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THE USE OF THE INTERPERSONAL PROCESS RECALL (IPR) MODEL VIDEOTAPE AND STIMULUS FILM TECHNIQUES IN SHORT-TERM COUNSELING AND PSYCHOTHERAPY

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By

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ABSTRACT

THE USE OF THE INTERPERSONAL PROCESS RECALL (IPR) MODEL VIDEOTAPE AND STIMULUS FILM TECHNIQUES IN SHORT-TERM COUNSELING AND PSYCHOTHERAPY

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The purpose of this study was to evaluate the effectiveness of using the Interpersonal Process Recall (IPR) model in counseling and psychotherapy. IPR videotape and stimulus film techniques were used as therapeutic interventions in combination with traditional dyadic treatment methods and compared with the use of the traditional treatment methods without IPR techniques. The basic question underlying the research project was whether clients who experienced IPR interventions would improve more than clients who did not experience IPR techniques in a range of 4 to 15 sessions.

The sample for this study consisted of 50 volunteer undergraduate and graduate clients who had requested help with personal concerns from the staff of the Georgia State University Counseling Center during the 1976/1977 academic year. Therapists were three counseling and clinical psychology staff interns and two staff therapists, all of whom regularly saw clients at the Center.

The experimental design used was a pretest-posttest control group design. The experimental group consisted of 25 clients who

received traditional counseling with the addition of IPR videotape feedback and stimulus film techniques. The control group consisted of 25 clients who received traditional counseling alone. Each therapist saw 10 clients, 5 in each treatment group. Clients were matched according to sex and time of entry into treatment and then randomly assigned to the treatment groups. The number of 50-minute treatment sessions for each client ranged from 4 to 15. The mean number of sessions completed per client was 10.4 for IPR clients and 8.1 for traditional clients.

For the IPR treatment clients, therapists were allowed to select the IPR techniques which they believed best suited their clients' individual needs. During the first 10 sessions, IPR techniques had to be used in a minimum of 50% of the sessions, and they had to be used in at least every other session or in two consecutive sessions followed by two traditional sessions. During the 10th through the 14th sessions, an IPR technique had to be used at least once. The techniques could have been used more if desired.

The measures used in this study included client self-report questionnaires and inventories, therapist questionnaires, and objective tape ratings of in-therapy client verbal behaviors.

The data were analyzed by multivariate and univariate analysis of variance procedures. Prior to the final between treatment group analyses, however, bivariate linear regression analyses for each subscale of each instrument were performed in order to obtain adjusted posttest scores free of pretest score differences. Significance testing was carried out at the .01 level. The results of the analyses

indicated no significant differences between treatment groups on any of the six measures.

Repeated measures multivariate and univariate analysis of variance procedures were also performed on the pre to post raw scores. The results indicated that there was significant pre to post movement ($p < .001$) for clients in both treatment groups on measures of client and therapist satisfaction within the counseling sessions and on measures of client self-actualization, but not on the in-therapy measures of client verbal behaviors. Clients indicated that they achieved 76% of their goals, and therapists rated their clients as achieving 70% of their goals at the conclusion of their counseling sessions.

IPR treatment clients who responded on a subjective comments form were generally very positive about the use of the videotape and stimulus films in their sessions. Therapists evaluated the IPR intervention techniques as beneficial, but they stated that maximum effectiveness from using the techniques can be achieved only with a great amount of therapeutic freedom and flexibility.

To my parents,

who both cared and valued education

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CHAPTER I

INTRODUCTION

Purpose

The purpose of this study is to evaluate the effectiveness of using Interpersonal Process Recall (IPR) videotape and stimulus film techniques along with traditional treatment methods in counseling and psychotherapy. This study is a modified replication of two earlier investigations (Schauble, 1970; Van Noord, 1973; Van Noord & Kagan, 1976). It incorporates recommendations made by these two authors; e.g., the sample size has been increased, the range of sessions has been lengthened, and flexibility has been introduced into the treatment design. The use of the IPR model along with traditional treatment methods is compared with traditional treatment methods used alone.

The Problem

Individuals with mental health problems have sought and received assistance from "helping" professionals from as early as 4,000 to 5,000 years ago. A surgical procedure was performed at that time which consisted of boring a hole in the skull and removing a portion of the bone. It is believed that this was done to liberate evil spirits which were supposedly causing the undesirable symptoms. Some reports suggest that the mortality rate may have been as low as 10%!

Although such treatment may have been acceptable 5,000 years ago, it was inevitable that intervention techniques would undergo certain refinements. Treatment methods advanced through shamanism and demonology to the nineteenth-century work of Joseph Breuer and Sigmund Freud, who found that certain key mental symptoms could be eliminated when patients talked of the circumstances surrounding the formation of the symptoms. This process was called a "talking cure" or "cathartic therapy." The "talking cure" process developed into the different therapeutic styles and techniques that therapists offer their clients today, along with, of course, drug therapies and behavior therapies.

While clients and therapists have offered convincing testimonials on the benefits of psychological treatment, it has been necessary that treatment methods be experimentally investigated in order that their effectiveness be proven. Many controlled evaluations of psychotherapy and counseling have offered support that such treatment does in fact work, though the issue is still debated. Summaries of such research are reviewed in the next chapter. As an example, Smith and Glass (1977) reviewed 400 controlled studies on psychotherapy and counseling and found that on the average the typical therapy client is better off than 75% of untreated controls. These authors did not find, however, any convincing evidence that one type of psychotherapy is better than another.

Researchers today are, on the whole, no longer asking if psychotherapy and counseling work, since this has been demonstrated. Rather, they are focusing upon the meaning of improvement with a stress on specificity (Bergin, 1971). What is needed today is further

examinations into what patient, therapist, and technique variables are important as determinants of client movement and growth (Gomes-Schwartz, Hadley, & Strupp, 1978). As part of the trend toward specificity, new techniques need to be developed and their effectiveness demonstrated (Bergin & Strupp, 1970).

Interpersonal Process Recall is a relatively new intervention model that has been used in counseling and psychotherapy. IPR includes the use of videotape feedback in the presence of an inquirer who facilitates the recall of thoughts, feelings, intentions, etc. It also includes the use of stimulus films to facilitate discussions of feelings, interpersonal stereotypes, and interpersonal problem areas. The original developmental research on IPR found that it was effective in accelerating and continuing client movement and growth (Kagan, Krathwohl et al., 1967).

Hartson and Kunce (1973) investigated the IPR model in group work and found it to be beneficial to socially inactive subjects who had low self-esteem. They did not find it to be significantly beneficial to socially active, high self-esteem subjects. Kingdon (1975) explored the use of IPR as a supervisory model and found that it significantly changed clients' levels of self-exploration over time, but that it did not produce differential effects in therapist empathy levels, client satisfaction, or clients' self-reported inhibition.

Schauble (1970) did a controlled study with 12 female undergraduate college counseling center clients and found that a structured sequencing of the IPR techniques did result in significantly greater client movement on process and relationship measures than

was observed on control clients. This study was then replicated with minor variations without finding any significant results (Van Noord, 1973; Van Noord & Kagan, 1976).

It is evident that the use of the IPR model in counseling and psychotherapy needs to be further examined. The current study is an attempt to replicate Van Noord's and Schauble's studies with certain major modifications, specifically, increasing the sample size, increasing the range of treatment sessions, and introducing flexibility in the use of the IPR techniques in an attempt to further our understanding of the effectiveness of the IPR model as a therapeutic tool. It is hoped that this research will stimulate further investigations toward more specificity, such as examining which IPR techniques work best with what types of clients at which stages in the therapeutic process.

Definition of Terms

Special terms used in this study are defined as follows:

1. Interpersonal Process Recall (IPR): The term used to describe the process of recording on videotape (e.g., the counseling relationship) and playing back the videotape for a recall and examination of the original experience. An additional person in the role of the "inquirer" facilitates this process. In this study the IPR model includes both the use of videotape recall and the use of stimulus films. Specific components of IPR that were used are described below.

2. Stimulus Films: These are short vignettes which are designed to simulate various kinds and intensities of emotional stress. The films are structured so that a filmed actor looks at clients and confronts them with various interpersonal stress situations. Client reactions to such situations then become the focus of the counseling sessions. This technique has also been called affect simulation in previous research.

3. Videotape Recall of Stimulus Films: Clients are videotaped while viewing the stimulus films, and the clients' videotaped reactions to the films become the focus of the counseling sessions.

4. Client Recall: A counseling session is videotaped. The counselor then either leaves the session temporarily or watches the recall through a one-way mirror or from an unobtrusive position in the room. The client reviews the videotape of the session with the aid of an inquirer.

5. Mutual Recall: A counseling session is videotaped. The counselor and client both review and videotape with the aid of an inquirer.

6. Significant Other Recall: A client and a significant other (without the counselor) are videotaped while discussing something meaningful in their relationship. The therapist then enters the room and functions as an inquirer for either the client alone or both the client and significant other while the videotaped session is reviewed.

7. Inquirer: The third person whose function it is to facilitate the videotape recall of a taped session. This person acts in an assertive yet nonjudgmental manner to assist either the client

alone (client recall) or the client and counselor together (mutual recall) to discuss reactions and recalled feelings, thoughts, images, intentions, etc. In previous research this role has been termed "interrogator." Schauble (1973) has called it the "Interpersonal Process Consultant," and the terms "recaller" and "recall worker" are also used.

8. Counseling, Psychotherapy, and Therapy: While a distinction between these terms in certain settings is valuable, they are used synonymously in this study. For the nature of treatment received by clients in this study, it is believed that ". . . there is no difference in the methods or techniques used" (Patterson, 1959, p. 11). Meltzoff and Kornreich (1970) have defined the treatment as follows:

> Psychotherapy is taken to mean the informed and planful application of techniques derived from established psychological principles, by persons qualified through training and experience to understand these principles and to apply these techniques with the intention of assisting individuals to modify such personal characteristics as feelings, values, attitudes, and behaviors which are judged by the therapist to be maladaptive or maladjustive (p. 6).

9. Counselors and Therapists: These terms are used synonymously in this study. They refer to professionally trained mental health workers who administer treatment in the form of counseling and psychotherapy.

Delimitations of the Study

The following factors delimit the generalization of the results of this study.

1. The subjects used in this study were undergraduate and graduate students enrolled at an urban southeastern university (Georgia

State University, Atlanta, Georgia) who came to the Counseling Center for help with personal problems. Their ages ranged from 17 to 37 years, with mean age of approximately 25 years.

2. The subjects were volunteers, and, therefore, the sample does not represent a random selection from the university population of students who seek counseling center help.

3. The subjects' problem areas were personal-social in nature rather than educational, vocational, or academic. They were not considered to be actively suicidal, severaly confused or disorganized, or in an extreme crisis situation.

4. The subjects were seen in counseling sessions that ranged in number from 4 to 15. This represents very short-term treatment.

5. The therapists were volunteer staff counselors who were given a 5-hour training program on the use of IPR techniques in counseling. None of the therapists had prior experience with the IPR model in a therapeutic situation.

6. Although flexibility was allowed in the use of the IPR model, the study did not examine the differential effects of the treatment program on different individuals with specific personality characteristics and problems.

Assumptions of the Study

The following assumptions were made in the present study:

1. That clients are capable of emotional, cognitive, and behavioral learning and growth in the dyadic therapeutic process and consequently can be helped to change in a positive direction.

2. That client movement and growth can occur in short-term therapy within a range of 4 to 15 sessions.

3. That client movement and growth can be validly and reliably measured by client self-report questionnaires and inventories, therapist questionnaires, and tape ratings from audiotape samples of the therapy sessions.

4. That clients' intratherapeutic growth will generalize to their extratherapeutic environment.

General Hypotheses

General hypotheses for this study are stated here. Specific research hypotheses are stated in Chapters III and IV.

1. Clients who receive personal counseling combined with IPR interventions will score higher on a measure of self-actualization, a correlate of mental health, than will clients who receive personal counseling without IPR.

2. Clients who receive personal counseling with IPR interventions will evidence more growth on rated therapy session process dimensions than will clients who receive personal counseling without IPR.

3. Clients who receive personal counseling with IPR interventions will be more satisfied with their experiences in counseling than will clients who receive personal counseling without IPR.

4. Clients who receive personal counseling with IPR interventions will achieve a higher percentage of their goals in counseling than will clients who receive personal counseling without IPR.

Theory

The theoretical framework that is used with the IPR model is an interpersonal theory of communications. Theoretical constructs have been discussed by Kagan (1975b, 1976), who was primarily responsible for the development of the IPR film "package." These constructs were included in the film series as a means of providing a cognitive basis in order to increase skill development in IPR communication training programs. They are viewed by Kagan as helpful but not crucial to acquire learning from the model. In this section there will be a general discussion of interpersonal theories followed by a more specific discussion of theoretical concepts which relate to different IPR videotape and stimulus film techniques that were used with the experimental counseling group in the current study.

