as a group, are expected to be disproportionately represented in the "Lo-empathy" categories.

Hypothesis V: Inexperienced therapists will obtain a greater frequency in the "Lo-empathy" categories than experienced therapists.

CHAPTER IV

METHOD

Subjects: The present study included a group of 36 psychotherapists at the MSU Counseling Center. This includes a senior staff group of twelve Ph.D. psychologists with degrees in counseling or clinical psychology; five second year interns; twelve first year interns (completing training for the Ph.D. degree in clinical or counseling psychology); and seven practicum students. The Ph.D. psychologists and second year interns are defined as the "experienced" group. The Ph.D. psychologists have completed training and range from one to approximately twenty years of therapy experience, while second year interns would have completed all course requirements, including practicum and would have already received a minimum of two years of intense individual therapy supervision. The first year interns and practicum students are defined as the "inexperienced" therapists in this study. The first year interns would have completed practicum course work which would have included both individual and group supervision for at least one year. Practicum students used as therapists in this study would have been in advanced practicum and therefore would have had some previous experience as therapists (at least one term) with individual and group supervision.

The above descriptions reflect minimal levels of experience and/or training for the two groups of therapists.

All therapists in this study worked with one client. The total therapist group consisted of 25 males and 11 females. Sex differences among therapists will not be compared in this study. The possibility of some selectivity of therapist-subjects exists since not all counselors at each level of training and experience who do therapy, participated in the formation of the tape library. Their participation stemmed from a voluntary basis.

Selection of cases: Tape recordings of therapy cases used in this study were selected from the tape library which has been compiled at the MSU Counseling Center. These tapes are continuous throughout therapy of undergraduates at MSU who voluntarily came to the Counseling Center, presenting personal-social problem areas in their lives. A selective procedure operated in the gathering of the library to the extent that the students, if determined to be appropriate to be seen in psychotherapy at the Counseling Center, were then asked if they would participate (i.e., all participation on the part of the students was voluntary).

In addition specific selection criterion for this study included: (1) a minimum of three taped therapy sessions; (2) participation in pre-and post-therapy testing; and (3) therapy conducted by one individual therapist who worked with the client

through termination. One case was dropped from the study because two different therapists had worked with the client. Number of interviews with clients by the experienced group of therapists ranged from 4 to 18 with a mean of 11.47. Breakdown of cases by sex indicates 24 female clients and 12 male clients with a total of 36 clients used in this study. There will be no attempt to compare sex differences among clients in this study. The rationale for this is based on the findings of Alexander (1967) that "the assumptions regarding sex differences in normals (which were the underlying bases for the hypotheses of this study) may not be at all applicable to male versus female therapy clients" (Alexander, 1967, p. 56). Although Alexander was primarily investigating the dependency variable he further reports that, "Data from the relationship categories also fail to support the hypothesis of a difference between sexes" (Alexander, 1967, p. 55).

Instruments:

MMPI: Pre-post differences in T-scores of clinical scales of the MMPI were used for selection criteria to place clients in a "successful" group versus an "unsuccessful" group. It should be pointed out here that these were selection criteria and do not necessarily reflect "absolute" success or failure of therapy. Rationale for use of this instrument as a measure of outcome is basedon several findings in the literature. Barron (in Welsh and Dahlstrom, eds., 1956) reports that patients seen for therapy in an outpatient clinic were categorized into an "improved" group

and an "unimproved" group as judged by behavioral criterion (such as loss of physical and/or psychological symptoms, improvement in relating to others, etc.). The two groups were then compared on the MMPI and while there were no statistically significant differences in scale scores, the unimproved group was "consistently higher on almost all scales" (Barron, in Welsh and Dahlstrom, eds., 1956, p. 520).

With respect to the issue of test-retest reliability, and change as result of therapy, with pre-post therapy testing using the MMPI, Schofield (1956) notes that test-retest correlations on the MMPI are lower for patients than normals. He feels that in view of evidence indicating that patients change more (one way or the other) on the MMPI than "normals," "it may be considered more proper to treat test-retest correlations in patients who have had therapy as indices, at least in part, of therapeutic efficacy rather than as a reliability coefficient" (Schofield, in Welsh and Dahlstrom, eds., 1956, p. 541).

This study, in keeping with notions of Barron (1956) separates the therapy group (on the basis of MMPI scores) into those who "change" or "improve" and those who "don't change" or "get worse." Criterion in this study for "successful" category on the MMPI was lowered T-scale scores on a majority of clinical scales. Criterion in this study for "unsuccessful" category on the MMPI was no change or elevation of T-scale scores on a majority of the clinical scales. The assumption here is that this will shed more

light on what variables contribute to change in what way, much more than studies in the past where there has been an "experimental" (therapy) group (with those who improve and those who either don't improve or get worse lumped together) and a "control" (no therapy) group.

Nonpossessive warmth scale: (NPW) The variable of "liking" has been defined and treated in this study as including notions from psychoanalytic theory, (under counter-transference), client-centered theory (unconditional positive regard), and others (see Searles, 1959; Nacht, 1962; Rogers, 1954; 1957; 1965; Jourard, 1959; Stoler, 1963; Truax, 1962). Truax and Carkhuff (1967) define the dimension of "nonpossessive warmth" (or unconditional positive regard) in much the same way that liking is treated in this study, i.e., a liking or caring for the client as an individual person, separate from evaluation of the person's thinking and/or behavior. As Truax and Carkhuff (1967) express it, "Thus a therapist can evaluate the patient's behavior or his thoughts but still rate high on warmth if it is quite clear that his valuing of the individual as a person is uncontaminated and unconditional" (Truax and Carkhuff, 1967, p. 58). Again, as presented earlier in this study, the notion here is of a basic caring for the client, i.e., including being able to feel hurt, get angry, etc., and is not necessarily at all accepting of any or all client behavior and attitudes. Based on the above commonalities of liking in this study with other known literature in this review, this writer

deemed it appropriate to use the NPW scale, as presented by Truax and Carkhuff (1967). (See Appendix A for copy of scoring manual which includes the NPW scale.) This scale is one of the methods available for scoring the variable directly from tapes of psychotherapy. The original NPW scale as presented by Truax and Carkhuff (1967) is modified for this study. This modification consists of the addition of a "stage 0" (in addition to the usual five stages of the scale). The rationale for this is that preliminary study indicated the therapist is not always communicating "liking" to his client, but may be very mechanically "gathering information," with no expression of positive or negative regard.

Scale for measurement of accurate empathy: This scale (Truax and Carkhuff, 1967) will be used to measure empathy of the therapist for the client from the tape recorded cases used in this study. This scale measures empathy as separate from the liking variable. This is in accordance with the notions of this study that the two variables to be measured are separate, but interact. The scale is designed to be used for analysis of tape recordings of therapy which fits the procedure of this study. (See Appendix A for a copy of the scoring manual which includes the accurate empathy scale.)

Procedure for selection of samples from tapes: Thirty-six therapy cases represent the total tape recorded therapy sessions sampled in this study. This is a total of 396 recorded

interviews. Tape recorded interviews varied from a minimum of three to a maximum of 22 with a mean of 11.00 per case. While each therapy case was broken down into three stages (early, middle, and late), one five minute segment was randomly selected from each recorded therapy session. This permitted obtaining data on each recorded session which later could be condensed into representative measures of the three stages of therapy. This procedure also makes available the study of any "trends" or unusual changes from session to session.

After selecting random five minute segments, each segment selected was transferred to another tape so that for each case, all five minute segments for each case were recorded in order (from early stages of therapy through late stages) on one composite tape. A scoring protocol accompanied each tape for a given case. This scoring protocol consisted of identifying data for the case and each sample segment which were: (1) the "counter" numbers indicating the points on the composite tape where a given segment began and ended; (2) statements by either client (cl) or therapist (T) which began and ended each segment; (3) the numerical scale for the two variables for each sampled segment (i.e., NPW and AE numerical scales); and (4) the case code name at the top of each page. This procedure was followed to insure that each rater (who would score independently) would be scoring for identical portions of therapy sampled. It insured that raters could only score the sampled portions and not be influenced by

any other segments of an individual tape from one session or by any segments of therapy other than that scored (since only the sampled five minute segments were available to the raters to listen to and score). This was an attempt to control for raters getting curious and/or involved in listening to segments of therapy other than that sampled for this study. (See Appendix B for a copy of scoring protocols.)

Scoring procedure: The scoring can be briefly summarized here. The rater listened to a five minute segment of therapy and circled a score for the scale measuring one of the variables of interest. He also circled a score for the other variable of interest. He did this for each segment with regard to each variable. The scoring of the "liking" variable included the modification of the NPW scale described previously.

Each rater was also provided with a scoring manual. This manual provided instructions summarizing the general procedure and a copy of each of the two scales used in the study, with a general definition for each scale and a definition of each point on the scale along with examples. (See Appendix A for copy of scoring manual.)

Procedure for obtaining scoring reliability: This study used two raters for scoring and reliability purposes (one rater was a fifth year graduate student in personality and the other rater was a fourth year graduate student in counseling psychology). One area of interest in the study was to demonstrate reliability

for two raters on over-all agreement for all therapy segments in the study. The two raters were supplied scoring manuals, and met with each other and the writer to discuss the scoring system and score practice tapes. (Practice tapes were taken from the same tape library as the sample, but for cases without post-test data, which made them ineligible for the sample for this study.) Several practice tapes were scored independently by each rater after they had initially become familiar with the scoring system and the reliability was checked for each series of practice tapes. The raters and writer met twice each week for discussion of scoring.

When orientation level of reliability had been met consistently on practice tapes, raters were supplied with tapes from the sample to score. Each rater scored all therapy tapes used in the study, and the average of their two ratings was used.

Statistical procedures to test hypotheses: Hypotheses under Hypothesis I were tested using tests for differences in frequency using the same measures and studying changes in subgroups of a large group (Walker and Lev, 1953). Hypotheses under Hypothesis II were tested using chi-square (Walker and Lev, 1953). Hypothesis III was using T-tests for differences in uncorrelated means. Hypothesis III-a and Hypothesis III-b were tested using T-tests for differences in correlated means (Walker and Lev, 1953). Hypothesis IV was tested using the F-test for differences in variances (Walker and Lev, 1953). Finally, Hypothesis V was

tested using tests for comparison of frequency by use of proportions (Guilford, 1956).

Analysis of MMPI Data: As noted previously, the selection criterion for "unsuccessful" outcome based on the MMPI was no change or elevation of T-scores on a majority of clinical scales. These were selection criteria and do not necessarily reflect "absolute" success or failure of therapy.

Differences in T-scale scores for each group (i.e., "successful" and "unsuccessful," hereafter referred to as "S" and "U") are summarized in Tables I and II.

Table I: Average change on each clinical scale of MMPI for "successful" group

Scale	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si
Average change in T-score units	-6.70	-12.60	-7.55	-6.20	-0.75	-8.20	-10.50	-12.85	-1.60	-5.5

Table II: Average change on each clinical scale of MMPI for "unsuccessful" group

Scale	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si
Average change in T-score units	+4.31	+2.12	+4.00	+4.00	+1.87	+3.56	+2.68	+4.75	+1.87	-1.43

These results indicate that the "successful" group did have lower T-score average on all clinical scales and the "unsuccessful" group did have elevated T-score average change on nine of the ten scales. Results here are similar to the findings reported by Barron (1956).