Traditional Freudian psychoanalytic theory stresses the importance of an individual's early psychosexual development and the effect it has on later personality characteristics, the importance of basic instincts, and the irrational and unconscious sources of behavior. As the theory evolved through Jung, Adler, and Rank, however, contemporary social conditions were increasingly believed to be additional determinants of the personality structure.

Karen Horney (1937), in noting differences in neurotic symptoms of 19th century Europe as compared with those of 20th century United States, became convinced that individual differences could not be explained on a purely biological and instinctual basis. Whereas Horney recognized the importance of parent-child relationships, she also believed that other interpersonal relationships were important

and that problems in living evolve from emotional conflicts and anxieties in these relationships. The formation of the neurotic personality was viewed by her as involving both intrapsychic and interpersonal (cultural) factors. In reacting to feelings of loneliness, helplessness, and a potentially hostile world, Horney theorized that the child can develop interpersonal attitudes toward parents that are either compulsively submissive, aggressive, or detached. These attitudes can then develop into characterological defenses and interpersonal styles of either self-effacement, narcissism, or resignation, which function to avoid the experience of anxiety. Difficulties arise because such defenses prevent the interpersonal closeness through which basic interpersonal needs, such as love, affection, and security, can be satisfied.

The individual who is best known for developing a theory of interpersonal relationships is Harry Stack Sullivan. Sullivan (1953) defined psychiatry as the study of interpersonal relations that are present in observable behaviors. Although he did not discount traditional intrapsychic Freudian dynamics, he believed that an individual could only be understood within the context of family, friends, and a broader social group. In treatment this theoretical basis is believed to be important because a client's responses to a therapist will be affected by past and present interpersonal relationships. The thoughts and feelings which are expressed toward the therapist will to some extent be displacements of thoughts and feelings from relationships not only with parents but also with other people. Sullivan believed that the therapist must become a participant and be

actively involved in the client's exploratory process and yet simultaneously be an observer of the interpersonal trends of which the client is unaware.

Sullivan viewed anxiety similar to the way in which Horney did. He thought of it as being a basic determinant in the development of the personality structure. Sullivan particularly stressed the role that anxiety is believed to play in current interpersonal relationships. An individual's response to anxiety in the therapeutic process is assumed to be central to understanding defenses and interpersonal patterns.

Kell and Mueller (1966) and Kell and Burrow (1970) also stressed the importance of understanding the role that anxiety plays in their theory of the interpersonal therapeutic situation. Kell and his associates believed that the therapist must become a participant with clients in the therapeutic process as well as an observer of interpersonal dynamics. The anxiety which clients experience with the therapist is seen as a usual accompaniment of behavioral change. Anxiety results from changes in the individual's emotional homeostasis, and such emotional changes with the accompanying anxiety are the initial stage for changes in attitudes, changes in cognition, and finally changes in behavior. Because the experience of anxiety is unpleasant to clients, however, they are theorized as being ambivalent about changing. They seem to present their typical defensive patterns to the therapist to resist changing until they are willing to be vulnerable and trust their therapist's adequacy. Clients are then likely to be ready to risk the intimacy which will hopefully

lead to new and positive emotional experiences followed by new and constructive interpersonal beliefs and behaviors.

The interpersonal theories of personality change appear to provide the most suitable theoretical rationale for the mechanisms by which the IPR techniques used in this study are believed to contribute to client movement and growth. Whereas these theories acknowledge the importance of early familial relationships in the development of the personality, they stress the client's present interpersonal relationships, including the relationship with the therapist. Anxiety is viewed as central to the client's problems in interpersonal relationships, with the client demonstrating ambivalence and approach-avoidance conflicts in an attempt to satisfy needs with the least amount of anxiety. Of particular importance in the interpersonal theories is the assumption that clients can change, and that change can occur as a result of the interpersonal therapeutic process through emotional, cognitive, and behavioral relearning. In the following section the recall process, the inquirer role, and the use of stimulus films are discussed with respect to relevant theoretical concepts.

The Recall Process

At the heart of the IPR methodology lies the recall process, in which a portion of the counseling session is videotaped and then immediately replayed for viewing by either the client alone (client recall) or the client and therapist together (mutual recall) with the aid of a third person who is called the inquirer. Possible reasons for the assumed effectiveness of recall are stated here.

One reason for using videotape recall is that it provides the client with what seems to be a neutral source of feedback. Although a therapist, family, and friends can also provide feedback, their statements can be more easily distorted due to transferential issues underlying the relationships. The videotape, on the other hand, is objective, and, if clients wish to examine it in depth, they can view their interactional behaviors and explore covert processes behind them. As the therapy progresses, clients can take risks and try out new ways of interacting with their therapist. Learning theory stresses the need for feedback in learning new behaviors, and the videotape appears to be an accurate way for the client to get such feedback.

As mentioned above, interpersonal theories of personality focus on the interpersonal patterns and defenses of clients as manifested in the relationship with the therapist. For change to occur, these defenses must be weakened and anxiety experienced by clients in a trusting relationship with the therapist. This is assumed to allow for the possibility of emotional, cognitive, and behavioral relearning. The videotape is believed to provide clients with a means of examining their relationship with their therapist with the safety of knowing the outcome, since the portion of the session they are examining has already occurred.

With the aid of the videotape, clients can pause, examine, and reflect upon the relationship that they have with their therapist. It is theorized that they can learn that they may focus much energy on current interactions with their therapist even though they may be

discussing third-party concerns outside the dyadic relationship. It is also theorized that they can learn that they may attempt to elicit certain responses from their therapist in order to control the way the therapist (and others) responds to them. Following this learning, it is assumed they can decide whether or not these eliciting behaviors are effective or ineffective in satisfying their wants and needs and whether or not they want to change the behaviors.

In client recall, it appears to be important that clients can examine their interpersonal patterns with the help of an inquirer but without the apparent threat of having to relate directly with their therapist. Although the therapist may be watching the session through a one-way mirror, and although clients are aware that the therapist is doing so, they are perhaps less likely to avoid areas of stress which were avoided in the original therapy session. They can review the videotaped session in a manner that is presumed to cause less anxiety, and, therefore, they are believed to be freer to be honest and own up to their covert processes. If the therapist does decide to observe the client's recall, the client's observations and discoveries can hopefully be integrated into therapeutic strategies for helping the client.

In mutual recall, on the other hand, it is hoped that clients can risk describing to their therapist their observations about their relationship. In going over a previous portion of a session, clients can check out perceptions of why they believe their therapist relates to them in certain ways, and they can request verbal feedback from their therapist about the effects of their interpersonal patterns

and defenses at specific points on the videotape. Mutual recall fits well into the interpersonal theories because it appears to allow for a more egalitarian therapeutic relationship than was provided by traditional theories with more authoritarian and detached therapist styles.

With the aid of the videotape and the inquirer, it is believed that trust can be developed sooner, and the client can then be more vulnerable to experience and differentiate prior emotions and thoughts which affect current interpersonal relationships. It is also believed that videotape can assist clients in internalizing and taking responsibility for their behaviors and behavioral changes because the feedback appears to be more neutral and can, therefore, be less easily denied or rationalized.

In significant other recall, where clients review a tape of an interaction between themselves and someone such as a spouse, parent, or close friend, it seems that clients can reflect upon and examine their interpersonal behaviors and the accompanying covert processes in an established relationship. Again, the videotape feedback appears to aid clients in internalizing and in taking responsibility for their interpersonal behaviors, as well as providing a tool for uncovering the meaning associated with approach-avoidance patterns and the anxieties underlying these patterns.

The Inquirer Role

Whereas videotape feedback is used as a therapeutic tool by many individuals in various ways (Berger, 1978), the inquirer role is

unique to the IPR model. The inquirer is a third person whose function it is to facilitate the client's recall (or both the client's and the therapist's recall) and self-analysis of underlying feelings, thoughts, images, expectations, and risks in the therapeutic process. The role of the inquirer is theorized as being important because the inquirer is relatively neutral and does not attempt to enter into another ongoing relationship with the client. Rather, it is the inquirer's function to assist the client (or the client and the therapist) in recalling and examining the previous session between the client and therapist.

It is intended that the inquirer will help the client learn from the recall through an active but nonjudgmental probing of the client's thoughts and feelings as they review the videotape. This procedure seems to channel the client's energy into self-analysis and self-learning. It is likely to bypass any effort the client may exert to manipulate and control the current relationship between the client and the inquirer, which, if it did occur, could be a further attempt by the client to externalize problems and avoid internal change. This process can bring forth anxious feelings in clients, however, because they must focus on the immediate past relationship with the therapist in an introspective manner. Clients are not allowed to ramble on about external relationships or material not discussed on the videotape as a possible defensive maneuver which could serve to avoid self-analysis. By examining the relationship with the therapist and avoiding another active ongoing relationship with their inquirer, it seems that clients can take the time to reflect upon

their behaviors and learn that they must take responsibility for changing their environment.

The inquirer role fits into interpersonal theories because it appears to be a means of aiding the client in discovering patterns of relating, anxieties, and possible ineffective displacements of thoughts and feelings from past relationships into the current relationship with the therapist. In mutual recall the inquirer is intended to facilitate the logical movement from what seems to be the relative safety of the past, recalled interaction between the client and the therapist to the more risky current interaction between them. It is theorized that clients can then learn to discuss openly their feelings and thoughts about the therapist and the therapeutic relationship directly with the therapist. They hopefully can become more intimate, more vulnerable, less defensive, and then can experience the accompanying anxiety in a safe environment. With new emotional outcomes in the relationship with their therapist, it seems that clients can then restructure their belief systems and begin to try out new ways of behaving.

Stimulus Films

In addition to the videotape recall process, the IPR model as implemented in this study included the use of stimulus films. These films are a series of short vignettes made up of professional actors who look directly at the viewer and display different types of emotions with varying degrees of intensity. The initial development of the films (Danish & Kagan, 1969; Kagan, Krathwohl et al., 1967;

Kagan & Schauble, 1969) occurred as a result of an evaluation of the IPR videotape recall process. It was observed that videotape recall was much more effective in those sessions where the client-therapist interaction was intense and where the client discussed problems and experienced feelings of a significant nature. For those sessions in which the client-therapist interactions were rather bland and lacking in emotional depth, it was speculated that it would be beneficial to first expose the client to various kinds and degrees of interpersonal risks. Whereas role playing and real-life acting may have been too risky for the clients, filmed actors seemed to be effective stimulants in getting the clients to discuss interpersonal problem areas and generalized stereotypes of interpersonal situations in which they did not discriminate or allow for differences between events or persons. It was theorized that the vignettes would help clients to experience feelings and discuss them with their therapists in the safety of the therapeutic environment. Clients could either view the vignettes and discuss their reactions with their therapist, or they could be videotaped while watching the vignettes and then use the tape for a recall of thoughts and feelings with the assistance of the therapist functioning in part as an inquirer.

The stimulus films were used in this study with clients partly because they are an integral component of the IPR model, and it was the IPR model as used in counseling which was evaluated in this study. As with the original developers of the model, however, it was assumed by the investigator that the use of videotape recall may not be effective or appropriate with all clients, particularly at the

beginning stages of therapy. For those clients who appear to be too threatened by seeing themselves on videotape, or who seem to be unable to participate in the self-analysis process, the stimulus films are intended to provide a means for clients to gradually begin talking about and experiencing feelings. By responding to filmed actors, it is theorized that clients are allowed to maintain their defenses and their control of the therapeutic situation and yet begin movement toward becoming more vulnerable, less defensive, and more trusting with their therapist. During this time it is hoped that the therapist will convey to the client a willingness to deal with the client's affects in depth. It is likely that the therapist will also be able to use the films diagnostically to determine which areas of interpersonal stress seem to produce anxiety in the client. The use of the stimulus films in therapy can be supported by the theoretical framework of the interpersonal theories because of the emphasis on the need to look at a client's problem areas in terms of interpersonal relationships, past and present. It is theorized that the stimulus films allow the clients to gradually let down their interpersonal defenses and experience anxiety with their therapist in order that they can undergo emotional, cognitive, and behavioral relearning, which is then followed by behavioral change.

Overview

In this chapter the purpose and problem were presented, terms were defined, and limitations, assumptions, and the general hypotheses were stated. The interpersonal theoretical framework underlying the

IPR model was discussed along with a description of theoretical concepts which are relevant to the recall process, the inquirer role, and the use of stimulus films in counseling.

In Chapter II a review of pertinent literature and research relating to psychotherapy and counseling, the evaluation of client movement and outcome, the use of videotape in counseling and psychotherapy, and the use of IPR videotape and stimulus film techniques in counseling and psychotherapy will be presented.

Chapter III contains the methodology of the study, including descriptions of the client and therapist samples, the treatments, the instrumentation, the research design, and the data analysis.

In Chapter IV the specific research hypotheses will be stated, followed by the results of the data analysis and a summary of client and therapist subjective comments.

And in Chapter V there will be a summary, conclusion, and discussion of the results, as well as implications for further research.

CHAPTER II

REVIEW OF LITERATURE

The review of literature in this chapter will be focused on the following areas relevant to the present study: (a) psychotherapy and counseling research, (b) evaluating client movement and outcome, (c) the use of videotape in counseling and psychotherapy, (d) the use of IPR videotape and stimulus film techniques in counseling and psychotherapy, and (e) a summary, including implications of the literature.

Psychotherapy and Counseling Research

Since 1952, when Professor Hans Eysenck made his original claim that there was no evidence that psychotherapy with neurotics was any more effective than no treatment at all (Eysenck, 1952), clinicians and researchers have been determined to reevaluate his conclusion through further investigation in order to find out if psychotherapy does in fact work. There have since been several major reviews of psychotherapy outcome studies, all of which have disputed Eysenck's original claim (Bergin, 1971; Bergin & Suinn, 1975; Gomes-Schwartz, Hadley, & Strupp, 1978; Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971; Luborsky, Singer, & Luborsky, 1975; Meltzoff & Kornreich, 1970; Smith & Glass, 1977).

Bergin (1971) reviewed Eysenck's original and subsequent outcome evaluations in which Eysenck attempted to show that two-thirds of all neurotics who enter therapy improve within two years and that two-thirds of neurotics who do not enter therapy also improve within the same time period. Bergin found that much of the original data were ambiguous, and he demonstrated that different rates of improvement can be calculated depending upon one's particular bias. His results indicate that the average therapy improvement rate is 65% and the spontaneous improvement rate is 30% (compared to Eysenck's 67% for both), which he believes is evidence for what he terms the "modest" positive effects of psychotherapy. Bergin then goes on to point out that many factors contribute to the so-called "spontaneous" remission phenomena, stating that subjects used in no-treatment control groups are really not controls at all because they often seek therapeutic help during the waiting period from other professionals (e.g., physicians, clergymen, teachers) and nonprofessionals (e.g., spouses, friends, fellow workers), as well as engaging in self-help procedures.

In reviewing more recent outcome literature, Bergin (Bergin & Suinn, 1975) again finds evidence for the positive effects of psychotherapy with the improvement rate averaging about 67%. He also states that there is a deterioration rate of about 10%. Compared with controls, there is a significant increase in the variability of criterion scores at posttesting in the treatment groups (Bergin, 1971). Thus, although psychotherapy has something unique about it that contributes to positive change in most clients, it can also cause

deterioration, which possibly would occur with fragile or very disturbed clients who are treated by inexperienced or incompetent therapists. More research needs to be done in this area, however, for there is no definitive evidence concerning which types of clients deteriorate under which types of treatment.

Meltzoff and Kornreich (1970) reviewed 101 individual and group outcome studies, and they found that 80% yielded positive results. They conclude:

> In short, reviews of the literature that have concluded that psychotherapy has, on the average, no demonstrable effect are based upon an incomplete survey of the existing body of research and an insufficiently stringent appraisal of the data. We have encountered no comprehensive review of controlled research on the effects of psychotherapy that has led convincingly to a conclusion in support of the null hypothesis. On the contrary, controlled research has been notably successful in demonstrating significantly more behavioral change in treated patients than in untreated controls. In general, the better the quality of the research, the more positive the results obtained (p. 177).

Luborsky et al. (1971) reviewed 166 outcome studies of adult patients in individual psychotherapy for predictors of success. They found that although some improvement is made by all patients on the average, initially sicker patients do not improve with therapy as much as initially healthier patients. Other important patient variables contributing to positive outcome are motivation, expectation, intelligence, the presence of strong affect (such as depression or anxiety), educational and social assets, and the ability to experience feelings deeply and immediately in the therapeutic process.

In a more recent review, Luborsky et al. (1975) reach what they call the "dodo-bird verdict," a phrase from Alice in Wonderland

representing the belief that it is usually true that "everybody has won and all must have prizes." By this they mean that controlled comparative outcome studies indicate that a high percentage of patients who have psychotherapy do in fact benefit from it. However, they also state that there is no evidence that any one form of psychotherapy treatment is any better than another. This, they suggest, may be a result of a common element in all treatments, e.g., that of the helping relationship with a therapist. Or it may be that when psychotherapies are compared with each other and they all achieve a high percentage of improved patients, it is difficult for any single form of psychotherapy to show a significant advantage.

Smith and Glass (1977) reviewed 400 controlled evaluations of psychotherapy and counseling. Their results were similar to previous reviews, finding that on the average the typical therapy client is better off than 75% of untreated controls. And although they found evidence to support the claim that psychotherapy does help, they did not find any important differences in effectiveness among different types of therapies.

There is a great deal of evidence, therefore, to dispute Eysenck's original claim that psychotherapy research does not support the effectiveness of psychotherapeutic treatment. Eysenck continues to be skeptical, however, for in the May 1978 issue of the American Psychologist, in a response to Smith and Glass (1977), he stated, "I would suggest that there is no single study in existence which does not show serious weaknesses, and until these are overcome I must

regretfully restate my conclusion of 1952, namely that there still is no acceptable evidence for the efficacy of psychotherapy" (p. 517).

From the results of the above reviews of psychotherapy outcome research, it appears that something happens in psychotherapy and counseling to contribute to positive effects in treated clients, although the basic issue is still debated. What actually happens to bring about beneficial results, if any, is unclear. The current study assumes that therapy does in fact help clients change, and the main research question here focuses on the issue of therapeutic techniques; namely, will the addition of the Interpersonal Process Recall techniques of using videotape and stimulus films in traditional therapy contribute positively to the therapeutic process in order for significantly positive effects to be observed in the therapeutic outcome?

Evaluating Client Movement and Outcome

Among the many problems in conducting psychotherapy and counseling research is the selection of suitable criteria for measuring client movement and outcome. Many criteria are currently being used for a variety of types of research, but there is no consensus concerning what are suitable or meaningful criteria (Garfield, Prager, & Bergin, 1971). If there were a common agreement on what criteria for change should be used in psychotherapy research, it would be much simpler to implement studies and compare results. Unfortunately, however, human behavior is extremely complex and complex behaviors are not easily measured. In addition to this, a researcher must make philosophical value judgments in determining phenomena to be observed

and measured (Zax & Klein, 1960), and researchers disagree concerning which phenomena are important and which can be evaluated to indicate positive change occurring as a result of the therapeutic experience.

A common distinction made is between criteria based on the client's behavior in the therapy situation, and criteria based on the client's behavior outside the therapy situation (Zax & Klein, 1960). If therapy is to be effective, it is logical to expect that certain positive changes will occur in the client's extratherapeutic world, and yet valid and reliable measures of such changes have been particularly difficult to obtain. Perhaps the most-used extratherapeutic criteria are those that are focused on relatively circumscribed individual behaviors which are recognized as central to the person's difficulty in living and easily recorded (Zax & Klein, 1960). For example, measures have been taken of job performance, school attendance, court appearances, grade point averages, and tranquilizer drug prescriptions filled. Such measures have generally been viewed as being the most relevant by the environmental or ecological psychologists. Extratherapeutic measures are also particularly relevant in the behavior therapies with problems such as circumscribed phobias, anxieties, weight control, and unassertive behaviors. Currently, such measures are seen as being increasingly appropriate in the intensive study of single cases where specific extratherapeutic goals can be agreed upon before therapy and measured after therapy (Bergin & Strupp, 1970; Gomes-Schwartz, Hadley, & Strupp, 1978).

In controlled process and outcome studies with a large number of clients in the traditional therapies, however, the use of

extratherapeutic measures has been very limited due to a host of philosophical issues involved concerning what constitutes meaningful extratherapeutic change, and also due to a wide variety of measurement problems. As Zax and Klein (1960) stated in their summary of psychotherapy research criterion measures: "The central problem here is the development of criteria of sufficient breadth that they are meaningful and representative of a wide range of functioning and yet, at the same time, circumscribed enough to be measured with reliability (p. 445).

For the current study, the literature was reviewed without finding extratherapeutic measures that are meaningful, reliable, and practical, and, therefore, it was decided that only intratherapeutic measures would be used. Internal criterion measures that have been used in psychotherapy and counseling research have been reviewed by Bergin (1971), Meltzoff and Kornreich (1970), Zax and Klein (1960), and Buros (1972).

As stated earlier, there is no consensus concerning what are the most suitable or the most meaningful criteria. A frequently used type of measure has been judgments or ratings of partial or overall client improvement made by the therapist (Garfield et al., 1971). This has the potentiality of being subjective, particularly when therapists are invested in and biased toward a certain type of client, technique, or general mode of treatment. On the other hand, it can be said that it is the therapists who really have intimate knowledge of their clients due to their direct work with them over a period of time, and, therefore, a therapist measure of client change represents

a meaningful evaluation that should be included along with other measurements.

Client self-evaluations have also frequently been used as measures of outcome or improvement (Garfield et al., 1971). These too have limitations due to possible distortions and inaccuracies that are both intentional and unintentional, consciously and unconsciously motivated (Meltzoff & Kornreich, 1970). Reviews of outcome criteria often mention Hathaway's "hello-goodbye effect," where clients attempt to exaggerate their problems at the beginning of therapy in order to get help, and then exaggerate how much they have improved at the end of therapy in order to rationalize their investment of time and money and to make their therapists feel good (Garfield et al., 1971; Meltzoff & Kornreich, 1970; Zax & Klein, 1960). Not often mentioned are the special class of clients who attempt to minimize their problems at the beginning of therapy in order to appear attractive and acceptable to their therapists, and then exaggerate their problems at the end of therapy in hopes of continuing the dependent relationship and/or to uphold their view of themselves as not being capable of improving, or not wanting to give up their symptoms due to secondary gains. Even with these limitations, however, the client is the person with the problem, and the consumer, it would seem, should be in a favored position to evaluate changes (Garfield et al., 1971).

More indirect client self-report measures have traditionally been used which are not as subject to distortion from social demands and response sets such as social desirability. The most frequently used of these in controlled outcome studies has been the MMPI, with the

D, Pt, and Sc scales being most sensitive to client changes (Meltzoff & Kornreich, 1970). A more recent instrument, the Personal Orientation Inventory (Shostrom, 1963), has been used increasingly in evaluating client changes (Bergin, 1971). This instrument has the advantage of measuring health-oriented qualities, as opposed to the MMPI, which has subscales relating to pathological dimensions.

The client-centered group of therapists and researchers developed more objective criteria of intratherapeutic verbal behaviors that can be rated by independent judges from audiotape samples of the therapy sessions. These have been used especially in measuring the so-called "core" therapist conditions of empathy, positive regard, and genuineness (Meltzoff & Kornreich, 1970). Although these criteria have been widely researched with significant results, the studies and the criteria have been increasingly criticized and the relationship of the "core" conditions to outcome has been questioned (Bergin & Suinn, 1975; Lambert & DeJulio, 1977).

Client criteria that have been measured by audiotape rating scales are depth of self-exploration (Truax & Carkhuff, 1967); owning of feelings, commitment to change, and differentiation of stimuli (Kagan, Krathwohl et al., 1967); experiencing (Gendlin, 1962); and openness and awareness (Wilkinson & Auld, 1975). Although these criteria represent areas thought to be important in client movement within therapy (process criteria), they are also believed to represent important dimensions in the client's extratherapeutic relationships, and, therefore, are appropriate measures of client growth (outcome criteria). They have the advantage of being measured by

objective observers via rating scales of audiotapes, and they therefore avoid some of the biasing limitations of therapist reports and client self-reports.

The reason no single criterion or set of criteria has been used in psychotherapy research is simply that we do not know which criterion measures most accurately reflect the true state of a client's change or lack of change. In fact, agreement among a variety of measures in single studies is often low, and it is because of this and our lack of knowledge about what constitutes true change that researchers often recommend utilizing a variety of measures in psychotherapy research (Bordin, 1974; Garfield et al., 1971). The measures used in the current study included client self-report questionnaires and inventories, therapist questionnaires, and objective tape ratings. They will be described in detail in the next chapter.

The Use of Videotape in Counseling and Psychotherapy

In recent years there has been a steady increase in the use of videotape techniques in counseling and psychotherapy. Articles dealing with this topic have appeared in a variety of publications, and reference lists which previously were typically meager are beginning to grow in size. There have been several reviews of the literature in this area which have generally been quite favorable to the use of videotape techniques in therapy, but the reviewers have stressed the need for further controlled research (Alger, 1969; Bailey & Sowder, 1970; Berger, 1978; Danet, 1968; Griffiths, 1974; Sanborn, Pyke, & Sanborn, 1975). In this section, the general use of videotape in

counseling and psychotherapy will be reviewed, and in the following section, the use of the IPR model with videotape and stimulus film techniques will be reviewed.

In the early 1940s, phonographic recordings were used by Carl Rogers and others for clinical training and research (Covner, 1942). The introduction of audiotapes made it convenient for recorded therapy sessions to be used in supervision, and the use of audiotape recordings in supervision steadily increased so that by the 1960s the videotape recorder was standard equipment in clinical training programs.