Group comparisons were also made for within and between groups on T-score averages for the ten scales. These results are summarized in the following four tables (Tables III-VI).

Table III: Pre versus post T-score comparisons within "successful" group

Scale	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si
Pre (N=20) Mean T-score	53.95	69.65	63.7	67.3	50.65	65.15	70.1	71.3	60.55	61.05
s.d.	11.25	9.24	9.76	11.19	19.80	4.98	9.47	9.88	11.35	10.43
Post (N+20) Mean T-score	47.75**	57.05**	56.15**	61.1*	49.9	56.95**	59.6**	58.45**	57.95	55.65**
s.d.	4.09	7.91	6.35	11.70	18.06	6.33	8.91	10.13	8.69	10.65

*The difference between pre-therapy and post-therapy scores is significant at the .05 level of confidence.

**The difference between pre-therapy and post-therapy scores is significant at the .01 level of confidence.

Table IV: Pre versus post T-score comparisons within "unsuccessful" group

Scale	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si
Pre (N=16) Mean T-score	50.37	55.43	57.37	59.43	49.68	56.87	59.62	59.75	57.25	56.37
s.d.	10.44	10.66	9.94	11.49	12.15	7.09	8.69	9.51	10.14	13.66
Post (N=20) Mean T-score	54.68	57.56	61.37	63.18	51.56	60.43**	62.31	64.5*	59.12	54.93
s.d.	9.72	17.40	7.71	12.71	13.65	9.80	9.09	11.08	10.79	13.82

*The difference between pre-therapy and post-therapy scores is significant at the .05 level of confidence.

**The difference between pre-therapy and post-therapy scores is significant at the .01 level of confidence.

Table V: Pre versus pre T-score comparisons between "successful" and "unsuccessful" groups

Scale	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si
Pre "S" (N=20) Mean T-score	53.95	69.65	63.7	67.3	50.65	65.15	70.1	71.3	60.55	61.05
s.d.	11.25	9.24	9.76	11.19	19.80	4.98	9.47	9.88	11.35	10.43
Pre "U" (N=16) Mean T-score	50.37	55.43**	57.37	59.43*	49.68	56.87**	59.62**	59.75**	57.25	56.37
s.d.	10.44	10.66	9.94	11.49	12.15	7.09	8.69	9.51	10.14	13.66

*The difference between the two pre-therapy scores is significant at the .05 level of confidence.

**The difference between the two pre-therapy scores is significant at the .01 level of confidence.

Table VI: Post versus post T-score comparisons between "successful" and "unsuccessful" groups

Scale	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si
Post "S" (N=20) Mean	47.75	57.05	56.15	61.1	49.9	56.95	59.6	58.45	57.95	55.65
T-score s.d.	4.09	7.91	6.35	11.70	18.06	6.33	8.91	10.13	8.69	10.65
Post "U" (N=16) Mean	54.68**	57.56	61.37*	63.18	51.56	60.43	62.31	64.5	59.12	54.93
T-score s.d.	9.72	17.40	7.71	12.71	13.65	9.80	9.09	11.08	10.79	13.82

*The difference between the two post-therapy scores is significant at the .05 level of confidence.

**The difference between the two post-therapy scores is significant at the .01 level of confidence.

Within the "S" group T-score means were significantly lowered on post-therapy testing for eight of the ten scales. These scales were: Hs, D, Hy, Pd, Pa, Pt, Sc, and Si. Within the "U" group T-score means were significantly elevated on post-therapy testing for two of the ten scales. These two scales were Pa and Sc. Implications of these changes on the MMPI will be treated in the discussion section of this paper.

The two groups (i.e., "S" and "U") were compared on pre-therapy test scores and were found to have significantly different T-score means on five of the ten scales. These scales were: D, Pd, Pa, Pt, and Sc. Comparison of the two groups on post-therapy testing yielded signifidantly different T-score means on two of the ten scales (Hs and Hy). It seems relevant to note here that while

the "S" group's pre-therapy T-scores were more elevated on all ten scales (with the possible implication of "higher degree" of pathology) than the "U" group, the post-therapy scores reveal that the "S" group's T-scores were lower on nine of the ten scales (although only reaching significance level on two). This would seem to suggest that the two groups, in effect, "passed" each other with the "S" group having higher elevation of scale scores before therapy and the "U" group having higher elevation of scale scores after therapy.

The two groups ("S" and "U") were also compared on two other scales on the MMPI. These were the K-scale and the ES-scale. Results of these comparisons are summarized in Table VII.

Table VII: Comparison of pre and post T-score changes on K and ES scales of MMPI for "S" and "U" groups

	ES		K	
"S" Group	$\bar{X}$	s.d.	$\bar{X}$	s.d.
Pre (mean T-score) (N=20)	50.80	9.84	48.50	4.91
Post (mean T-score) (N=20)	60.60**	9.77	52.10*	6.15
"U" Group	$\bar{X}$	s.d.	$\bar{X}$	s.d.
Pre (mean T-score) (N=16)	57.75	8.27	53.68	8.49
Post (mean T-score) (N=16)	59.96	n.s. 7.37	52.31	n.s. 7.49

*Pre-post score difference is significant at the .05 level of confidence.

**Pre-post score difference significant at the .01 level.

There were no significant changes on the two scales for "U" group, while the "S" group changed significantly on both of the scales in a direction of increased elevation. It can be noted in the table that while the "S" group started out with definite lower scores on these scales than the "U" group before therapy, post-therapy testing revealed the "S" group had increased scores on these scales and were then at approximately the same "level" on the scales as the "U" group, which did not change notably on the scales. Possible implications of this will be considered in the discussion section of this paper.

Reliability: The determination of consistency in scoring was obtained with the method of Ebel (1951). This method focuses on analyzing components of variance. In keeping with the findings of Kammerschen (1965) raters were trained over a period of approximately 4-6 weeks with each rater independently rating approximately 75 segments in training following the initial period of learning the scale. Raters worked independently after initial learning of the two scales, and also met approximately twice each week to discuss the scales.

Raters had more difficulty learning the NPW ("liking") scale than the AE scale. Raters experienced the NPW scale as less clear than the AE scale and much of the time spent in discussion among the raters dealt with the problem of operationalizing the general definition of the scale as well as the definitions of each stage. When therapists were actively criticizing (which tended

to be rare in this sample) and expressing little regard for the client, this was easier for raters to differentiate than when they were trying to differentiate within the "liking" area of the scale which seemed to require listening for more subtle cues. Providing raters with prepared tapes and protocols identifying each segment permitted consistency for exactness of material rated and permitted going back to re-listen to segments and discuss their scoring during the training period. Table VIII summarizes reliability results for the two scales used in this study.

Table VIII: Reliability of two independent raters rating all data on the variables of liking and empathy

Variable	Clients	Therapists	No. of rated segments	Coefficient of reliability
Liking (NPW Scale)	36	36	396	r_{tt} = .7255a
Empathy (AE Scale)	36	36	396	r_{tt} = .7611a

a = Ebel's method (1951)

These results are in keeping with previous reliability coefficients in work done with these scales in 28 different studies as reported by Truax (1967).

CHAPTER V

RESULTS

This section is divided into two major subsections. The first deals with a general statistical description and this is followed by a subsection reporting results on testing of the hypotheses.

Description of tape data: The general characteristics of the data are presented here in order to present a complete over-view of the distributions of the variables of interest to this study (i.e., liking, empathy, and therapist experience level).

1. Distributions of variables measured in the sample:

The distributions for the scores on scales measuring both variables approximate a normal distribution. However, the distribution of scores on the liking variable is much more compact, especially in regard to the modal score. This modal score on the NPW scale here is 3.0 which is the lowest level of "positive regard" or the "liking" portion of the scale as opposed to the "disliking" portion. This score (3.0 on the 6 point scale) was assigned 250 times out of 396 segments scored. The accurate empathy scale, on the other hand, does not have a modal score with such a high frequency (modal score on the AE scale is 5.5 with a frequency of 72 times out of 396 segments) and thus the

distribution of that variable is not as compact and "peaked." The distributions and frequency of values are summarized in figures I-IV. (See figures I-IV in Appendix C.)

The results of the breakdown of distributions for experienced and inexperienced therapists are very similar to those presented by Truax (1967) (pp. 108-109) where he discusses findings on the variables in training studies. A comparison of results on the two variables for this study and the training studies Truax mentions are summarized in Table IX.

Table IX: Summary of mean scores on liking and empathy for experienced and inexperienced therapists in present study and training studies reported by Truax (1967)

Mean Scores	Empathy (AE)	Liking (NPW)
Truax--Experienced Therapists	5.2	3.1
Truax--Graduate Psychology Trainees	5.1	3.0
Truax--Lay Trainees	4.6	2.8
Present Study--Over-all	5.0	3.0
Present Study--Experienced Therapists	5.3	3.1
Present Study--Inexperienced Therapists	4.7	2.9

2. Relationship between NPW and AE scales: The two scales are intended to be independent of each other and the variables of

liking and empathy are considered as separate and measured as such. Truax (1966) reports a somewhat high correlation (r_{xy}=.54) between the AE and NPW scale. The correlation between the AE and NPW scales obtained in this study (r_{xy}=.57) is high enough to suggest that the two scales overlap and may measure some "common components."

3. Comparison of experience levels: As summarized in Table IX, the experienced therapists obtained higher means on the two scales than the inexperienced therapists. The mean for experienced therapists on the empathy scale was 5.3009; their mean on the liking scale was 3.1243. The mean for inexperienced therapists on the empathy scale was 4.7203; their mean on the liking scale was 2.8923. Differences between the means on the two scales for the two groups were not significant. The number of interviews in therapy was compared for the two groups. The inexperienced therapists averaged 11.47 interviews per case, and the experienced therapists averaged 10.57 interviews per case. This difference in number of interviews is not significant.

4. Comparison of "S" and "U" cases: The "S" and "U" groups were compared to determine differences on level of scoring of the two variables on the AE and NPW scales. The "S" group had a mean of 3.0929 on the liking scale and a mean of 5.2013 on the empathy scale. The "U" group had a mean of 2.9000 on the liking scale and a mean of 4.7705 on the empathy scale. Again, these differences were not significant.

Tests of individual hypotheses:

a) Hypotheses dealing with expected change in liking for clients:

Hypothesis I: There will be changes in the number of cases experiencing therapeutic conditions of different levels of liking and empathy.

I-a: Therapeutic conditions of "Hi-liking-Hi-empathy" will increase through middle and late stages of therapy.

I-b: Therapeutic conditions of "Lo-liking-Hi-empathy" will decrease through middle and late stages of therapy.

I-c: Therapeutic conditions of "Lo-liking-Lo-empathy" and "Hi-liking-Lo-empathy" will not change in number of cases included in middle and late stages of therapy.

This hypothesis was tested using tests for differences in frequency (Walker and Lev, 1953). None of the frequency changes were significant. Hypotheses I-a and I-b were not supported by the data. Hypothesis I-c was supported by the data in that non-significant results were predicted for these two categories (see Table X for summary).