Recordings have also been used as part of the therapeutic process, and as early as 1948, Freed found that a recording of a session could be played back to a client immediately after it was made for a therapeutic self-confrontation which then led to further discussion between client and therapist. He found this to be particularly effective with children in play therapy, and also in the treatment of character disorders because subtle nuances of interpersonal behavior could easily be seen by the client, nuances which the therapist had difficulty verbalizing back to the client without the aid of recordings.

Bailey and Sowder (1970) have reviewed several published articles on the use of audiotape techniques with a variety of types of clients and patients in several settings. They report that many of these articles are filled with personal testimonials saying that audiotape playback greatly expedites the therapeutic process. They conclude that even though many therapists are personally impressed with audiotape techniques, the benefits have not been demonstrated experimentally.

Bailey mentioned his own study, in which 24 inmates at a federal women's prison were randomly assigned to either a playback group, a "regular" therapy group, or a nontherapy control group. No significant differences were found on outcome measures between groups. The playback group was, however, significantly more verbally productive than was the regular therapy group, suggesting that audiotape feedback had an effect on the process of psychotherapy but not on the outcome in his experiment.

The advent of videotape recording equipment in the 1960s allowed for the visual dimension to be added to the audio dimension in therapeutic feedback techniques. And the more recent availability of high-quality, lower cost, portable videotape equipment has made the videotape recorder a common piece of hardware in university counseling centers, private and public institutional settings, and even in private practice clinics. Many enthusiastic personal reports about the beneficial uses of videotape recall techniques have appeared in the literature for the past 20 years, but controlled studies supporting these personal claims have been lacking.

A pioneering study in the area of videotape playback was conducted by Moore, Chernelle, and West (1965) at a private psychiatric inpatient service at the University of Mississippi Medical Center. Eighty patients who were consecutively admitted were divided into an experimental group and a control group. The majority of these patients were depressive or schizophrenic women. Although both groups had psychiatric interviews which were videorecorded, only the experimental group patients viewed these recordings. The initial interviews

were 12 minutes, and subsequent interviews were 5 minutes. The experimental group always reviewed the current interview plus all previous videotaped interviews in sequence.

Despite the fact that this "videotherapy" took an average total time during hospitalization of only 60 minutes, the results were impressive: whereas 47.5% of the experimental patients were discharged as cured or greatly improved, only 12.5% of the controls were discharged as such. The average length of hospitalization was also longer for the experimental group: 24 days compared to 18 days for the controls. It is unknown how this longer average length of stay may have confounded the results. There were many methodological defects to this study, but the results were certainly a stimulus to further investigation in the area of videotape recall in inpatient settings. Stoller (1967) has described the use of focused feedback with regressed hospitalized patients in groups, and he offers clinical evidence supporting the use of videotape recall techniques with this population.

Danet (1968) has reviewed the use of videotape self-confrontation techniques in group psychotherapy, and he states that although the clinical work of therapists has demonstrated the effectiveness of videotape feedback as a therapeutic tool in group psychotherapy, there has been a "striking absence" of research studies. Danet mentioned his own investigation of videotape feedback in groups under what he termed "relatively controlled conditions." His findings, although inconclusive, suggested that patients in the experimental group (N = 7) tended to be more anxious, more erratic in their

sociometric ratings, less positive in their self-evaluations, and lower in ratings of self-improvement than were patients in the control group (N = 7). These data supported the possibility that the videotape playbacks had a disruptive influence on the group's processes. He hypothesized that the rigid method of presenting the playback material which he used at the beginning of each session in order to introduce experimental control resulted in the disruptiveness and anxiety in the experimental group. And he states that the feedback process may not have been handled in a sensitive and skillful manner. He concludes that more research needs to be done to determine if there are in fact harmful effects from the use of videotape playback. He asks the question: "For which individuals and under what conditions is exposure to one's self-image in this manner a beneficial experience?" (Danet, 1968, p. 256).

Gelso (1974) has reviewed the research on the effects of making audio and video recordings on counselors and clients in counseling sessions. He notes that early research suggested no adverse effects, particularly on clients. And he states that there are common beliefs that (a) Counselors are often more disturbed by audio and video recording procedures than are their clients, (b) The inhibition that counselors think that therapy recordings produce in their clients is really a projection of their own disturbances, and (c) The slight disruption that recordings may cause in clients will quickly disappear. Gelso questions these beliefs, and he cites some of his own research to indicate that audio recordings do in fact inhibit clients and that video recordings inhibit them even more. He concludes that this issue

is best viewed as a cost-benefit question in which the benefits of recordings must be weighed against the potentially adverse effects. It should be noted here, however, that Gelso's research was done with counseling sessions in which the audio and video recordings were used for counselor supervision of the client sessions, and that the recordings were never used as therapeutic techniques within the sessions. This is drastically different from the use of videotape recall in the present study, where the clients and therapists immediately reviewed the videotapes in the sessions, and then erased them afterwards without anyone other than the inquirer seeing them.

Sanborn, Pyke, and Sanborn (1975), in a more recent review of videotape playback in psychotherapy, have synthesized the results in the literature on some of the various techniques. They find that there is a consensus against concealing the camera and other equipment, that almost all therapists prefer an immediate replay rather than a delayed one, and that relatively short segments are better than longer ones. They conclude that the preponderance of research has found that self-confrontation via videotape recall is helpful, and that videotape has been successfully used as an adjunct with individual, group, marital, and family therapy.

Griffiths (1974) is more cautious in his review of the videotape feedback literature. He sees a definite need for more objective assessments of the effectiveness of the use of feedback in therapy. He believes that individual differences in response to feedback need to be researched, and that an attempt must be made to determine mechanisms which mediate changes related to feedback. This would allow

theoretical models of feedback to develop which would facilitate further empirical research and clinical application.

Milton Berger (1978) summarized research and many different uses of videotaping in treatment and training in his edited work, Videotape Techniques in Psychiatric Training and Treatment (Revised Edition). Berger is extremely positive about the present and potential value of utilizing video recall in the therapeutic process. In one of the chapters, Norman Kagan (1978) discussed the utility of the IPR model and the research based on this model in various human interaction settings. The use of the IPR model in counseling and therapy will be discussed in the following section.

The Use of IPR Videotape and Stimulus Film Techniques in Counseling and Psychotherapy

This section is a review of the research on the IPR model as it has been used in counseling and psychotherapy. The IPR model includes the use of both videotape recall and stimulus film techniques. IPR has been used in many different human interaction settings with a variety of types of professionals, paraprofessionals, and nonprofessionals. It has been used in training mental health workers, medical students and personnel, secondary school teachers, college faculty, prison employees, supervisory personnel, policemen, and other groups. The research based on IPR in areas other than in counseling and psychotherapy will not be reviewed here, but a summary of such research with references is available (Kagan, 1975b).

The use of IPR as a method to accelerate client progress in counseling and psychotherapy has been reported in the literature for

several years, both in intensive case study form and in controlled experimental research. The two controlled studies which are most similar to the current study are discussed in depth following a summary of other related investigations. The initial development and research on IPR was reported by Kagan, Krathwohl et al. (1967). IPR videotape recall techniques were studied with counselors and prison inmates. It was first found that client recall (without the counselor observing the session) did not result in client movement. When the experiment was repeated with the counselor joining the client in mutual recall, however, client movement did occur. This led to the tentative conclusion that client growth could be accelerated, but only if the counselor was actively involved in the recall process so that he could identify and understand client insights and then deal with them in subsequent counseling sessions.

A related initial study was conducted by the same researchers with three college counseling center clients seen by two counselors for three sessions each. The first session included client recall, the second session included a discussion with the inquirer but without the use of videotape, and the third session included mutual recall. The results of this study indicated that one counselor was more effective with clients than the other, and that the more effective counselor had significantly better results with client recall (in which the counselor watched the recall session from another room through a one-way mirror), whereas the less effective counselor had significantly better results with mutual recall (in which the counselor actively participated). Although the sample size and number of

sessions were very small in the study, the writers were able to make tentative conclusions:

> The IPR procedure provides the client with insights into his interpersonal behavior but it is necessary that the counselor be able to integrate these insights into his ongoing relationship with the client if growth is to be accelerated. It would appear that the more competent counselors under such conditions, gain new understanding from studying the session between the interrogator* and his client, and gain less from taking part in the interrogation. The less competent therapists, on the other hand, may either not understand the dynamics uncovered in recall or may not be able to implement them, thus frustrating the client's new understandings--perhaps even retarding client growth (Kagan, Krathwohl et al., 1967, pp. 319-320).

An early study using IPR recall in small counseling groups was conducted by Hurley (1967). In this experiment one IPR recall session was introduced during the fifth session of a 10-session counseling group. When compared with two control groups, the IPR intervention group did not result in any statistically significant advantage on measures of self-disclosure. An analysis of pre and post tape recordings and the observations of the group leaders indicated, however, that the introduction of IPR did in fact alter the style of group interactions in a positive direction. It was concluded that repeated IPR treatments would have been necessary to result in significant differences on the criterion measures.

In an early IPR case study (Kagan, Krathwohl, & Miller, 1963), separate client and therapist recalls were found to simulate client movement in a 38-year-old female who suffered from periods of depression and a rigid, nonsexual relationship with her husband. After

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*The inquirer was originally called the interrogator.

5 months of counseling in which the client had made little progress, an IPR session was introduced which included both client and counselor recall. With the aid of the videotape and the inquirer, the client was able to talk about previously repressed affect and gain insights into her own behavior. As a result of the surfacing of repressed affect and new insights during recall, the woman's relationship with her husband became more spontaneous and her sexual relations with him were reactivated, and the counseling progressed significantly.

Hypnosis was used to facilitate the recall process in a case study (Woody, Kagan, Krathwohl, & Farquhar, 1965) of a 21-year-old male counseling center client who had problems with dependency, social inadequacy, and sexual uncertainty. The use of hypnosis appeared to heighten the client's sensitivity to the videotape, increase his involvement in the recall procedure, and allow him to become more cooperative in the therapeutic process. The client stated that he felt the hypnotic IPR procedure facilitated his progress in counseling, and his relationship with his therapist improved following the IPR sessions.

IPR has also been used with more severely disturbed clients. A case study was reported (Resnikoff, Kagan, & Schauble, 1970) in which client recall was introduced during the 12th treatment session. The client was an 18-year-old, bright, well-read, high school senior who suffered from mild to acute psychotic reactions. The IPR procedure was used during the 12th session to uncover underlying dynamics of depression that he was experiencing at the time. During the recall it was learned that the client (a) had a much richer imagery than he

had disclosed to his therapist, (b) had worked through much of the material previously presented without conveying this to his therapist, and (c) was much more committed to his therapist than he was previously willing to admit. The 9th through the 15th sessions were rated by judges who had no knowledge of the IPR session. The ratings of client movement on five variables following the IPR session increased positively, and the protocols of the post-IPR sessions indicated a heightened psychological clarity and forcefulness in the client.

Stimulus films (affect simulation) were added to the IPR techniques (Danish & Kagan, 1969; Kagan & Schauble, 1969) to facilitate the client's discussion of reactions to highly emotional interpersonal situations, to discover individual client stereotypes in interpersonal behaving, and to discover interpersonal emotional problem areas in which the client desires change. Vignettes from mild to intense degrees of affect were made in four general areas: (a) hostility, (b) fear of hostility, (c) affection, and (d) fear of affection. Observations were made of clients who were videotaped while watching the short filmed vignettes with their therapists, followed by a recall of the videotape which then became the focus of the counseling session. The therapist facilitated this recall by using inquirer leads. The stimulus films were also found to be beneficial when used without the aid of the videotape, and the process was found to be effective with counseling groups as well as with individual clients. It was believed that the films were especially helpful at the initial stages of counseling so that clients could learn that it was acceptable to talk about feelings and discuss interpersonal relationships. These films

have been used as an effective training tool in a variety of settings with a variety of clients, and they have been integrated into research on the physiological correlates of emotions (Archer, Fiester, Kagan, Rate, Spierling, & Van Noord, 1972).

Hartson and Kunce (1973) used a combination of stimulus films, dyadic recall, and group recall techniques to assess the effectiveness of IPR in accelerating group psychotherapy in a controlled experimental study. They found that in six sessions the IPR treatment clients showed significantly higher changes in self-disclosure and readiness for group behavior and participated in significantly higher therapeutic interchanges than did clients in the traditional T groups. The T group clients, however, had significantly higher satisfaction scores. The study was conducted with two samples and there appeared to be a differential treatment effect: No treatment differences were observed between high self-esteem, socially active (YMCA) subjects, whereas the IPR self-confrontation methods were beneficial to low self-esteem, socially inactive (counseling center) subjects on whom the T group direct confrontation methods seemed to have an adverse effect.

In a recent study, Kingdon (1975) did a controlled cost/benefit analysis of IPR used as a counselor supervisory technique. Cost was defined as the possible inhibitory effects of using videotape on client self-exploration, whereas benefit was defined as client satisfaction, increased supervisor ratings, and increased counselor empathy levels. Only three sessions of client and counselor recall were used in this study, and although inhibitory effects due to videotaping were

found during the second session, these effects began to dissipate during the third session with IPR clients self-exploring at a deeper level than traditional treatment clients. No significant results were found, however, on measures of empathic understanding, client satisfaction, and supervisory ratings of counselors' performance between the traditional and the IPR treatment clients.