Table X: Summary of frequencies of cases involving various conditions of liking and empathy

	Hi-like Hi-empathy	Hi-like Lo-empathy	Lo-like Hi-empathy	Lo-like Lo-empathy
Stage I (early)	19	6	5	6
Stage II (middle)	21 n.s.	7 n.s.	3 n.s.	5 n.s.
Stage III (late)	18 n.s.	6 n.s.	3 n.s.	9 n.s.

n.s. = not significant

b) Hypotheses dealing with impact of liking-empathy combinations on the success of therapy:

Hypothesis II: Clients who are predicted successes based on liking-empathy conditions at any stage in therapy will be actual successes.

II-a: Clients who are "predicted successes" in the early stage of therapy will be "actual successes" on outcome measure.

II-b: Clients who are "predicted successes" in the middle stage of therapy will be "actual successes" on outcome measure.

II-c: Clients who are "predicted successes" in the late stage of therapy will be "actual successes" on outcome measure.

In order to test this hypothesis, data from the sub-hypotheses were recorded in contingency tables and chi-square values were computed. These results are summarized in Table XI, XII, and XIII.

Table XI: Hi-liking-Hi-empathy conditions as related to outcome for early stage of therapy

	Actual successful	Actual unsuccessful	
Predicted successful	11	8	x^2=0.0891 n.s.
Predicted unsuccessful	9	8	

Table XII: Hi-liking-Hi-empathy conditions as related to outcome for middle stage of therapy

	Actual successful	Actual unsuccessful	
Predicted successful	11	10	x^2=0.2057 n.s.
Predicted unsuccessful	9	6	

Table XIII: Hi-liking-Hi-empathy conditions as related to outcome for late stage of therapy

	Actual successful	Actual unsuccessful	
Predicted successful	12	6	x^2=1.8225 n.s.
Predicted unsuccessful	8	10	

None of the tests of the sub-hypotheses of this hypothesis reached a level of significance, therefore the data do not support this hypothesis. Because of the possibility that the lack of significant results in this area was related to lack of meaningful categorization into predicted success or failure, the over-all relationship of the MMPI results to the variables of liking and empathy was determined through the method of correlation among ranks.

Absolute change on MMPI scales for all 36 cases was ranked as were scores on "liking," empathy, and the two variables combined. Rank-order correlations were then computed (Walker and Lev, 1953); however none of the correlations were significant.

Hypothesis II-d: Clients who experienced "Hi-liking-Hi-empathy" conditions by the last stage of therapy will be categorized as "successful" on outcome measure. Again, this hypothesis was tested by placing data in a contingency table and computing a chi-square value. Results of this analysis are summarized in Table XIV.

Table XIV: Relation between predicted and actual outcome and high level conditions at any time in therapy

	Actual successful	Actual unsuccessful	
Predicted successful	18	11	$x^2=2.5625$ n.s.
Predicted unsuccessful	2	5	

This deals with the idea that if high conditions of both liking and empathy occur together at any time in therapy, they will contribute to an "actual" successful outcome. Data are in the expected direction, but do not reach the significance level required to support this hypothesis.

Data were analyzed on a post-hoc basis in this area to determine the relationship of predictions based on high levels of therapy conditions for empathy and liking throughout therapy, to actual

outcome. There were eight cases in which the therapeutic conditions of empathy and liking were high throughout therapy. Five of these were "successful" on outcome measure and three were "unsuccessful." There was no significant relationship between predictions based on high level conditions of empathy and liking throughout therapy and actual outcome for these eight cases.

Data were also analyzed on a post-hoc basis to determine the effect on predictive ability of removing those cases on which average change was minimal (less than 1 T-scale unit). The effect of this was to remove five "false positives" (i.e., cases for which success was predicted but were categorized as actually unsuccessful). However, outcome predictive ability based on high level conditions of empathy and liking still did not reach the .05 level of significance although it was beyond the .10 level.

c) Hypotheses dealing with relationship of experience level of therapists to the liking and empathy variables:

Hypothesis III: Experienced therapists will have a lower mean on the NPW scale than inexperienced (naive) therapists in the early stage of therapy.

III-a: Experienced therapists will have a higher NPW scale mean in the late stage of therapy as contrasted to the early stage.

III-b: NPW mean will not differ in the late stage of therapy as compared to the early stage of therapy for inexperienced therapists.

Data relating to these hypotheses were tested using methods for differences in means. Hypothesis III was tested using a method for difference in uncorrelated means. Hypotheses III-a and III-b were tested using a method for differences in correlated means. Results are summarized in Table XV.

Table XV: Comparison of mean scores on NPW scale in early and late stages of therapy for experienced and inexperienced therapists

	Early stage		Late stage	
	$\bar{x}$	S.D.	$\bar{x}$	S.D.
Experienced therapists	3.19	0.2646	2.92 a	0.3471
Inexperienced therapists	2.84 c	0.4123	3.10 b	0.7639

a = difference is significant beyond .05 level ($P < .02$) in opposite direction to that of Hypothesis III-a.

b = Non-significant difference which therefore supports Hypothesis III-b.

c = difference is significant beyond .01 level in direction opposite to that of Hypothesis III.

Hypothesis IV: Experienced therapists will obtain smaller variance among empathy scale scores than inexperienced therapists. In order to test this hypothesis differences in variance were tested using the ratio of the two variances. Table XVI contains the summary of this test.

Table XVI: Comparison of variance among empathy scale scores for experienced and inexperienced therapists

	Experienced therapists	Inexperienced therapists	F-ratio
Variance of empathy scores	1.5276	1.7735	F=1.1609 n.s.

Data do not support this hypothesis although the direction of differences is in keeping with expectations.

Hypothesis V: Inexperienced therapists will be represented at a greater frequency in the "Lo-empathy" categories than experienced therapists. In order to test this hypothesis data were compared for differences in proportions for Lo-empathy scores. Results are presented in Table XVII.

Table XVII: Comparison of frequency of lo-empathy scores of experienced and inexperienced therapists

	Proportion of Lo-empathy scores for all segments of therapy
Experienced therapists	57/201 = .2835
Inexperienced therapists	80/195 = .4102 a

a = differences in proportions are significant beyond the .01 level ($P < .004$) in direction hypothesized.

Data support Hypothesis V in the expected direction.

CHAPTER VI

DISCUSSION

Relationship of change of liking for clients according to stage of therapy:

Liking was expected to change in therapy, especially for those clients where the therapist maintained a high level of empathy. This follows the reasoning of Truax et al. (1966), that liking for a specific client will depend on the therapist's reaction to him rather than training of a therapist to give "positive regard" to any and all clients. In a similar vein, Chessick (1965) stresses that a consistent high level of empathy for a client over a long period of time will contribute to a therapist beginning to feel "love" for the client. The sub-hypotheses under Hypothesis I predicted that therapists who did maintain a high level of empathy for clients would (in certain cases) eventually come to care for the client and thus the client would experience a high level of both empathy and liking from the therapist. Significant change in liking or not liking of clients was not expected for therapists who were judged to be at a low level of empathy. The data did not support the hypotheses that therapists who maintained a high level of empathy increased their liking for a client. Data were in agreement with the expectation of no significant change in level of liking scores for cases where therapists maintained a low

level of empathy. One possible implication of this finding is that a high level of empathy for a client might enable a therapist to be more aware of a client's feelings and typical interactions in relationships. While this increased awareness and understanding does not necessarily mean that the therapist will come to care for the client, it would tend to increase any possibility of increased appreciation for him.

Examination of patterns of liking-empathy conditions for stages of therapy, indeed, did not reveal any prevalent directional patterns in the data of this study.

Relation of predicted outcome to actual outcome; where predictions are based on combinations of empathy and liking scores:

One possible way to determine the influence of a variable on therapy is to try to isolate the effect of that variable on the outcome. This was attempted in the present study through predicting outcomes based on measures of the variables of liking and empathy. Hypothesis II (a through d) dealt with the relationship of predicted to actual success with varying conditions of liking and empathy. To summarize, this hypothesis predicted that cases with conditions of high levels of both liking and empathy would lead to a "successful" outcome based on pre-post MMPI measures. Predictions made from levels of conditions of the two variables did not coincide with outcome measure at a level significantly different from "chance." Correlations between the variables of liking

and empathy, and scores on MMPI were computed, and none of these were significant. Thus, the conclusion can be made that the present study was unable to predict change in scores on the MMPI based on scores on the two scales measuring liking and empathy, respectively.

The finding tends to contrast several of the findings reported in the literature in the last few years, as well as expectations of this study based on review of the literature in different theoretical positions. Generally, past research has supported a relationship between high levels of "liking" or non-possessive warmth, empathy, and a "successful" outcome. (See Rogers, 1957, 1961, 1965; Stoler, 1963; Truax, 1963; Truax and Carkhuff, 1966.) It may be worth taking a close look at the breakdown in predictions on the study (see Tables XI, XII, XIII, and XIV in Results section). The last table (Table XIV) deals with the relation of predicted and actual success based on the premise that if high conditions of both liking and empathy occur together at <u>any</u> time in therapy, they will contribute to "actual success." Indeed this method does accurately predict eighteen out of twenty "actual successes" correctly. However, it only predicts correctly for five out of sixteen cases where the actual outcome was judged to be unsuccessful. It was noted in the results section that post-hoc analysis revealed that if one eliminated cases whose average change on MMPI scales was less than 1 T-scale unit the accuracy of the predictions was increased. The method

used then predicted five out of eleven "unsuccessful" cases accurately.

This study cannot go beyond concluding that it was unable to demonstrate a relationship between levels of liking and empathy and outcome of therapy. However, it might be useful to consider possible explanations of why this is the case.

An unexpected finding on MMPI data seems to be relevant here. Initial selection of cases in a "successful" or "unsuccessful" grouping was done by examination of each individual's pre and post MMPI profiles. If the profile was elevated following therapy on a majority of clinical scales it was placed in the "unsuccessful" group. If the profile decreased on a majority of clinical scales it was placed in the "successful" group. Following analysis of tape data for the two groups, MMPI data was compared for statistical differences within and between the two selection groups. The unexpected finding in the analysis was that the two groups were more <u>alike</u> following therapy than before therapy. As is described in detail later in this chapter, the two groups rather than being equally "sick" or "disturbed" (as reflected on the MMPI) <u>before</u> therapy were more characteristic of one "disturbed" group and one "normal" group!

Twenty-nine of thirty-six clients experienced high level therapeutic conditions of liking and empathy in this study. If one admits of a possibility that these conditions were experienced by a "disturbed" group and a normal group, there is an interesting

possibility of why accuracy of prediction breaks down on the normal group. Data limitations were such that the only outcome measure available on all thirty-six clients was pre-post MMPI scores. Thus "change" was measured on the basis of increase or decrease on MMPI scales. However, as a group, the normal group did not have the potential of the more disturbed group to lower scale averages. It would seem reasonable, then, that on a test such as the MMPI a more disturbed group (e.g., with more anxiety, symptoms, etc.) would, as a result of therapy, lower their scores more than a more normal group who did not have such a high degree of anxiety and symptoms prior to therapy. In effect, on this kind of scale, a normal group has "no place to go"! It would then be possible that the normal group did benefit from high level conditions of liking and empathy, but the scale used here was not sensitive to such changes. Admittedly, a weakness of the present study was the use of one scale as the only criterion measure of change. However, if cases had been eliminated which had only the MMPI as any kind of outcome measure 22 of the 36 cases would have been lost to the study. This writer judged that such a loss of data would be too extensive, when therapy data is not easily obtained. It goes without saying that further work in this area would benefit from several criterion measures in addition to a scale such as the MMPI used here.

Perhaps this failure to correctly predict unsuccessful outcomes also is related to a more complex explanation of what

contributes to "success" in therapy. Previous research referred to above supports the idea that the ability to care for a client and provide sufficiently high conditions of empathy are important, basic "prerequisites" to successful therapy. However, their presence does not "guarantee" a successful outcome. In other words, if a client experiences low conditions of empathy and liking in therapy, the relationship will never develop enough trust and support to withstand exploration of intense and painful conflicts of the client, and will thus be "doomed" to failure. Liking and empathy, then, are necessary to permit development of a therapeutic relationship with the potential for change.

Another possibility in the limitation of predictive ability in this study lies in the area of measurement. The intention of the writer was to accurately measure the liking of a therapist for a client specific to that relationship (as opposed to an overall "nurturant" level of a therapist, or the "generic social liking" Mills (1964) referred to). Mills (1964) suggested that when he measured liking for patients, he felt that what was measured may have been closer to a "general social liking" than a specific caring for an individual patient. In referring to measures used in his study he points out that "it may well be that the difference between liking for people generally and liking for patients is so qualitative that the present gross quantitative measures were not able to discriminate between the two" (Mills, 1964, p. 67). It would seem possible that liking for a specific client measured

in the present study was "contaminated," i.e., the specific liking of a client is measured by the NPW scale, but it also tends to reflect the general "level of warmth" of a therapist in any verbal communication which would be a complicating factor. One can observe in Figure I of Appendix C that scores on the NPW scale are grouped around the scale score of 3.0 with a high modal score frequency (250/396 therapy segments). This rather marked centralizing tendency on the NPW scale may mean that this scale is rather insensitive as far as ability to differentiate how much different therapists care for clients, with the exception of particularly strong expressions of disliking or liking.

Level of liking compared with experience level of therapists and stage of therapy:

Hypothesis III dealt with expected differences in level of liking expressed in the early phases of therapy for experienced versus inexperienced therapists. Experienced therapists were predicted to obtain a lower mean reflecting their less intense involvement with the client in the initial phase of therapy. However, results indicated that experienced therapists had a significantly higher mean on the scale measuring liking than inexperienced therapists did in the early stage of therapy. If one retains the reasoning that a higher mean score on the NPW scale is reflecting greater liking and expression of it for the client, then it would appear from these data that experienced therapists, rather than being less expressive of their liking for a client in the initial

phase of therapy, are actually more expressive of it than inexperienced therapists are.

Another, possibly more plausible interpretation of these data again deals with measurement and the NPW scale used in the present study. Truax and Carkhuff (1967) discussing this scale emphasize that "warmth must be genuine with the aspect of a personal encounter" (Truax and Carkhuff, 1967, p. 37). They also describe the warmth as specific to the particular client being worked with. It is possible that some therapists are more warm than others with all of their clients. One of the aspects of this scale involves different levels of uncritical acceptance of the client's feelings (as opposed to behavior) by the therapist. Perhaps experienced therapists are generally more accepting than inexperienced of whatever feelings the client communicates about himself, even early in therapy (i.e., they are less likely to be "surprised" by clients sharing certain strong feelings, e.g., anger, dependency). The inexperienced group in this study consisted of primarily first year interns and some practicum students. Mills (1964) found that new interns tended to temporarily withdraw the direct satisfaction of their need to nurture in counseling. The fact that the inexperienced group consisted primarily of interns in the present study and the relationship of the need to nurture to the expression of affection (liking) for clients presents the implication that the more experienced therapists are more comfortable and natural or "genuine" in expression of acceptance

and affection related to need to nurture than any of the inexperienced therapists. This explanation is certainly in keeping with findings here. Again, evidence here suggests that the NPW scale may be a complex of factors encompassing much more than the "liking" variable per se, which has implications to be discussed in regard to further research in this area.

With regard to Hypothesis III-a, differences in means on the NPW scale for experienced therapists are significant, with experienced therapists having a lower mean in the late stage of therapy rather than in the early stage, as had been hypothesized. Again this could suggest that experienced therapists are actually more expressive of their liking of a client early in therapy than they are later on. However, this seems improbable in view of the literature and theoretical expectations. If one considers the probability that experienced therapists tend to elicit initially powerful patterns of client feelings, then client-counselor interchanges at a later stage of therapy might be less expressive of caring than in earlier stages because client feelings are less strongly expressed. Admittedly, this is a post-hoc speculative explanation, but it seemed to be worthy of some consideration, at least with an eye to needs in future research of this variable.

Inexperienced therapists do not differ significantly in their expression of liking for a client when the early and late stages are compared for them, as reflected in the testing of Hypothesis III-b.

In summary then, at least in the present study, inexperienced therapists do not express liking differentially in the early and late stages of therapy, but experienced therapists, contrary to expectation, not only express more liking early in therapy than inexperienced therapists, but also within their own group express liking more in the early stage of therapy than they do in the terminal phase.

Mills (1964) points out that Rogers would predict increased liking with experienced therapists. This might reflect the increased sensitivity of experienced therapists in terms of their greater flexibility to paying attention to aspects of the client that were attractive (likable) other than "surface" behavior and feelings. This seems to relate to notions of some authors (Chessick, 1965; Fromm-Reichmann, 1950) that a high level of empathy typically occurs before a therapist experiences caring for a client in a non-judgmental, appreciative way, and indeed, is a prerequisite of it. This leads into the findings with regard to therapist experience and level of empathy attained in therapy.

Level and consistency of empathy in relation to different levels of therapist experience:

The final hypotheses dealt with comparison of experienced and inexperienced therapists on the variable of empathy. Hypothesis IV proposed greater variance among inexperienced therapists; however results although in the expected direction, did not reach the .05 level of significance. The results were in the expected

direction. One can only conclude here that experienced therapists in this study did not differe significantly from inexperienced therapists in variance of empathy scores.

Hypothesis V was intended to reflect the lack of training and/or experience of the inexperienced group of therapists resulting in periods of therapy where they would be clearly much less empathic than experienced therapists ever were. Data supported this hypothesis in the expected direction, as differences in frequency of low empathy scores for the two groups were significant beyond the .01 level ($P < .004$). In keeping with the reasoning leading to this hypothesis, then, it is probable that inexperienced therapists have periods of time in therapy when they are less in touch with what the client is feeling, and their reactions to him, than experienced therapists do.

This finding gives further confirmation to the work of Abeles (1961, 1962, 1963) dealing with sensitivity of therapist-trainees, and like Abeles' work, has implications for training. In discussing training work with neophyte therapists Abeles (1963) agrees with others about the need to make the trainee more perceptive of client feelings. He goes on to say:

> We would add here that we attempt to make the trainee aware of the range and complexity of feelings in his clients. In addition to this, a further aim of supervision is to make the trainee aware of the impact his client's feelings have on him. In other words we expect the trainee to use himself as a clinical instrument in the sense that he is encouraged to use his own reactions to client's affect as part of the therapeutic interaction. It has been

> our observation that this is a rather difficult task for many trainees. Previous academic training has tended to emphasize the importance of an "objective, scientific, somewhat aloof attitude" which tends to conflict with our attempts to develop their subjective feelings as a therapeutic tool (Abeles, 1963, p. 2).

Both aspects mentioned by Abeles are part of being "empathic" with a client. Abeles (1963) later cites evidence that this is trainable with neophyte therapists. This is also in keeping with notions expressed by Truax et al. (1967), that empathy is trainable. This "double awareness" (i.e., of the client's feelings and one's feelings as a result of the impact of the client's feelings) as part of empathy is supported and expanded by Kell and Mueller (1966) where they speak of the "reciprocal impact" of client and counselor, as well as the need of the counselor to be aware of it and the client's feelings so he might aid the client in expanding on feelings involved in his conflict.

Apparently experienced counselors, because of their greater experience and/or training are generally more aware of all levels of the client's feelings throughout therapy. Experienced therapists, then, will probably get to "know" their clients sooner and in more depth than inexperienced therapists. When this is considered it throws light on the earlier finding of this study (in the opposite direction of that hypothesized) that experienced therapists had higher averages on the NPW scale early in therapy than inexperienced therapists. The implication is that in keeping with notions of Chessick (1965) and Fromm-Reichmann (1950), empathy

does indeed lead to "love" or caring for the client. Fromm-Reichmann several years ago, writing about this area, stressed that when you learn of the patient's history and dynamics, through appropriate use of empathy the problem of a "judgmental" liking will not occur. Rather you will accept him as a person who wants to change and whom you want to help change. She also stresses that awareness of emotional reactions to clients is extremely important in terms of the therapist using this awareness to understand what the client does dynamically in interpersonal relationships.

In support of this reasoning, further post-hoc analysis of data revealed that for more disturbed clients, seen by experienced therapists, conditions of simultaneous high liking and high empathy existed for at least one stage of therapy 100 % of the time. Inexperienced therapists attained these conditions 75% of the time when working with the more disturbed group of clients. This was not true for either group of therapists with the more normal group of clients. As will be further discussed later in this chapter with regard to pre-therapy findings on the MMPI, this is suggestive of enhanced therapist involvement with more disturbed clients. Perhaps therapist's experience a more "normal" client as less challenging, interesting, and/or generally less stimulating to work with.

Post-hoc analysis of data also indicated a significant (chi-square value=7.25; P .01) relationship between high conditions of empathy over any stage of therapy, and outcome. This latter finding, while it could be criticized as a possible statistical artifact, is in keeping with a conclusion of the primary importance of a high level of empathy, and conditions of liking following a high level of empathy.

Finally, in this post-hoc analysis, there was a clear relationship (5/5 cases) between low conditions of empathy throughout all stages of therapy and outcome categorized as unsuccessful. This lends increased support to the idea of low level conditions definitively linked to unsuccessful outcome.

It certainly would seem reasonable then, that with a consistently higher level of empathy, more experienced therapists will know more of their client and how and why he feels the way he does, and could then be more appreciative of him as a person and have an earlier response to him as a more "likable" human being.

This also implies that as a therapist gets to know how and why a client feels as he does in relationships, the therapist can: (1) appreciate or "like" him more and feel warmer and more nurturant toward him (all probable components of the NPW scale); (2) help him expand (according to the views of Kell and Mueller, 1966) on his conflict and become aware of it in the therapeutic relationship with the increased chance of impact; and (3) possibly initiate change in the client's patterns of functioning.

It may also be that the increased ability to be more

empathic is what permits the therapist to maintain and explore an initial relationship with a client who is impulsive, unlikable, an externalizer, and has other characteristics associated with both poor therapy prognosis and limited likableness as a person. In view of difficulties in working with such people, perhaps the initial ability to empathize is the most powerful tool to initiate therapeutic impact.