In another recent study, Grana (1977) investigated the effects of varying the frequency of videotape feedback during short-term counseling. This was not a true IPR study in that the therapist functioned as the inquirer during recall, rather than using a third-person inquirer who would have been more neutral in the therapeutic process. Grana had therapists act as their own inquirers because he believed the results would be more generalizable, since, in his opinion, bringing in outside inquirers was not practical. Twenty-four university students were assigned to one of four groups which met for five weekly 1-hour sessions and varied in videotape recall frequencies, i.e., 0, 1, 3, or 5 recalls. No significant differences were observed. Grana suggested that the videotape feedback was an additional counseling technique which contributed only small amounts of variance to the change scores, resulting in small rather than large effects. He concluded from client evaluation statements that videotape feedback was either a neutral or beneficial factor in the counseling process, that a routine every-session approach to video feedback was confining and possibly disruptive to a close client-counselor relationship, that video feedback may require a highly motivated and responsible client to achieve maximum effects, and that

the timing of the video feedback may be very important with its use being particularly effective at the stage when the client moves toward becoming more responsible for changing behaviors.

In two intramodel analog studies designed to investigate the ability of individuals to accurately recall feelings of "comfort" and "discomfort" while watching a videotape of a previous session, Katz and Resnikoff (1977) found support for the validity of the basic IPR recall process. Results from studies of role-playing counseling students (Study 1) and intimate couples (Study 2) produced moderate correlations between self-ratings of in vivo feelings on an event recorder during a session and self-ratings of feelings recalled while viewing the videotape feedback. It was also found that a greater reliability of recall was obtained by playing the client rather than the counselor role (Study 1) and by having one's self-rated in vivo feelings disclosed to a partner during the original ongoing session (Study 2). This study is significant in that it examined and gave support to one of the basic components of the IPR model.

The two most important IPR research projects with respect to the current study are Schauble's study on the use of IPR in therapy (Schauble, 1970) and Van Noord's modified replication of it (Van Noord, 1973; Van Noord & Kagan, 1976). Because of their specific relevance here, these studies will be covered in more detail than were previous studies.

Initially, Schauble conducted a pilot study to determine if the IPR model could be successfully integrated into a therapeutic treatment program. Nine clients were assigned to either one of two IPR treatment

groups or to a traditional group and then seen for six individual sessions each. The results were encouraging, for the IPR treatment clients were found to make more progress on four process measures of client growth than did control clients.

In Schauble's main study, he had a sample of 12 female counseling center clients and two doctoral intern therapists. Each therapist treated three clients with IPR techniques in addition to traditional methods and three clients with traditional methods alone. Both treatments consisted of six sessions. The IPR treatment group followed a structured sequence: (a) session 1--traditional, (b) sessions 2 and 3--videotape recall of stimulus films (affect simulation), (c) sessions 4 and 5--client recall with counselor observation through a one-way mirror, and (d) session 6--mutual recall with client and therapist. The theory of this progression was (a) that the client needed to learn that it was appropriate to talk about feelings and examine them in emotionally stressful interpersonal situations, but to do it in a safe environment (videotape recall of stimulus films); (b) that the client needed to identify feelings experienced during the counseling relationship, but to do it with the safety of an objective third person (client recall); and (c) that the client needed to experience and deal with feelings in the immediacy of the counseling relationship, progressing from the "there and then" of the videotape to the "here and now" of the counseling session (mutual recall).

Schauble used five dependent variables as pre and post measures: (a) the Characteristics of Client Growth Scales (COGS, Kagan, Krathwohl et al., 1967; Schauble & Pierce, 1974), (b) the Depth of

Self-Exploration Scale (DX, Traux & Carkhuff, 1967; Carkhuff & Berenson, 1967), (c) the Wisconsin Relationship Orientation Scale (WROS, Steph, 1963), (d) the client and therapist forms of the Therapy Session Report (TSR, Orlinsky & Howard, 1966), and (e) the Tennessee Self-Concept Scale (TSCS, Fitts, 1965). Significant between group differences in favor of the IPR treatment clients were found on the three subscales of the COGS, as well as on the DX and the WROS. Significant change scores within treatment groups, pre to post, were found on the COGS and the DX for the IPR clients but not for the traditional clients. Significant between group differences in favor of the IPR clients were found on two subscales of the client form of the TSR: client feelings about coming to the session, and client feelings about progress made in the session. Significant change scores within treatment groups, pre to post, were also found on these two client subscales of the TSR for IPR clients only. And a significant change score, pre to post, in favor of the IPR treatment clients was found on one subscale of the therapist form of the TSR: therapist looking forward to session. No other results were significant. Schauble (1970) concludes:

> In light of the changes observed in client behavior in therapy as a result of the IPR intervention and the significant differences between the behavior of clients in the IPR treatment and the traditional treatment group, it is assumed that the IPR procedures are a potentially potent tool for use in accelerating client progress in therapy. Even in light of the limitations of the small N in this study, the fact that significant differences were found in two separate studies in only six sessions seems too meaningful to ignore (p. 150).

Van Noord replicated Schauble's research with certain modifications: (a) He used 12 therapists, each seeing only one client, half

of whom were in the IPR treatment group and half in the control group; (b) He used a posttest-only design and a multivariate analysis of covariance with five dependent variables and a covariate of therapist empathic understanding; (c) He used only the client form of the TSR without using the therapist form; and (d) He substituted the Miskimins Self-Goal-Other Discrepancy Scale (MSGO, Miskimins & Braucht, 1971) and his own Peer Information Questionnaire in place of the TSCS and the WROS. As with Schauble, Van Noord used a highly structured sequencing of the IPR model: (a) session 1--traditional, (b) session 2--stimulus films, (c) session 3--video recall of stimulus films, (d) sessions 4 and 5--client recall with counselor observation through a one-way mirror, and (e) session 6--mutual recall. No significant differences were observed between groups on the total MANCOVA nor on separate ANCOVAs on individual measures. Subjective comments by clients, however, suggested that the IPR techniques were beneficial and helpful in self-exploration and in exploration of the client/counselor relationship. Van Noord (1973) concludes:

> The primary observation stemming from the results of the present study is that of the difference in outcome between this study and that of Schauble in 1970. An important implication of the fact that effects of IPR/affect simulation treatment were noted in the Schauble study but not in the present experiment is that those previous results must be looked upon with more skepticism than would be the case were this study not conducted. That is, while the results of either of those projects may be valid, the fact that differences between treatment groups were noted in the original project but not in the present one to some extent weakens the positive implications of results obtained in the Schauble study (p. 147).

Both Schauble and Van Noord reported that a frequent therapist criticism focused on the imposition of structure in the IPR treatment

group. The rigid sequential use of the techniques was not always seen as helpful by the therapists because it did not take into account each individual client's unique growth rate and needs. Schauble (1970) stated,

> A criticism of the IPR treatment suggested by both therapists was that the step by step program delimited their freedom to respond to their clients' individual needs. In other words, the research dictated a rigid schedule of IPR experiences which did not take into account the unique growth rate of each client; that is, in the interest of uniform treatment within groups the therapist was allowed no flexibility in varying the approach to meet client needs (p. 134).

Van Noord (1973) speculated on possible harmful results of using the rigid structure: "While the organization of the progressive movement was done on a logical basis, possibly there were negative effects resulting from not using specific techniques at differing points in the therapy process according to individual client needs as determined by each therapist" (p. 148). He goes on to recommend that further investigations be conducted in which therapists are allowed to use the different IPR techniques with more flexibility and where they are allowed to choose particular techniques for particular clients at particular stages in the therapeutic process. He noted that mutual recall was thought to be especially helpful for several clients in his study.

A suggestion by both Schauble and Van Noord for further research was that the impact of the IPR techniques in therapy should be studied over a longer period of time, hypothesizing that in a more extended therapy program the positive effects of the IPR techniques might be more fully realized. And both researchers noted that their

sample size was very small and they recommended that it be increased in further research.

Summary

A review of the literature on controlled studies in counseling and psychotherapy indicates that there is adequate evidence for the beneficial effects that clients receive from therapy when compared to untreated controls. Bergin (1971) has pointed out, however, that although psychotherapy has something unique about it that contributes to positive change in most clients, it can also cause deterioration in some clients who have not been treated in a competent manner. It is not surprising that if psychotherapy has the power to effect positive change, it also has the power to effect negative change. Additional research is needed, therefore, to determine what works best with whom under which conditions. As part of such research, there is a need to develop and test new techniques (Bergin & Strupp, 1970). Although controlled comparative outcome studies give evidence that a high percentage of clients who have therapy do in fact benefit from it, most reviewers have not found that there is evidence to support any one form of treatment as being better than another (Luborsky et al., 1975; Smith & Glass, 1977).

A major problem in counseling and psychotherapy research is the selection of suitable criteria for measuring client movement and outcome. Human behaviors are complex and not easily measured, and researchers cannot agree on the philosophical value judgments needed in deciding which phenomena are important and, therefore, which

phenomena should be measured to give evidence of positive change occurring as a result of the therapeutic experience. With the current problems with process and outcome measures, it has been recommended that a variety of measures be used (Bordin, 1974; Garfield, Prager, & Bergin, 1971).

The last two decades have seen a steady increase in the use of videotape recall as a therapeutic technique. Although therapists who use videotape in their treatments report that videotape can be a very effective tool, controlled research has had mixed results and there is a definite need for further investigations.

The IPR model includes the use of videotape recall and stimulus films. It was originally developed by Kagan, Krathwohl et al. (1967) for use in counselor education, but the model has also been developed into therapeutic intervention techniques. The use of IPR in counseling and psychotherapy has been found to be effective in accelerating client movement in case studies and in some controlled studies, but the results have been inconsistent in the controlled studies. Research on the effectiveness of IPR in therapy is still in the initial stages, just as the use of IPR in therapy is still in the beginning phase of development.

The current study was undertaken with the belief that, although research has proven that counseling and psychotherapy can effect positive changes in clients when compared to untreated controls, continued research must be made on the effectiveness of new techniques in order to eventually gain specificity concerning what works best with whom under which conditions. The measures used in this study

included client self-report questionnaires and inventories, therapist questionnaires, and objective tape ratings of therapy sessions.

The IPR model in this study was researched using IPR interventions in a therapeutic design that incorporated recommendations from two similar studies (Schauble, 1970; Van Noord, 1973; Van Noord & Kagan, 1976). In these two studies the sample size was 12, and in the current study it was 50. Whereas the previous number of sessions was limited to 6, the number of sessions in the current study ranged from 4 to 15, thus allowing for more flexibility and for the possibility of an increased exposure to IPR techniques. The range of sessions used in this research was somewhat arbitrary. It was the belief of this researcher, however, that significant results could be obtained on the average (allowing for individual differences) after four sessions in which two of the four sessions included IPR interventions. And although it was possible that nonrepresentative growth data were obtained from some of the clients who had not terminated at the time of the 15th session (due to regression, negative transference, etc.), these effects should have been randomized between treatment groups.

Meltzoff and Kornreich (1970) have reviewed the literature on temporal variables and outcome, and they found evidence to support the assumption that client movement and growth can occur in short-term therapy. The range of these sessions also reflects the growing trend of actual practice in university counseling centers and mental health clinics to see clients in very short-term treatment. For those clients who continued beyond the 15th session, it was assumed that

IPR interventions would result in more client movement than would occur without the IPR interventions in the control group.

The most important difference between the current study and those of Schauble and Van Noord was the use of IPR techniques on a flexible basis. This was designed so therapists could choose particular techniques for particular clients at particular stages in the therapeutic process. A detailed description of treatments along with the instruments used for measurement follows in Chapter III.

CHAPTER III

METHODOLOGY

The following is a detailed description of the sample, treatments, instrumentation, design, hypotheses, and data analysis used in the study.

Sample

Clients

Permission was first obtained from the research committee of the Georgia State University Counseling Center for the use of clients in this experiment. The 50 clients who participated in the study were undergraduate and graduate students at Georgia State University who had requested counseling at the Counseling Center during the 1976/1977 academic year.

In order to be asked to participate, a potential research client had to: (a) have a presenting problem that was primarily personal/social in nature rather than educational, vocational, or academic; (b) not be considered actively suicidal or in an extreme crisis situation; (c) be willing to make a commitment to at least four counseling sessions, and (d) be considered appropriate for traditional, dyadic counseling (e.g., clients who were most suitable for group counseling, anxiety reduction, assertiveness training, etc., were excluded).

Initial contacts with clients were made by either the investigator or one of the research therapists. This took place either in the intake session (if the investigator or research therapist was on intake duty), in a brief personal or telephone interview, or during the initial counseling session. Clients were told that counseling techniques were continually being evaluated at the Center to see if they were effective in meeting student needs. Then they were asked if they would be willing to participate in a research project in which videotape and films may or may not be used as part of the therapy procedures. Those who agreed signed a consent form.