Finally this finding and the reasoning here has implications for training. It appears that while liking is not directly trainable but may be an important "ingredient" contributing to successful therapy, empathy is trainable and can contribute to increased liking. Thus while one cannot train a young therapist to care for his clients, one can train him to be empathic to a degree that he will at least be better able to determine if there is anything about a person "worth caring for" and investing further time and/or energy in therapy.

Implications of general characteristics of data with regard to the findings on hypotheses:

Distribution of NPW scale scores in relation to the sample of therapists:

It can be noted in Figures I, II, III, IV (see Appendix C) that the liking variable had a peaked distribution. Specifically, 250/396 ratings made on this scale were at the 3.0 point on the scale. This score on the scale is the lower of the three scale points on the "liking" portion of the scale. It could be taken to represent a positive caring by the therapist, but not

with the intense affective involvement that is more characteristic of points "4" and "5" on the scale. The occurrence of this score at a high frequency for all therapy segments rated in the study may reflect that the group of 36 therapists in this study were generally nurturant, warm people who do not frequently express strong criticism or anger toward clients inappropriately (though data indicate that this does occur in therapy--and is probably appropriate within the context of the therapeutic relationship at the time).

It is recalled that Edward's (1957) definition of the nurturant need includes "showing affection toward others" as an important aspect. This would suggest that, since therapists are often highly nurturant people, one "contaminating factor" involved in the attempt to measure specific liking of clients is the contribution of the expression of the therapist's nurturant need. This could interfere with a "clean" measure of specific liking to the degree that any therapist (experienced or inexperienced) expresses nurturance to any client (even those he feels "neutral" toward or eventually comes to dislike).

Other information which might be applicable to this finding deals with the characteristics of therapists sampled in this study. They were a voluntary group who come from a large university counseling center. In addition, practicum students and/or interns in this study would consist of students who come out of clinical or counseling psychology graduate programs at MSU, where

both programs are considered to be high quality programs. A therapist trainee who might be often highly critical, not very nurturant and express dislike for a client easily, or operated "mechanically" in therapy, might not have progressed far enough in the program to be involved as a practicum student or intern (e.g., such a student might have been encouraged to change fields within psychology at the M.A. level degree). In other words, this sample was undoubtedly a selective one to the degree that the chance of therapists being present who would consistently offer low level conditions of liking and empathy were minimized by the nature of the staff quality and quality of the training programs.

The possible "contaminating" influences of expression of nurturance by therapists and/or "generic social liking" (Mills, 1964) in the measurement of specific liking for clients needs to be considered in any plans for future research on this variable in therapy.

Comparison of experience levels of therapists with previous research:

Results of this study for levels of the variables of empathy and liking are quite similar to those cited by Truax and Carkhuff (1967) in work with training of therapists. Generally, although differences are not significant, experienced therapists average higher on both scales, with the greater discrepancy occurring on the empathy scale. This is understandable from a viewpoint of empathy as changing with increased training and/or experience while

liking is less influenced by training and/or experience.

Further qualitative implications of client groupings based on change in MMPI scores:

Breakdown of cases into a "successful" or "unsuccessful" category was described earlier. The two groups were compared on T-score averages for the ten scales used, and findings were of interest. On the ten MMPI scales initially used to categorize cases, the "successful" group was more elevated on all ten scales prior to therapy, reaching a statistically significant level on five of the scales. Post-therapy comparisons on the same ten scales reveal the "successful" group to have dropped on all ten scales, significantly so on eight of the ten scales (see Tables III, IV, V, VI in Method section). The "unsuccessful" group was found to be elevated on nine of the ten scales following therapy. However, only two of the ten scales were significantly elevated following therapy for this group. If one looks at the "absolute" levels and pattern of pre-therapy scores for the two groups, the "successful" group appeared more "disturbed" on the MMPI prior to therapy, while the "unsuccessful" group was more within a "normal" range on the MMPI. One could speculate here that possibly the "successful" group was more disturbed prior to therapy and thus had more possibilities available, in terms of changing in a direction of "normality" as measured by the MMPI. This reasoning seems to be supported by post-therapy comparisons of the two groups, where both tend to be in the same area of the MMPI,

with most of the ten scales around a T-score of between 50 and 60.

In view of this finding the two groups were compared post-hoc on two other scales on the MMPI, namely the "K" and "Es" scales. On these two scales the "unsuccessful" group again did not change significantly, but the "successful" group changed significantly on both scales, receiving elevation of scores on both following therapy. Of particular interest here is the change of the "successful" group on the ego strength scale. While they started out prior to therapy almost ten points below the "unsuccessful" or "no change" group, they increased their average on this scale so that they were at the same level as the "unsuccessful" group following therapy. Again this seems to support the speculation that the "successful" group was more "disturbed" prior to therapy and therefore had more possibilities of changing in a constructive direction than the "unsuccessful" group which appeared more "normal" prior to therapy.

The writer would postulate here that perhaps it would be more accurate when describing the two groups to talk of a group ("successful") who were more upset prior to therapy (especially in terms of symptoms) than the other group ("unsuccessful") who were more characteristic of "normals." If this is the case, the "unsuccessful" group was really not what one could call a "failure" group. This is also in keeping with the finding that while the "unsuccessful" group experienced lower level conditions of liking and empathy than the "successful" group these lower conditions

did not reach a lower level that was statistically significant. Perhaps the lower numerical values on the liking and empathy measures for the "unsuccessful" group merely reflect that the therapists experienced these individuals as less disturbed or "hurting" less, and thus were not as intensely involved with them as were the therapists with the more "disturbed" group.

Implications for future research:

Three considerations for future research are of interest following the findings of the present study.

First of all it might be useful for a future study to consider the underlying factors contributing to the NPW scale (Truax, 1967) used in this study to measure specific liking for a given client. In view of previously mentioned possibilities that nurturant behavior of the therapist and "generic social liking" (Mills, 1964) could "contaminate" the measure of liking for a specific individual (client), it would be useful to compare the NPW scale with other "direct" measures of liking.

A second need for future work which would apply to the above difficulty would be to have further work on these variables where several clients were seen by one therapist with "equal" levels of disturbance prior to therapy and then examine outcome and the variables of empathy and liking. This might throw increased light on how, for example, experienced therapists will vary from client to client in terms of liking and empathy.

Finally, in recent literature more and more work is being

reported with videotapes of therapy. McGuire and Stigall (1966) report that their work with videotape research indicated that use of videotape does not distort therapy. This is a relatively new area and their assertion is still open to question. However, one can speculate on increased accuracy of measuring therapy process variables with the viewing of expressions, gestures, etc., available to trained raters.

CHAPTER VII

SUMMARY

Much of the research and thought in recent years on therapy process variables has stressed the importance of the emotional reaction of the therapist to the client. Within this realm, the condition of high liking for a client, if combined with a condition of high level of empathy was thought to be a basic prerequisite of successful therapy. An effort was made to determine the relation of high level conditions of empathy and liking to outcome of therapy, and to experience level of therapists. The extent of the contribution of different therapeutic conditions to outcome is important in attempts to understand what factors regularly lead to change as a result of therapy. Findings on these conditions in relation to therapist experience have implications for selection and training of therapists as well as implications for the conduct of therapy.

Generally, hypotheses were that high level conditions of liking and empathy would facilitate accurate prediction of success. It was expected that level of empathy would remain consistent for a given therapist throughout the therapy. The level of liking, however, was considered to be changeable, so long as high level conditions of empathy existed in the therapeutic situation.

It was hypothesized, then, that some clients experiencing a high level of empathy would experience change in the direction of increased liking from their therapist, as therapy progressed. It was also predicted that experienced therapists will initially communicate less liking as they allow the therapy to develop. Experienced therapists were also expected to be more consistent in level of empathy established, as well as to be most successful in avoiding conditions of low empathy.

Therapists used in this study included twelve Ph.D. psychologists, five second year interns, twelve first year interns, and seven practicum students at the Michigan State University Counseling Center. All therapists in the study worked with an individual client.

The level of liking was measured using the Nonpossessive Warmth Scale presented by Truax and Carkhuff (1967). Level of empathy was measured using the Accurate Empathy Scale of Truax and Carkhuff. Tapes analyzed were composite tapes from random samples of each therapy hour for each case. Tapes were scored by two advanced graduate students following a training period during which they established the ability to use the scales on a reliable basis. Outcome measure was limited to change on the clinical scales of the MMPI. Cases were sorted into categories of "successful" and "unsuccessful" on the basis of increase or decrease on a majority of the clinical scales. All data were obtained from the therapy tape library established at the Michigan

State University Counseling Center.

Results revealed an inability to accurately predict change on MMPI scores from measure of therapeutic conditions of liking and empathy. This was discussed as possibly relating to: (1) the confounding effects on the NPW scale of social liking and general expression of nurturant needs, as well as an insensitivity of the scale to react to subtle differences which seem to characterize such a variable; and (2) the effect of a relatively homogeneous sample of therapists in this study who are generally nurturant, warm, empathic people. The possibility that the effect of high levels of the conditions did lead to change which the MMPI was not sensitive to was considered. This seemed to be especially possible, in view of the finding that the clients in this study could be classified into a disturbed and a normal group, rather than two equally disturbed groups. It was considered that the disturbed group had more potential for changes such as symptom alleviation, which the MMPI is more sensitive to.

Findings regarding the relationship of empathy to experience were in keeping with expectations. This was discussed as relating to the ability of experienced therapists to attain higher levels of empathy, and to avoid therapeutic conditions of extremely low levels of empathy. This has implications for training in empathy, and supports other work indicating that empathy can be trained. The effect of greater empathic ability of experienced therapists on their greater skill in becoming aware of "likeableness"

in a client was discussed.

It was generally concluded that the therapeutic conditions of high levels of liking and empathy are necessary to establish potential for change as a result of therapy. Low level conditions do not permit the development of trust in a therapeutic relationship that will be necessary for exploration of intensive conflict.

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APPENDICES

APPENDIX A

SCORING MANUAL

I: General Procedure: Samples to be scored will consist of 5 minute segments of taped therapy interaction. Segments will begin at a complete statement by the client or therapist, and will end at a complete statement by the client or the therapist. Raters will assign one score for each variable for each segment. A "complete statement" here is defined as: (1) starting with the beginning of a sentence, i.e., a segment will not start in the middle of a statement by either the client or the therapist; (2) this statement can be as brief as "yeah....," "Mhm," "why...," "well..." etc. Scores for each variable on each segment may be entered individually by the rater on the prepared rating sheets.

II: Scale for the measurement of Accurate Empathy: This scale is taken from Truax and Carkhuff. (1967)

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

It is not necessary--indeed it would seem undesirable--for the therapist to share the client's feelings in any sense that would require him to feel the same emotions. It is instead an appreciation and a sensitive awareness of those feelings. At deeper levels of empathy, it also involves enough understanding of patterns of human feelings and experience to sense feelings that the client only partially reveals. With such experience and knowledge, the therapist can communicate what the client clearly knows as well as meanings in the client's experience of which he is scarcely aware.

At a high level of accurate empathy the message "I am with you" is unmistakably clear--the therapist's remarks fit perfectly with the client's mood and content. His responses not only indicate his sensitive understanding of the obvious feelings, but also serve to clarify and expand the client's awareness of his own feelings or experiences. Such empathy is communicated by both the language used and all the voice qualities, which unerringly reflect the therapist's seriousness and depth of feeling. The therapist's intent concentration upon the client keeps him continuously aware of the client's shifting emotional content so that he can shift his own responses to correct for language or content errors when he temporarily loses touch and is not "with" the client.

At a low level of accurate empathy the therapist may go off on a tangent of his own or may misinterpret what the patient is feeling. At a very low level he may be so preoccupied and interested in his own intellectual interpretations that he is scarcely aware of the client's "being." The therapist at this low level of accurate empathy may even be uninterested in the client, or may be concentrating on the intellectual content of what the client says rather than what he "is" at the moment, and so may ignore or misunderstand the client's current feelings and experiences. At this low level of empathy the therapist is doing something other than "listening," "understanding," or "being sensitive"; he may be evaluating the client, giving advice, sermonizing, or simply reflecting upon his own feelings or experiences. Indeed, he may be accurately describing psychodynamics to the patient--but in the wrong language for the client, or at the wrong time, when these dynamics are far removed from the client's current feelings, so that the interaction takes on the flavor of "teacher-pupil."

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.

Example:

C: I wonder if it's my educational background or if it's me.
T: Mhm.
C: You know what I mean.
T: Yeah.
C: (Pause) I guess if I could just solve that I'd know just about where to hit, huh?
T: Mhm, mhm. Now that you know, a way, if you knew for sure, that your, your lack, if that's what it is--I can't be sure of that yet.
(C: No)
T: (Continuing)....is really so, that it, it might even feel as though it's something that you just couldn't receive, that it, if, that would be it?
C: Well--I--I didn't, uh, I don't quite follow you, clearly.
T: Well (pause), I guess, I was, I was thinking that--that you perhaps thought that, that if you could be sure that, the, uh, that there were tools that, that you didn't have, that, perhaps that could mean that these--uh--tools that you had lacked--way back there in, um, high school
(C: Yah)

T: (Continuing)...and perhaps just couldn't perceive now and, ah...

C: Eh, yes, or I might put it this way, um (pause). If I knew that it was, um, let's just take it this way. If I knew that it was my educational background, there would be a possibility of going back.

T: Oh, so, I missed that now, I mean now and, uh....

C: .....and really getting myself equipped.

T: I see, I was--uh--I thought you were saying in some ways that, um, um, you thought that, if, if that was so, you were just kind of doomed.

C: No, I mean...

T: I see.

C: Uh, not doomed. Well let's take it this way, um, as I said, if, uh, it's my educational background, then I could go back and, catch myself up.

T: I see.

C: And come up.

T: Um.

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.

Example:

C: You've got to explain so she can understand....

T: Mhm, mhm (in bored tone)

C; Without--uh--giving her the impression that she can get away with it, too. (Excitedly)

T: Well, you've got a job satisfying all the things that--seem important, for instance, being consistent, and yet keeping her--somewhat disciplined and telling her it's good for her. (Conversationally)

C: There's where the practical application of what we have just mentioned comes into being. (laughs)

T: Mhm, mhm. (Sounding bored)

C: And when it's a theoretical plan--

T: Mhm.

C: It's beautiful! (Shrilly)

T: Mhm--mhm.

C: But....

T: (Interrupting) Something else about it that I feel really dubious about (banteringly)--what you can really do on the practical level (inquiringly)--I sometimes say that's what--we're most encouraged about, too. (Mumbling)

C: (Chiming in loudly) Yes--uh--there are many--uh problems in our lives in the practical application of--trying to be consistent. (Informatively)

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.

Example:

C: Now that you're....know the difference between girls; I think they were about 9 to 8 years old and, uh, they were just like dolls, you know, and (laughs) uh, I used to spend a lot of time with 'em. I used to go over there and would spend more time with these kinds than what would with....

T: Mhm, hm.

C: But nobody ever told me why I was dragged in here. And I own my own place, I have my, my....and my farm, I think I still own them. Because that, there was a little mortgage on it. And, uh, (pause) my ex-wife but I don't seen how in the world they could change that.

T: Mhm, hm.

C: But they sold my livestock and, uh, I, I worked with horses, and they sold them all, and ah....

T: I think probably, should I cross this microphone? (Noises)

C: And then I had a bunch of sheep.

T: Mhm, hm.

C: And that, which I know that I was not ill. Now, I'll tell you what she might've meant in what way I was ill. Now I'll tell 'ya, I batched it out there on the farm and I maybe just didn't get such too good food at the time. Now, whether she wanted to call that ill, or whether she wanted to call it mentally ill, that she didn't say.

T: Mhm, hm.

C: But she says I was ill, well, they could put that I was sick that I didn't have the right kind of food because I gained quite a bit of weight after I was brought in here.

T: Mhm, hm.

C: Yeah, but she didn't say which way she meant or how she meant that.

T: Uh, huh.

C: And she wouldn't give me any explanation and then I got mad at her.....

T: Mhm, hm.

C: ...and of course I told her off. Then I asked her if she, they kept from me for a long time that my stock was sold and I thought quietly, anyhow, I says, I won't give my work....

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.

Example:

C: If--if--they kicked me out, I--I don't know what I'd do--because.....

T: Mhm.

C: I--I--I am really dependent on it. (Stammering)

T: Even though you hate this part--you--say, "My God, I--I don't think I could--possibly exist without it either."

(C: Mhm)

T: And that's even the--that's the worst part of it. (Gently)

C: (Following lengthy pause) Seems that--(catches breath) --sometimes I--uh, the only thing I want out of the hospital--s'tuh have everyone agree with me...

T: Mhm, hm.

C: ...that's--I--I--I guess that if (catches breath)--everybody agreed with me--that everybody's be in the same shape I was. (Seriously, but ending with nervous laughter)

T: Mhm, well, this is sort of like--uh--feeling about the friend who--didn't want to do what I wanted to do; that--even here--if you agreed with me--this is what I want because if you don't agree with me, it means you don't like me or something. (Reflectively)

C: Mmmmmmmmm (thoughtfully)--it means that I'm wrong! (Emphatically, quick breathless laugh)

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.

Example:

C: I gave her her opportunity....
T: Mhm.
C: ...and she kicked it over. (Heatedly)
T: Mhm--first time you ever gave her that chance, and--she didn't take it? (Inquiring gently)
C: No! She came back and stayed less than two weeks--a little more than a week--and went right straight back to it. (Shrilly) So that within itself is indicative that she didn't want it. (Excitedly) (T answers "Mhm" after each sentence.)
T: Mhm, mhm--it feels like it's sort of thrown--right up in your face. (Gently)
C: Yah--and now I would really be--crawling....
T: Mhm.
C: ...if I didn't demand some kind of assurances--that, that things was over with. (Firmly)
T: Mhm, mhm, it would be--pretty stupid to--put yourself in that--same position where it could be sort of--done to you all over again. (Warmly)
C: Well, it could be--yes! I would be very stupid! (Shrilly)
T: Mhm.
C: ....because if it's not him--it might be someone else. (Emphatically)

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 constrast 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.

Example:

T: You're sort of--comparing--things you do do, things you have done--with what it would take to be a priest--is that sort of--the feeling? (Very gently)
C: (Following long pause) I don't know. (Meekly, then a long pause)
T: Suppose we mean right now feeling real guilty? (Softly)
C: (Sighs audibly) Real small. (Very softly--protracted silence)--I can't see how I could feel any different--other than--feeling small or bad....

T: Mhm.
C: ...guilty (Softly)
T: Things you've done just--so totally wrong to you--totally bad--you can't help sort of--hating yourself for it? (Assuming client's tone)--is that the sort of quality? (Very gently, almost inaudibly)
C: (Following pause)--And yet right now I feel as though I want to laugh--be gay.
T: Mhm.
C: I don't feel anything else. (Monotonously)
T: (Speaking with client) Right at this--at this moment?
C: Mhm.
T: So--it's too much to really feel--very miserable and show it? (Inquiringly)
C: Yeah, yeah (urgently). I--I--don't want to show it anyway. (Haltingly)

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 with the client 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.

Example:

C: Th--the last--several years--it's been the other way around--I mean he'll say, "Well let's--go do this or that," and --and I--sometimes I actually wanted to, but I'd never go because--I feel like I'm getting my little bit of revenge or something. (Voice fades at end)
T: By God, he owed it to you, and,--if he didn't come through, you'll just punish him now...
C: Yah.
T: ...now it's too late or--something. (Very softly)
C: (laughingly) Yah--that's--uh--that's just the way I--uh--now it's too late--It's your turn to take your medicine now. (Assuming therapist's tone)
T: Mhm...it's pretty--that's a--pretty childish way to think, but--I know uh--if I went home tomorrow, I'd do it tomorrow--if I had the chance.
C: Mhm, yeah--like that...
T: (Interrupting and overtalking client) One part of you could say, "Well, this is stupid and childish 'cause I--I want to be with him,"--and yet--another part says, "No, you gotta make him pay for it--you want <u>him</u> dangling there now." (Gently)

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.

Example:

C: The way she wanted me and I was always terribly afraid that she wouldn't put up with me, or would put me out, out (T: Yeah) I guess I can get something else there, too, now I was always afraid that she didn't really care.

C: I still think that though. (T: Mhm) 'Cause I don't know for sure.

T: Mhm. And don't really know for sure whether she cares or not.

C: (Pause) She's got so many other, uh, littler kids to think about.

T: Mhm.

C: That's why...

T: Maybe she likes them better or...

C: No, it's not that, I think she likes us all. (Pause) I think seein' that I'm the black sheep but, uh, the only one that served time and, that--'n got in the most trouble. Seein' that I hurt her so much, that's why I think she's starting ta--she just don't care for me anymore. (T interjects "Mhm" after most completed thoughts.)

T: You believe, maybe, "because I have hurt her so much, maybe she's fed up with me, maybe she's gotten to the point where she just doesn't care." (Long pause)

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.

Example:

T: ....I s'pose, one of the things you were saying there was, I may seem pretty hard on the outside to other people but I do have feelings.

C: Yeah, I've got feelings. But most of 'em I don't let 'em off.

T: Mhm. Kinda hide them.

C: (Faintly) Yeah. (Long pause) I guess the only reason that I try to hide 'em is, seein' that I'm small, I guess I got to be a tough guy or somethin'.

T: Mhm.

C: That's the way I, think people might think about me.

T: Hm. Little afraid to show my feelings. They might think I was weak, 'n take advantage of me or something. They might hurt me if they--knew I could be hurt.

C: I think they'd try, anyway.

T: If they really knew I had feelings, they, they really might try and hurt me. (Long pause)

C: I guess I don't want 'em to know that I got 'em.

T: Mhm.

C: 'Cause then they couldn't if they wanted to.

T: So I'd be safe if I, if I seem like a, as though I was real hard on the outside. If they thought I was real hard, I'd be safe.

III: Scale for the measurement of Nonpossessive Warmth: This scale is taken from Truax and Carkhuff's (1967) presentation of it, with the exception of the addition of the "stage 0."