Prior to being contacted, all potential clients were assigned to either the experimental or control group. When asked to participate, neither the client nor the therapist had knowledge of the group assignment. After the client agreed to participate, the therapist opened a sealed envelope with the group assignment inside and told the client whether or not videotape and/or stimulus films would be used in the sessions.

It should be noted that this is not a random sample, but rather a volunteer sample. Approximately 15% of the potential clients who were asked to participate responded that they did not wish to be part of the research project. Although it is impossible to know the exact reasons for these refusals, it appeared that some of the unwilling clients feared an invasion of privacy due to the research measures, even though they were told that confidentiality would be maintained and that no names would be used in any of the reports. Other unwilling clients expressed a dissatisfaction with the idea of using specific

techniques, such as the videotape and stimulus films, and it appeared that some of these clients experienced the thought of using videotape and films as a loss of control over the therapeutic process. And a few clients indicated that they were unwilling to commit themselves to four sessions, preferring to sample a few sessions and then decide whether they wished to continue with therapy.

The IPR and traditional groups were compared on the following demographic variables: sex, age, grade point average (GPA), and class standing. A summary of these data is presented in Table 1 below. Two-tailed *t*-tests indicated that the differences between the IPR and traditional treatment groups on the variables of age ($t[48] = 1.06$, $p = .30$), GPA ($t[40] = .55$, $p = .58$), and class standing ($t[48] = 1.86$, $p = .07$) were not significant at the .05 level.

Table 1: Comparison of Treatment Groups According to Sex, Mean Age, Mean GPA, and Mean Class Standing

	IPR Counseling Group	Traditional Counseling Group
Sex	14 females/11 males	16 females/9 males
Mean age	25.8 years	24.4 years
Mean GPA	3.1	3.0
Mean class standing	3.7[a]	3.1

[a]Based on class standing when freshman = 1; sophomore = 2; junior = 3; senior = 4; and graduate = 5.

Subject Mortality

A total of six clients who began the study terminated their counseling sessions without completing the research procedures. Four of these clients were in the control group and two were in the IPR group. The number of sessions completed for these clients before termination ranged from one to four. In one case of a traditional group client the person did not wish to continue, stating that the only reason he began was because one of his professors said he needed it and that he no longer agreed with his professor. In two cases (one in the traditional group and one in the IPR group) the clients dropped out of school and moved to another city. And in the remaining three cases (two traditional clients and one IPR client) the individuals stopped coming to the sessions and refused to complete the research procedures with no reasons given.

An attempt was made to replace each of these clients with the next client of the same sex on the waiting list who agreed to participate in the project. In two cases in the control group, however, male clients were replaced with female clients because only female clients were on the waiting list. This resulted in the final sex distribution within each of the groups being slightly unequal, with 14 females and 11 males in the IPR counseling group and 16 females and 9 males in the traditional counseling group, a difference which was unlikely to confound the results.

Therapists

Five Georgia State University Counseling Center therapists were used in this study. Each therapist saw 10 clients, 5 of whom were in the IPR group and 5 in the traditional group. This was not a random sample of all the therapists at the GSU Counseling Center, for each therapist volunteered to participate in the research project. Three therapists were interns who had completed all requirements except the dissertation for the Ph.D. degree (two were in a clinical psychology program and one was in a counseling psychology program). One therapist was a senior staff, full-time employee at the Center. And one therapist was a doctoral student staff counselor who worked three-quarters time at the Center. Each of the therapists was trained in traditional styles of counseling and therapy and each was eclectic in using a variety of styles and techniques (e.g., intrapersonal, interpersonal, emotional, cognitive, behavioral). Only one of the therapists had previous experience with IPR, but none of them had ever used IPR techniques as an adjunct to traditional therapy.

Therapists were given a 5-hour training program on the use of IPR in therapy. Three hours were spent on videotape recall procedures and 2 hours were spent on stimulus film procedures. During this time, therapists were instructed in the operation of the videotape recorder, the camera, the monitor, and the 16mm sound projector so that they could use this equipment without the assistance of a media technician. In addition to this formal training, therapists were given the IPR manual (Kagan, 1976) and were asked to read the chapters on affect simulation (stimulus films) and the inquirer role and function.

Treatments

Clients who were research subjects in both the IPR and control groups completed between 4 and 15 counseling sessions before taking the posttests. The number of sessions within this range varied in order that flexibility could be maintained according to individual client needs as determined by the therapists and clients. Although clients could terminate at any time, they had to complete at least four sessions in order to be used in this study. For those clients who continued beyond 15 sessions, posttests were taken after the 15th session. Nine clients in the IPR treatment group and two clients in the traditional group continued counseling beyond the 15th session after completing the posttests. Of the total 462 counseling sessions completed in this study, 260 were for the IPR group clients and 202 were for traditional group clients. The mean number of sessions completed per client was 10.4 for IPR clients and 8.1 for traditional clients. A two-tailed t-test indicated that the difference between these two means is significant at the .05 level: $t(48) = 2.10$, $p = .04$. For a comparative summary of the mean number of sessions (and ranges) for therapists and treatments, see Table 2, p. 58.

The initial sessions for clients in both groups were similar, allowing therapist and client to meet each other and begin identifying client concerns and goals. This time also gave the therapist the opportunity to answer any additional questions that the client had about the research requirements or the counseling treatment. An audiotape was collected from the 50-minute session for subsequent rating by judges on the initial level of client functioning.

Table 2: Mean Number of Sessions and IPR Interventions (and Ranges) for Therapists and Treatments

	Mean No. (and Range) of Sessions for Traditional Clients	Mean No. (and Range) of Sessions for IPR Clients	Mean No. (and Range) of IPR Interventions for IPR Clients	IPR Interventions Used
Therapist 1	11.6 (8-15)	11 (5-15)	4.4 (2-6)	16 mutual recalls 6 stimulus films
Therapist 2	7 (6- 8)	8 (5-11)	3.6 (2-6)	9 client recalls (unobserved) 7 mutual recalls 2 stimulus films
Therapist 3	8 (4-15)	10.4 (5-15)	4.2 (2-6)	20 mutual recalls 1 stimulus film
Therapist 4	4.6 (4- 5)	9 (4-15)	3.8 (2-6)	12 mutual recalls 7 stimulus films
Therapist 5	9.2 (7-12)	13.6 (8-15)	5.4 (3-6)	10 mutual recalls 8 stimulus films 6 significant other recalls 2 video recalls of stimulus films 1 client recall (observed)
All therapists combined	8.1 (4-15)	10.4 (4-15)	4.3 (2-6)	65 mutual recalls 24 stimulus films 10 client recalls 6 significant other recalls 2 video recalls of stimulus films

Traditional Counseling Without IPR (Control Group)

The 25 clients of the five therapists who received the traditional treatment alone had sessions that were conducted in no set pattern, which permitted the therapists to use their normal, eclectic, dyadic treatment methods. During these 50-minute sessions, therapists assisted their clients in working on both intrapersonal and interpersonal problem areas. Therapists were told to use their familiar methods of counseling interventions. In addition, they were told that it was allowable for the client to bring a significant other into the sessions to work on mutual problem areas. This was done in order to equate for the possible use of significant others in the mutual recall technique in the IPR experimental group as described below.

Counseling with IPR (Experimental Group)

The therapists treated their IPR group clients according to the following session framework and intervention techniques. During the first 10 sessions, an IPR technique had to be used in a minimum of 50% of the sessions; the techniques were used in at least every other session or in two consecutive sessions followed by two traditional sessions. The techniques could be used in more than 50% of the sessions if desired. During the 10th through the 14th sessions, an IPR technique had to be used at least once.

Therapists were allowed to select the IPR technique which they believed was most suitable in facilitating each IPR client's growth

or problem-solving ability during a particular session. Therapists were encouraged to use as many of the techniques as possible, but there was no requirement that each technique had to be used. Also, any particular technique could be used as much as desired to facilitate client movement as determined by each therapist for each client.

Traditional counseling without IPR was used for all first and last sessions, allowing for audiotape recordings of sessions which were similar in structure to those in the traditional (control) treatment group. Traditional counseling was also used in those sessions where the therapist chose not to use an IPR technique within the limits of the guidelines stated above. As with the traditional group clients, these sessions were unstructured and conducted using the therapists' normal, eclectic, dyadic treatment methods.

IPR Techniques and Session Procedures

The specific IPR techniques which the therapists were allowed to choose from and the session procedures connected with these techniques are listed below. In using the techniques, therapists operated the videotape, camera, monitor, and the 16mm projector without the aid of a media technician.

Stimulus films (affect simulation). Clients viewed at least five filmed vignettes which were selected by the therapist according to individual client problem areas. After viewing each vignette, the client discussed with the therapist those thoughts, feelings, images, memories, etc., that the client had while watching the vignette. The client's reactions to the vignettes became the focus of the counseling

session. Inquiry techniques were used by the therapists in facilitating client reactions, but the therapist was not strictly limited to these techniques and used other intervention methods as well. This process took up either the whole session or part of it, with any remaining portion of the 50 minutes being spent in traditional counseling procedures, the content of which was often stimulated by the films. The three IPR films used for this and the following procedure are part of the IPR film series (Kagan, 1975a).

Videotape recall of stimulus films (affect simulation). Clients viewed at least five vignettes and were videotaped while watching them. The videotape was played back for the client (either after each vignette or after all of them) for a recall of the client's reactions to the vignettes. The therapist facilitated the client's recall through inquiry techniques, while not being limited to only these techniques. This recall became the focus of the counseling session, and it took up either the entire remainder of the session or part of it, with any remaining portion of the 50 minutes being spent in traditional counseling procedures.

Client recall. A traditional counseling session was videotaped for 10 to 15 minutes. An inquirer (someone other than the therapist) then entered the room and facilitated the client's recall of the initial period with the aid of the videotape for a period of 20 to 30 minutes. During this inquiry period the therapist could either: (a) watch the recall from an unobtrusive position in the room or through a one-way mirror in an adjoining room (with the client's knowledge that the therapist was watching) or (b) leave the session

completely and wait in another location until the inquiry time had elapsed. During the final 10 to 20 minutes of the 50-minute session, the inquirer left the room and the therapist returned for a final period of traditional counseling.

Mutual recall. A traditional counseling session was videotaped for 10 to 15 minutes. An inquirer then entered the room and facilitated the videotape recall of the initial period with both the client and the therapist actively involved in the recall for 20 to 30 minutes. After this recall period, the inquirer left the room and traditional counseling took place for the remaining 10 to 20 minutes of the 50-minute session.

Significant other mutual recall. The client and a significant other (without the therapist) were both videotaped while talking about something that was meaningful to their relationship for 10 to 15 minutes. The therapist then entered the room and functioned as an inquirer to facilitate the recall of the videotape by the client and the significant other for 20 to 30 minutes. The remaining 10 to 20 minutes of the 50-minute session was conducted as a traditional session with the therapist and either the client alone or the therapist and both the client and significant other together.

The results of the actual IPR techniques selected by each therapist for their IPR clients as well as summary data are presented in Table 2, p. 58. Of the 107 IPR interventions that were completed in this study, 65 were mutual recalls, 24 were stimulus films, 10 were client recalls, 6 were significant other recalls, and 2 were videotape recalls of stimulus films.

Inquiry (Recall) Procedures and Inquirers

For the 65 mutual and 10 client recalls conducted in this study as part of the IPR interventions, objective, third-person inquirers or recallers were used for 20 to 30 minutes during the 50-minute IPR counseling sessions. The clients were always informed in advance about the inquirers, and brief introductions between clients and inquirers were made for initial meetings either prior to or at the beginning of the sessions.

It was the inquirer's task to facilitate the client's recall during client recall or the client's recall and the therapists' recall during mutual recall of the previous 10- to 15-minute counseling session. With the aid of the videotape, the inquirer kept the interaction primarily focused on the "there and then" of what actually already had happened prior to the inquirer's entry into the room. Thus, by avoiding "here and now" interactions between the inquirer and either the client or the therapist, the inquirer maintained a relatively neutral position and did not become another therapist who interpreted, confronted, reflected, etc. The inquirer facilitated the recall by asking either the client or the therapist short, exploratory leads (e.g., "Do you remember what you were feeling?" or "What were you thinking at that time?" or "What did you want from your therapist then?"). The inquirer role is explained in detail in the IPR instructor's manual (Kagan, 1976).

Nine individuals served as inquirers for the recall sessions, including the investigator, a research assistant, two staff counselors,

two research therapists, two counseling psychology doctoral students, and one intern counselor. The inquirers were trained in the inquirer role for 5 hours after reading about it in the IPR instructor's manual. During this time they made practice videotapes of simulated counseling sessions and practiced the role with each other. The matching of inquirers with clients occurred primarily on the basis of scheduling and times available. A majority of clients experienced recall with more than one inquirer. Frequencies of conducted mutual and client recalls by inquirers are found in Table 3 below.