General Definition: The dimension of nonpossssive warmth or unconditional positive regard, ranges from a high level where the therapist warmly accepts the patient's experience as part of that person, without imposing conditions; to a low level where the therapist evaluates a patient or his feelings, expresses dislike or disapproval, or expresses warmth in a selective and evaluative way.

Thus, a warm positive feeling toward the client may still rate quite low in this scale if it is given conditionally. Non-possessive warmth for the client means accepting him as a person with human potentialities. It involves a nonpossessive caring for him as a separate person and, thus, a willingness to share equally his joys and aspirations or his depressions and failures. It involves valuing the patient as a person, separate from any evaluation of his behavior or thoughts. Thus, a therapist can evaluate the patient's behavior or his thoughts but still rate high on warmth if it is quite clear that his valuing of the individual as a person is uncontaminated and unconditional. At its highest level this unconditional warmth involves a nonpossessive caring for the patient as a separate person who is allowed to have his own feelings and experiences; a prizing of the patient for himself regardless of his behavior.

It is not necessary--indeed, it would seem undesirable--for the therapist to be nonselective in reinforcing, or to sanction or approve thought and behaviors that are disapproved by society. Non-possessive warmth is present when the therapist appreciates such feelings or behaviors and their meaning to the client, but shows a nonpossessive caring for the person and not for his behavior. The therapist's response to the patient's thoughts or behaviors is a search for their meaning or value within the patient rather than disapproval or approval.

Stage 0: The therapist is obtaining background information, or encouraging the client to expand on the basic conflict initially presented. The therapist is neither communicating liking for the patient or disliking for the patient. The therapist is active and interested.

Example:

T: Can you tell me more about the way you wanted to understand your parents as a child?

C: I--I'm not sure what you mean.

T: Mhm. Well, earlier you mentioned you always tried to do what your--your parents wanted, but it was often very confusing to you.

C: Yah.

T: I--I was just wondering if you can expand on that some for me? Maybe give some examples.

C: Oh--oh, yeah, sure, lots of 'em.

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.

Example:

C: ...and I don't, I don't know what sort of a job will be offered me, but--eh....
T: It might not be the best in the world.
C: I'm sure it won't.
T: And, uh...
C: ...but...
T: But if you can make up your mind to stomach some of the unpleasantness of things...
C: Um hm.
T: ...you have to go through...you'll get through it.
C: Yeah, I know I will.
T: And, ah, you'll get out of here.
C: I certainly, uh, I just know that I have to do it, so I'm going to do it but--it's awfully easy for me, Doctor, to--(sighs) well, more than pull in my shell, I--I just hibernate. I just, uh, well, just don't do a darn--thing.
T: It's your own fault. (Severely)
C: Sure it is. I know it is. (Pause) But it seems like whenever I--here--here's the thing. Whenever I get to the stage where I'm making active plans for myself, then they say I'm high. An...
T: In other words they criticize you that...
C: Yeah.
T: So tender little lady is gonna really crawl into her shell.
C: Well, I--I'll say "okay."
T: If they're gonna throw, if they're gonna shoot arrows at me, I'll just crawl behind my shield and I won't come out of it. (Forcefully)
C: That's right. (Sadly)
T: And that's worse. (Quickly)
C: (pause) But why don't they let me be a little bit high? Why--right now I'm taking...
T: (Interrupting) Because some people...
C: (Talking with him)...600 milligrams of malorin, whatever that is, malorin
T: ...because a lot of people here don't know you very well at all. And because people in general, at times, you have to allow that they could be stupid. You too. I mean you're stupid sometimes, so why can't other people...
C: So much of the time.
T: Why can't other people? I mean, you're an intelligent person and are stupid. Why, why can't you allow that other intelligent people can also be stupid? When it comes to you they don't know very much.
C: Hmmmm. (Muttering)

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 non-possessively warm response would be expected; he shows a complete passivity that communicates almost unconditional lack of regard.

Example:

C: (At point of near hysteria throughout) (Sighs) Sometimes I get pressure in my head, and that's when I--just--lost control of myself--I can't...

T: You don't hardly know what you're doing at those times, is that it?

C: No, I don't!

T: It isn't your fault, is that the way it feels, what you're doing (pause)--when you're like that?

C: (With exasperation) Yes, that's the way it feels, it--it's been that way ever since I was a kid, I don't know why--I wanted to be normal like other kids, and I tried hard but--(silence)--I went down to my sister's and it was a regular nut house down there, I couldn't work. I had good jobs working at the hotel--as a hostess--and I might just as well have been here, it was such a nut house. And my brother made us--(Silence) But, I've been threatened with this place, ever since I was a kid. They come to take me once but my dad wouldn't let 'em. (Silence) I mean it was such an upsetting home all of the time, and my brother said he'd go to the judge, and when I was 29, they'd take me. I lived in fear all the time! (Pause) I went to church, and I tried to read the Bible, and to--pray and--I took care of children. And a--and my dad would always say mean things to my mother and I tried to help and do what I could but... (Silence) (Sighs)

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.

Example:

C: It's gettin' so I can't even--can't even sleep at night anymore--roll and toss all, toss all night long...

T: Pretty upset?

C: Oh, well, just lay there and think of everything--and some of the guys that come in after I did. There, there's some of them guys what of gone home, 'n' I'm still in here.

T: It's sort of up to you when you, as to when you go.

C: You can't do anything?

T: Well, I said, I sort of feel you have been--ah--you've been holding down that job--you still work in the kitchen, don't ya?

C: Yeah. (Mumbles)

T: Okay, but you--you been holding that job, and you have your card, well, okay. You fouled up somewhere, but you'll have your card again. And, well, you, in a sense showed the staff that you can handle these things, without getting into difficulties, you are on your way home.

C: That doggone kitchen detail, detail--seven cents a day--just ta scribble a bunch of junk. (mumbled)

T: Well, you're sure as hell not gonna get rich on it--What about this trouble, talking about money--what about this trouble you were raising the last time? About borrowing some money from this gal, have you come to any decision on that?

C: Well (pause) I'd rather not say, I ain't gonna say nothin' as long as that tape recorder's on.

T: Want me to turn it off for a while?--It's a part of the project. That's why I sort of feel it's your responsibility to--to record these things.

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 repress 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.

Example:

T: One thing that occurs to me is I'm so glad you came. I was afraid you wouldn't come. I had everything prepared, but I was afraid you wouldn't come. (Pause)

C: What--would you have thought of me then? I guess maybe I shouldn't have, but I did anyway (Rapidly)

T: Is that--like saying, "Why or what?" But, partly you feel--maybe you shouldn't have come--or don't know if you shouldn't or "not should." There's something about--feeling bad that could make you--not want to come. I don't know if I got that right, but--because if you feel very bad the--then, I don't know. Is there anything in that?

C: Well--I've told you before, I mean, you know, two things that, when I feel bad. I mean one that always--I feel that there's a possibility, I suppose, that, you know, that they might put me back in the hospital for getting that bad.

T: Oh, I'd completely forgotten about that, yeah--yet, and that's one thing--But there is another?

C: Yeah, I already told you about that, too.

T: Oh, yeah, you sure did--I'd forgotten about it--and the other you've already said, too?

C: I'm sure I did tell it. (Pause)

T: It doesn't come. All I have when I try to think of it is just the general sense that if you feel--very bad, then it's hard or unpleasant to--but, I don't know--so I may have forgotten something--must have. (Pause)

C: You talk--you always, hear what I'm saying now, are so good at evading me, you always end up making me talk anyway...

T: You're right.

C: You always comment on the question or something, and it just doesn't tell me.

T: (Interjecting) Right, I just instinctively come back--to you when I wondered--what I, well like saying, because--that's what I felt like saying. You mean to--you mean to say that a few minutes ago we had decided that I would talk...

C: Well, you--you mentioned it, but (T: Right) that's as far as it got.

T: You're right--and I just--was thinking of what you're asking--I'm more interested in you right now than anything else.

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.

Example:

T: And I can sort of sense--and when you want to, when you feel like it, I'd be glad if you shared some of those....

C: What? (Abruptly)

T: I said, when you want to, and when you feel like it, I'd be glad if you shared some of those feelings with me...

C: (Breaking in and speaking with therapist) Why, why--whoa, whoa, whoa....

T: (Continuing) I'd like to just sort of see'm...

C: Why, you gettin' rich off this silent character or somep'n or what 'laugh) Ten, fifteen, twenty dollars an hour? (Loudly) Then he just sits here--an' that's it, huh? Oh, I know. (Mumbling)

T: I'd say that--that's a good point--what'ya mean? (Softly) (Laughs)--I sometimes get paid fifteen, twenty dollars an hour, but that, I'm not getting paid....

C: (Interjecting loudly, overtalking therapist) Why, the state's paying ya' that now, ain't they?

T: Not for you, no. I thought you might think that.

C: Who is, then? (Insistently)

T: No, I get a salary from the University for doing research. (calmly)

C: Oh--research! (Incredulously)

T: Mhm. (Pause)

C: I think that's just a--roundabout way to put it--th--that's what, that's what I think.

T: Well, let's put it this way; I get it, but--I get exactly the same salary whether--I see you or not. (Gently)

C: Oh, there, there probably is a--there probably is a--that type doctors there, but--uh, but I wouldn't call it research! (Scornfully) I, I, I, I, I, I, I, I, don't know, I don't know. I don' care--I don'--I...(Ending in angry confusion).

T: (Speaking with conviction) Well, I'd like you to know--that, that's not research.