Table 3: Frequency of Conducted Recalls by Inquirers

Inquirers	Inquirer's Sex	Number of Recalls Conducted
1	Male	28
2	Male	19
3	Female	13
4	Female	4
5	Male	3
6	Male	2
7	Female	2
8	Female	2
9	Female	2

Physical Environments

All counseling sessions for both the IPR and traditional groups were held in rooms at the Georgia State University Counseling Center. The therapists used their own offices for all of the traditional

client counseling sessions and for those IPR client counseling sessions in which no IPR intervention technique was used. These offices were similar in design; each was relatively small, windowless, and typically contained a desk, three comfortable chairs, a bookshelf, and an unconcealed audiorecorder and microphone.

All sessions for the IPR group where an IPR technique was used were conducted in a separate room used by all of the therapists. This room was also relatively small (15 ft. x 6 ft.) and windowless. It contained the necessary media equipment which was completely unconcealed: a SONY AV-3650 (half-inch tape, reel-to-reel) videotape recorder, a Shibadan camera, a portable TV monitor, a microphone, a Kodak 16mm autoload projector, and a screen that was attached to the wall. There was also a one-way-vision mirror through which client recalls could be observed from an adjoining room, but this mirror was always covered with a curtain unless an observed client recall was taking place.

Instrumentation

Five measures were used as criteria for the study: (a) the Personal Orientation Inventory (POI, Shostrom, 1963); (b) a modified version of the therapist and client forms of the Therapy Session Report (TSR, Orlinsky & Howard, 1966); (c) a modified version of the therapist and client forms of the Client Description of Problem Scale (pre) and the Progress of Counseling Rating Scale (post) (CDPS/PCRS, Seidam & June, 1972); (d) the Characteristics of Client Growth Scales, consisting of the three separate scales of Owning of Feelings (OF),

Commitment to Change (CC), and Differentiation of Stimuli (DS) (COGS, defined by Kagan, Krathwohl et al., 1967; revised into a 5-point scale by Schauble & Pierce, 1974); and (e) the Depth of Self-Exploration Scale (DX, defined in a 9-point scale by Truax & Carkhuff, 1967; revised into a 5-point scale by Carkhuff & Berenson, 1967).

In addition to these formal instruments, an informal "Comments" sheet was also included on which clients could give their personal thoughts and opinions about their counseling sessions. Therapists were interviewed after their clients had completed their research sessions in order to obtain their informal evaluations of the usefulness of the IPR videotape and stimulus film techniques.

The Personal Orientation Inventory (POI)

The Personal Orientation Inventory is an instrument that has been widely used in counseling and psychotherapy research, both with individual clients and with groups. In addition to the information found in the POI Manual (Shostrom, 1974), the many research studies based on the use of the POI and validity and reliability data are summarized in the Handbook for the POI (Knapp, 1976). The theoretical structure of actualizing therapy used in the development of the POI is presented in Actualizing Therapy: Foundations for a Scientific Ethic (Shostrom, Knapp, & Knapp, 1976). Much of the following description of the POI was taken from these three primary sources.

The POI is made up of 150 two-choice, paired-opposite statements having to do with values, attitudes, and self-percepts. The examinees are asked to select one statement of each pair which they believe to

be most true of themselves. The initial item pool was collected from private therapists who formulated the statements on the basis of problems of value judgment faced by their clients. The items selected for the 12 POI subscales were chosen by rational procedures according to the theoretical constructs of self-actualization. Writers in humanistic psychology associated with these constructs include Maslow, Reisman, Rogers, May, and Perls.

Each item in the inventory is scored twice. The first scoring is for one of the first two subscales (Inner Directed and Time Competent) with no item overlap. The second scoring is for the 10 following subscales, each measuring some relevant aspect of self-actualization. Shostrom (1976) states that this is not a forced choice instrument, and that the item format is better described as paired-opposites. The scale scores are normative rather than ipsative, and an individual can have high scores on all 12 scales or low scores on all 12 scales. Whereas one common method of handling the 150 items is simply to use the sum of the two major subscales as the overall measure of self-actualization (Damm, 1972), it was decided that each of the 12 subscale raw scores would be used as measures in this study since they relate to conceptually different aspects of self-actualization, each of which would seem to be important in this comparative counseling research.

The first major subscale is Time Competent (Tc with 23 items) and measures the degree to which a person can live primarily in the present without regrets and resentments from the past and without idealized expectations and goals for the future. The second major

subscale is Inner Directed (I with 127 items), measuring the extent to which one can be primarily independent and self-supportive, guided by inner motivations rather than external influences.

The third subscale is Self-Actualizing Value (SAV with 26 items), measuring the degree to which an individual holds the general values of self-actualizing people. The fourth subscale is Existentiality (Ex with 32 items), measuring one's flexibility in applying values in life. The fifth subscale is Feeling Reactivity (Fr with 23 items), measuring the sensitivity of responsiveness to one's own needs and feelings. The sixth subscale is Spontaneity (S with 18 items), measuring one's ability to freely express feelings behaviorally. The seventh scale is Self Regard (Sr with 16 items), measuring self-worth. The eighth subscale is Self Acceptance (Sa with 26 items), measuring the ability to accept oneself in spite of weaknesses. The ninth subscale is Nature of Man--Constructive (Nc with 16 items), measuring the degree to which one sees man as essentially good. The tenth subscale is Synergy (Sy with 9 items), measuring the ability to be synergistic and view the opposites of life as meaningfully related. The eleventh subscale is Acceptance of Aggression (A with 25 items), measuring an individual's ability to accept anger within oneself as natural. The twelfth and final subscale is Capacity for Intimate Contact (C with 28 items), measuring the degree to which one can have warm interpersonal relationships.

A review of the instrument in Buros (1972) suggests that the content validity of the POI scales is good, with a variety of content in the items used in the broadly defined scales. In the initial

predictive validation study reported by Shostrom (1964), doctoral-level psychologists nominated criterion samples of "self-actualizing" and "non-self-actualizing" individuals who then took the POI. When compared on their results, the "self-actualizing" group had higher mean scores that were statistically significant on 11 out of the 12 subscales, thus indicating a consistent difference between "self-actualizing" and "non-self-actualizing" groups on the POI. Other validation studies for individuals and groups are summarized in the Handbook for the POI and in the POI Manual.

Test-retest reliability coefficients reported in the POI Manual for a sample of 48 undergraduate college students on the two major subscales are .71 (Time Competent) and .77 (Inner Directed). Coefficients for the other subscales for this sample ranged from .52 to .82.

Use of the POI in the present study seemed particularly appropriate for the counseling center sample because the actualizing model is really an educational model in which responsibility for movement is shifted from the therapist to the client. As a measuring instrument, emphasis is placed on mental health rather than clinical pathology. Items are stated and scale constructs interpreted in a nonthreatening language which stresses the positive effects of therapy rather than focusing on the absence of illness or clinical symptoms. The time for taking the test (about 30 minutes) made it a feasible instrument to use along with other instruments for pre- and posttesting. And the normative data in the manual are geared to a college student population with the standard score profile sheet based on norms of 2,607 entering college freshmen.

The Therapy Session Report (TSR)

The Therapy Session Report used in this study was a modified version of the two questionnaires, one for clients and one for therapists, devised for use in the Psychotherapy Session Project (Orlinsky & Howard, 1966). The modified forms (see Appendix A) were revised in order that they could be used as pretests and posttests, and the items used were similar to the items used by Schauble (1970) in his research on the use of IPR in counseling. Five of the six questions on the report are parallel for the therapists and clients, whereas one question on each of the therapist and client forms was dissimilar.

This evaluation instrument gave an opportunity for clients to rate various dimensions of the therapeutic experience by answering the following six questions on the posttest forms (parallel questions were used for the pretest forms): (a) The last few sessions have been. . . ? (b) How do you feel about coming to the last few sessions? (c) How much progress do you feel you made in dealing with your problems during the last few sessions? (d) How well do you feel that you are getting along, emotionally and psychologically, at this time? (e) How well did your counselor seem to understand what you were feeling and thinking during the last few sessions? and (f) How helpful do you feel your counselor was to you during the last few sessions?

The therapists evaluated the therapeutic experience similarly by independently answering the following six questions: (a) The last few sessions have been. . . ? (b) How motivated for coming to counseling was your client during the last few sessions? (c) How much progress did your client seem to make in the last few sessions? (d) How well

does your client seem to be getting along at this time? (e) How much were you looking forward to seeing your client during the last few sessions? and (f) To what extent were you in rapport with your client's feelings lately?

The Client Description of Problem Scale (CDPS) and The Progress of Counseling Rating Scale (PCRS)

Although the Therapy Session Report was included in this study as a measure of global satisfaction for various dimensions of the therapeutic experience, the investigator also wanted to use a more specific measure on which clients and therapists could rate the degree of achievement on individual counseling goals. The Client Description of Problem Scale (pretest) and the Progress of Counseling Rating Scale (posttest) served this purpose. They are modified versions (see Appendix B) of the originals which were developed for use in counseling research by Seidam and June (1972).

The CDPS and PCRS consist of the same items on the pretest and posttest on both the therapist and client forms. There are 18 possible goals listed (e.g., improving my ability to have close relationships with the opposite sex, dealing with unhappiness and depression, and becoming more aware of the true nature of my feelings), and there are also three open spaces where additional individual goals can be listed. Following each goal on the PCRS is a 9-point scale on which the clients and therapists rated the degree to which a particular goal was a problem (G) and the extent to which the goal was achieved (A) during the counseling sessions. The format

was similar on the initial CDPS, except that the degree to which it was hoped a goal would be achieved was marked on the 9-point scale.

For the final analysis, a single index of perceived goal attainment was calculated by the investigator according to the following procedures. For both the CDPS and the PCRS, a ratio was calculated by taking the number marked on the 9-point scale for achievement of a goal (A) minus one, and dividing it by the number marked on the scale for the degree that a particular goal was a problem (G) minus one, summing these ratios, and then dividing by the total number of goal items marked: $\Sigma(A-1/G-1)/N$. One was subtracted in each case in order that the first number in the 9-point scale could be interpreted as either no goal or no achievement on a goal, or, in other words, zero progress. In each case A was not to exceed G. In the instances that A did in fact exceed G, A was actually calculated as being equal to G; that is, the goal was calculated as being totally achieved.

The Characteristics of Client Growth Scales (COGS)

The COGS consist of the three separate scales of Owning of Feelings (OF), Commitment to Change (CC), and Differentiation of Stimuli (DS). Whereas the other measures used in this study are self-report and therapist-report written instruments, the COGS have the advantage of being more objective measures since they are rating scales that were used by two judges who independently rated audiotapes of first and last counseling sessions. Originally these scales were developed by Kagan, Krathwohl et al. (1967) to provide a method of measuring client progress in therapy with the following properties:

(a) They were not identified with any single counseling theory; (b) They were operationally definable and thus had objectivity and research utility, and the definable characteristics represented meaningful elements of counseling progress; (c) They were not necessarily exclusive of each other, thus the client could display two or more of the characteristics at any given moment; and (d) They were not intended to describe everything that went on in the counseling relationship. The criteria that were chosen for rating client progress represent obvious tasks that are necessary for client movement: (a) The client must own his discomfort and be aware of his feelings, (b) The client must commit himself to changing, and (c) The client must clearly differentiate stimuli in his world.

The three scales used in this study (OF, CC, DS) were revised by Schauble and Pierce (1974) so that each scale consists of five continuous levels where 1.0 is low and 5.0 is high. The complete scales with examples at each level can be found in Appendix C. The scales have been found to be valid and reliable instruments in several therapy research studies (Kagan, Krathwohl et al., 1967; Resnikoff, Schauble, & Kagan, 1970; Schauble, 1970; Schauble & Pierce, 1974; Van Noord, 1973; Van Noord & Kagan, 1976).

The Depth of Client Self-Exploration Scale (DX)

The DX is a measure that is very similar in construction to the Owning of Feelings Scale, the Commitment to Change Scale, and the Differentiation of Stimuli Scale. It was used in this study along with the COGS as an objective measure of client progress in counseling

since it served as a rating scale for two judges who independently rated audiotapes of first and last counseling sessions. Originally it was constructed as a 9-point scale (Truax & Carkhuff, 1967); it was then later revised into a scale of five continuous levels (Carkhuff & Berenson, 1967), where 1.0 is low and 5.0 is high. The complete scale with examples at each level can be found in Appendix C. Another name that is used for this scale is Helpee Self-Exploration in Interpersonal Processes (Carkhuff, 1969).

In order for clients to progress in counseling they must risk talking about personally relevant material with some degree of spontaneity and emotional feeling. The DX measures the extent to which clients engage in self-exploration, ranging from no demonstrable intrapersonal exploration to a very high level of self-probing and exploration. Further descriptions of the scale along with reliability and validity data on outcome research can be found in the sources mentioned above (Carkhuff, 1969; Carkhuff & Berenson, 1967; Truax & Carkhuff, 1967).

Rating of Criterion Tapes

Two independent judges were used to rate the audiotapes from the first and last counseling sessions on the clients' levels of owning of feelings (OF), commitment to change (CC), differentiation of stimuli (DS), and depth of self-exploration (DX). Both judges were doctoral students in counseling psychology programs who were at the internship level in their training. Both had extensive previous

experience with behavioral rating scales which are used in process and outcome research.

Training sessions in which the raters learned the OF, CC, DS, and DX scales consisted of a total of 8 hours in three separate sessions. During this time the investigator provided a description of the scales and then had the judges make practice ratings on audiotapes of counseling sessions that were similar to the research tapes. The practice tapes were stopped at various points and the judges' ratings were compared. A good deal of discussion occurred among the judges and investigator in order to delineate each of the five levels of each of the four rating scales. At the end of the practice sessions there appeared to be close interjudge agreement, as indicated by approximately four out of five ratings of perfect agreement.

The judges rated the audiotapes independently. Neither judge had knowledge of the group, IPR experimental or traditional control, to which the clients had been assigned. This was accomplished through a totally random presentation of the taped segments on master tapes.

Selection of Audiotape Segments for Rating

A total of 50 clients participated in this study, resulting in a total of 100 audiotapes (50 from the initial counseling sessions and 50 from the final counseling sessions), each of which was approximately 50 minutes long. Since it was impractical to rate every minute of all the tapes, it was necessary to decide on a segment sampling procedure. Several previous psychotherapy process research studies have explored the results of sampling audiotapes by different

procedures (Kiesler, 1966; Kiesler, Klein, & Mathieu, 1965; Kiesler, Mathieu, & Klein, 1964; Miller & Maley, 1969). This research indicated that segment sampling can accurately represent the total therapy session, that interrater and rerate reliabilities are unaffected by segment length, that the discriminatory power of the ratings is generally independent of segment length, and that segments can be taken from the total tape in standard time periods or at random, but that for small samples random sampling produces the possibility of offering unrepresentative data.

With the above information in mind, the following sampling procedures were used for this study: Three 4-minute segments were drawn from each pretape, and three 4-minute segments were drawn from each posttape; these three segments consisted of the 4 minutes immediately following the initial 5 minutes on the tape, the middle 4 minutes, and the 4 minutes immediately preceding the final 5 minutes of the tape. Thus, 4-minute segments were used from standard time periods.

All segments, pre and post, experimental and control, were then randomly ordered and dubbed onto master cassette audiotapes (in duplicate) for independent ratings by each judge. Ratings were made on each client statement within the 4-minute segments on the dimensions of OF, CC, DS, and DX.

Reliability of Ratings

Tinsley and Weiss (1975) have reviewed the different methods of calculating interjudge reliabilities. The interjudge reliabilities in this study were calculated according to Ebel's formula (Ebel, 1951),

using a two-way analysis of variance technique. Although each client statement was rated on each of the four dimensions of OF, CC, DS, and DX, the reliabilities obtained were based on the average ratings of the three segments on each audiotape since this was the unit of analysis that was used in evaluating client movement. Interjudge reliability coefficients for the total audiotape sample (50 pretapes and 50 posttapes) are reported in Table 4 below. These reliabilities indicate that the ratings are sufficiently reliable for further analysis. For the final statistical procedures on these ratings, the averages of the two judges' ratings were used on each of the four dimensions.

Table 4: Reliability Coefficients for Pretape and Posttape Ratings on the Client Dimensions of OF, CC, DS, and DX

Dimension	OF	CC	DS	DX
Coefficient	.81	.75	.79	.68

Client Written Comments and Therapist Reactions

In addition to the formal measurements that were reviewed above, a "Comments" page was offered on an optional basis to the clients at the completion of their sessions. This allowed for an informal evaluation of the treatment programs. Clients were asked to indicate any impressions, reactions, or opinions that they wished to share about their counseling sessions.

Therapists were also asked for their informal evaluations of the research project during an audiotaped interview following the completion of their final research counseling sessions. During this time they made specific comments on the degree to which they believed the IPR videotape and stimulus film techniques were useful or not useful to them in helping their clients meet their goals.

Collection of Data

Audiotapes of the first and final research sessions were collected on each client; the tapes were then rated on the client dimensions of OF, CC, DS, and DX. After the initial session and prior to the second session, each client completed the POI, the CDPS, the TSR, and a brief biographical form for sex, GPA, and level in school. Following the final research session each client completed the POI, the PCRS, and the TSR, as well as the "Comments" form on an optional basis. These instruments were administered by testing personnel in the testing office of the Counseling Center at Georgia State University.

After the initial session of each client, the therapists completed the CDPS and the TSR. After the final research session of each client, they completed the PCRS and the TSR. Informal reactions of therapists were obtained through an audiotaped interview after all 10 clients for each therapist had completed the research.

It should be noted that although videotapes were used in the IPR experimental group as a counseling technique, they were not collected

for any form of data analysis; they were erased following recall to preserve confidentiality.

Research Design

The experimental design used in this study was the Pretest-Posttest Control Group Design; this is design 4 as described in Campbell and Stanley (1963). The illustration of this design is presented in Figure 1.

Group		Pretest		Posttest
IPR Treatment (N=25)	R[a]	O_1	Y	O_2
Traditional Control (N=25)	R	O_3	Y	O_4

[a]R = random assignment of matched pairs.

Figure 1. Research design

A total of 50 subjects were used in this study. Each of the five research therapists saw 10 research clients, and, of these 10, 5 were assigned to the IPR experimental group and 5 to the traditional control group. Although the five therapists maintained control over which 10 clients they included in the research, the investigator maintained control over the assignment of clients to treatment groups.

Clients were matched according to sex and time of entry into treatments and then randomly assigned to either the counseling with IPR group or the counseling without IPR group. Matching according

to sex was performed in order to have groups with corresponding numbers of each sex. Matching according to time of entry into treatments was performed in order to have clients begin counseling at corresponding times in each group. This was performed because initially there were not enough clients on the waiting list to randomly assign 50 clients to the groups, and, therefore, each client could not begin treatment at the same time. Thus, the first two males to begin treatment for each therapist were matched and randomly assigned to groups, and the first two females to begin treatment for each therapist were also matched and randomly assigned to groups, followed by the next two matched pairs, etc., until the groups were filled.

Pretests (client self-reports, therapist reports, and audiotapes which were later rated by independent judges) were collected after the first sessions. This was done in order to control statistically for any possible initial differences in clients which might have confounded final differences between the two groups, as well as to provide for more powerful statistical analyses.

Hypotheses

The following hypotheses are stated directionally in favor of the IPR experimental group. This is done with the understanding that parallel null hypotheses were tested prior to the following alternative hypotheses.

H_1: Clients who receive personal counseling with IPR interventions will score higher on a measure of self-actualization, a correlate of mental health, as measured by higher adjusted

posttest subscale scores on the POI than will clients who receive personal counseling without IPR.

H_2: Clients who receive personal counseling with IPR interventions will achieve a greater awareness of their feelings, a clearer motivation for growth-producing change, a more accurate ability to discriminate environmental stimuli, and a greater ability to engage in self-exploration in interpersonal situations as measured by higher adjusted posttest audiotape ratings on the scales of OF, CC, DS, and DX than will clients who receive personal counseling without IPR.

H_3: Clients who receive personal counseling with IPR interventions will be more satisfied with their experiences in counseling than will clients who receive personal counseling without IPR as measured by higher client and therapist adjusted subscale scores on the TSR.

H_4: Clients who receive personal counseling with IPR interventions will achieve a higher percentage of their goals in counseling than will clients who receive personal counseling without IPR as measured by higher client and therapist adjusted posttest scores on the PCRS.

In the final statement of the specific research hypotheses in the next chapter, H_3 and H_4 will each be divided into parallel client and therapist hypotheses which will result in a total of six primary hypotheses.

Additional informal hypotheses will also be stated in the next chapter predicting pre to post movement for clients in both treatment groups on the POI, on the COGS and DX, and on the client and therapist forms of the TSR. The null hypothesis (informal) will be stated for clients in both groups predicting no change pre to post on the client and therapist forms of the CDPS/PCRS. These hypotheses are considered as being "informal" because they do not relate to the major design of the study, which is to compare the outcome effects of IPR treatment clients with traditional treatment clients. Also, the informal

hypotheses need to be viewed with some caution since there was no nontreatment or attention placebo control group. This type of group would have ruled out the possibility of pre to post outcome growth due to history and maturation effects without the aid of counseling.

Analysis of the Data

The data resulting from this investigation were analyzed for differences between the IPR experimental group and the traditional control group by four MANOVA computer runs and two ANOVA computer runs. Prior to the final analyses, bivariate linear regression analyses for each subscale of each instrument were performed explaining the posttest in terms of the pretest. From these, a predicted posttest score for each participant on each subscale was computed. These predicted posttest scores were subtracted from actual posttest scores yielding "adjusted" or "residualized" change scores free from pretest score differences. The adjusted change scores were then analyzed in 2 x 5 (treatment by therapist) MANOVAs and ANOVAs according to the following division of the instruments:

1. POI (clients): A 2 x 5 MANOVA (with equal cell frequencies) was used on the adjusted posttest raw scores for each of the 12 subscales to test for between group differences.

2. OF, CC, DS, and DX (clients): The tape ratings made by the two independent judges on each one of these four subscales were averaged and then analyzed for between group differences by a 2 x 5 MANOVA (with equal cell frequencies) on the adjusted posttest scores.

3. CDPS/PCRS (clients): A 2 x 5 ANOVA (with equal cell frequencies) was used on the adjusted posttest scores on this scale to test for between group differences.

4. CDPS/PCRS (therapists): A 2 x 5 ANOVA (with equal cell frequencies) was used on the adjusted posttest scores on this scale to test for between group differences.

5. TSR (clients): A 2 x 5 MANOVA (with equal cell frequencies) was used on the adjusted posttest scores for each of the six subscales to test for between group differences.

6. TSR (therapists): A 2 x 5 MANOVA (with equal cell frequencies) was used on the adjusted posttest scores for each of the six subscales to test for between group differences.

The pretest data were collected in this study in order to adjust the posttest scores for initial differences. The hypotheses were then tested by the above statistical procedures on the adjusted posttest scores. In order to gather additional information, however, analyses were performed on the pre and post data in order to determine if the IPR and traditional treatment clients scored significantly higher on posttest scores than they did on pretest scores. To do this, two three-way ANOVAs and four three-way MANOVAs were used (treatment x therapist x time) with repeated measures on the last dimension. These six computer runs followed the division of instruments as stated above for the analyses on the adjusted posttest scores.

These data were analyzed on a Univax 70/7 computer using programs taken from SPSSH, version 6.01, and BMD X69(12V).

If one total MANOVA had been used including all 30 subscale dependent variables, the significance level would have been set at .05. However, since six separate computer runs were performed on the adjusted posttest scores to test the hypotheses, the significance level was set at .01. This .01 level was also used for the six three-way repeated measures analyses performed to test for pre to post differences within groups.

Subjective client and therapist comments were also examined non-statistically for between group differences of personal reactions to the treatment conditions.

Summary

The sample for this study consisted of 50 undergraduate and graduate clients who had requested help with personal concerns from the staff of the Georgia State University Counseling Center during the 1976-1977 academic year. Therapists were three counseling and clinical psychology staff interns and two staff therapists who, like the clients, volunteered to participate in the project.

The experimental design used was a pretest-posttest control group design. The experimental group consisted of 25 clients who received traditional counseling with the addition of IPR videotape feedback and stimulus film techniques. The control group consisted of 25 clients who received traditional counseling alone. Clients were matched according to sex and time of entry into treatments and then randomly assigned to the groups. Each therapist saw 10 clients, 5 in each group. The number of 50-minute treatment sessions ranged from

4 to 15 for each client, and therapists were allowed to choose specific IPR intervention techniques according to individual client needs.

The five measures used as criteria for the study were the Personal Orientation Inventory (for clients), the Therapy Session Report (for clients and therapists), the Client Description of Problem Scale/the Progress of Counseling Rating Scale (for clients and therapists), the Characteristics of Client Growth Scales (for clients), and the Depth of Self-Exploration Scale (for clients). Ratings on these last two scales were made from audiotape samples from first and last sessions by two independent judges. Data from the first three instruments were collected after the first and last sessions. Subjective client and therapist comments were also obtained.

Hypotheses were stated directionally in favor of the IPR experimental group. The data obtained in the study were analyzed for differences between the experimental and control group by four 2 x 5 (treatment by therapist) MANOVA and two 2 x 5 ANOVA computer runs. Prior to these final analyses, bivariate linear regression analyses for each subscale of each instrument were performed in order to obtain adjusted posttest scores free of pretest score differences. Additional analyses were performed to test for pre to post differences using four three-way MANOVAs and two three-way ANOVAs (treatment x therapist x time) with repeated measures on the last dimensions. The .01 level of significance was used in all cases.

CHAPTER IV

ANALYSIS OF THE DATA

In this chapter an analysis of the data is presented based upon the methodology described in Chapter III. In the first section, the results of the analyses on the adjusted posttest scores for between treatment group differences are presented. In the second section, the results of the analyses in the pre and post raw scores for pre to post differences within the two treatment groups are presented. In the third and fourth sections, the results of a