APPENDIX B

RATER_____

CLIENT NAME _____

SEGMENT NO._____ BEGINS AT_____ ENDS AT_____

SEGMENT BEGINS WITH_____ENDS WITH_____

LIKING SCORE 0 1 2 3 4 5

EMPATHY SCORE 1 2 3 4 5 6 7 8 9

SEGMENT NO._____ BEGINS AT_____ENDS AT_____

SEGMENT BEGINS WITH_____ENDS WITH_____

LIKING SCORE 0 1 2 3 4 5

EMPATHY SCORE 1 2 3 4 5 6 7 8 9

SEGMENT NO._____ BEGINS AT_____ENDS AT_____

SEGMENT BEGINS WITH_____ENDS WITH_____

LIKING SCORE 0 1 2 3 4 5

EMPATHY SCORE 1 2 3 4 5 6 7 8 9

APPENDIX C

FIG. I: FREQUENCY OF SCORES ON LIKING SCALE FOR 36 CLIENT-THERAPIST PAIRS

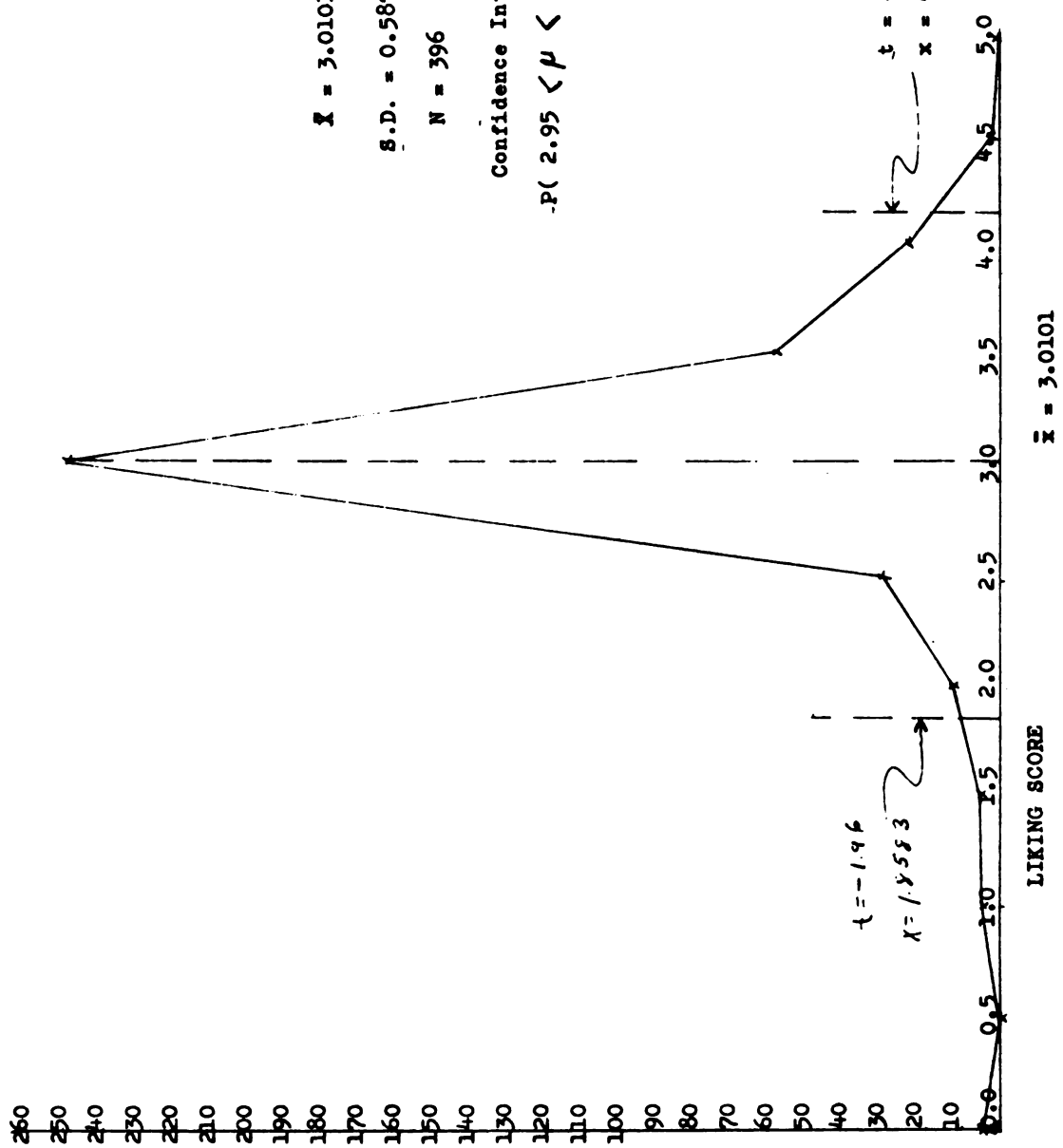

FIG. II: FREQUENCY OF SCORES ON THE EMPATHY SCALE FOR 36 CLIENT-THERAPIST PAIRS

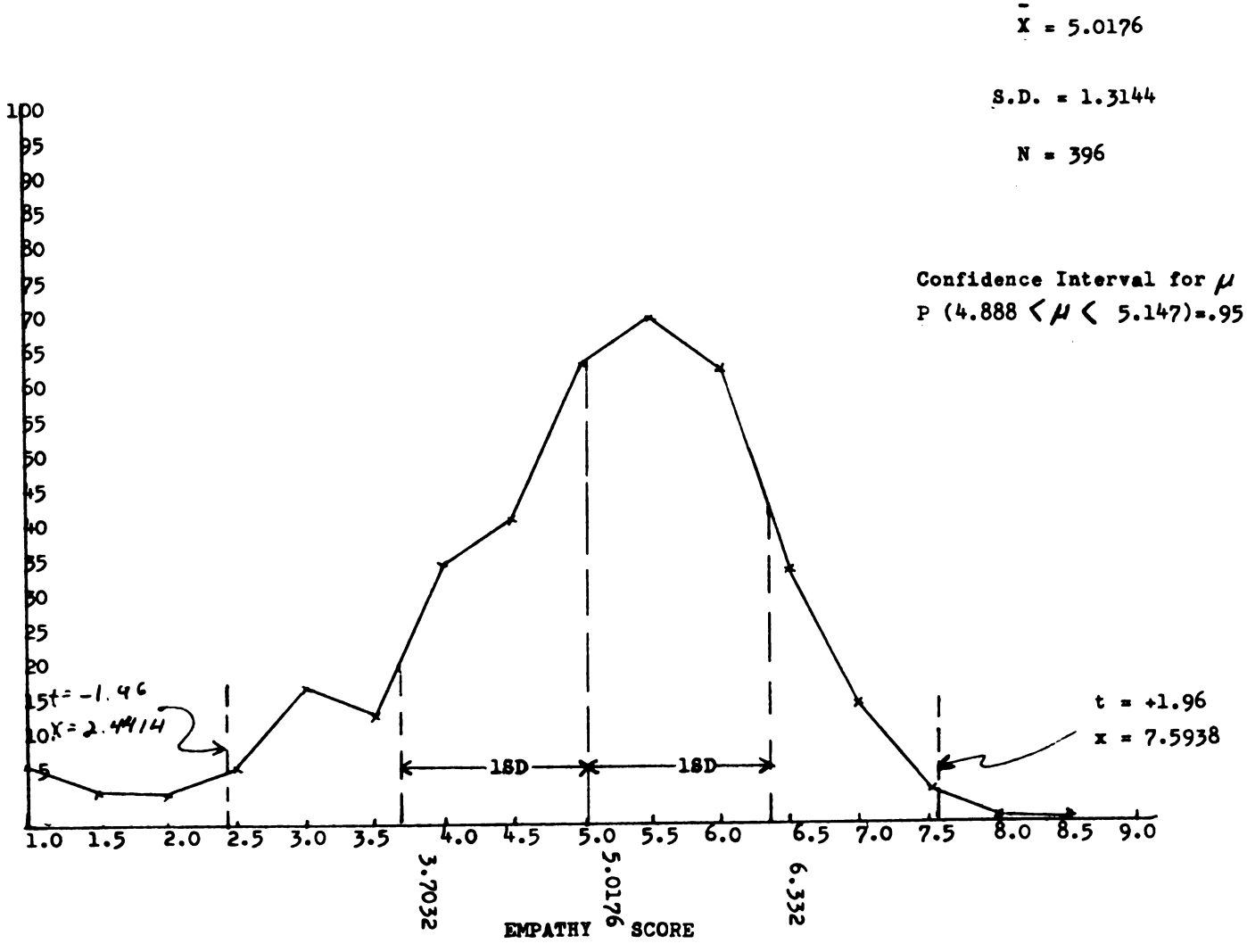

FIG. III FREQUENCY OF VALUES ON LIKING FOR "SUCCESSFUL" AND "UNSUCCESSFUL" CASES

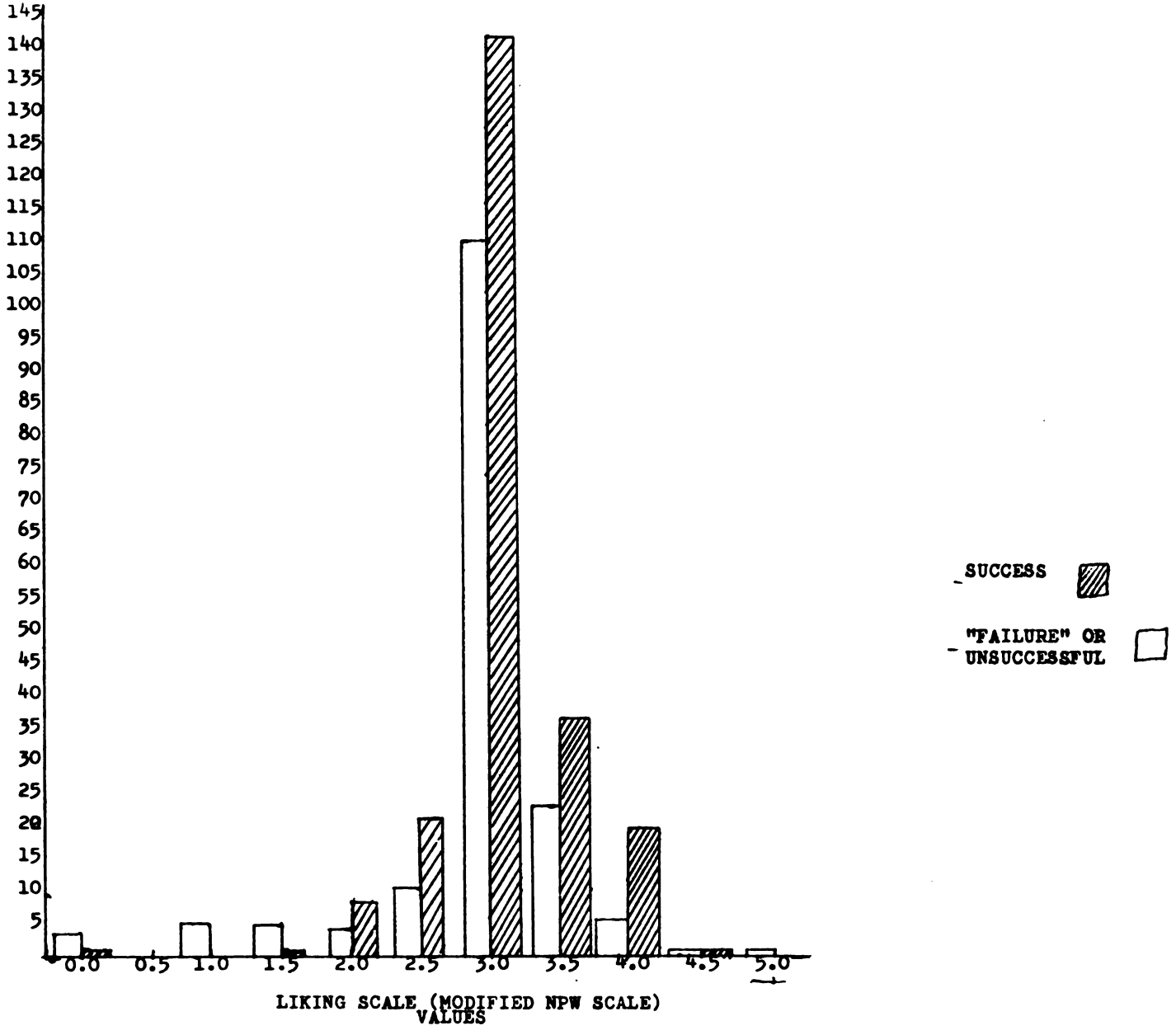

FIG. IV FREQUENCY OF VALUES ON EMPATHY FOR "SUCCESSFUL" AND "UNSUCCESSFUL" CASES: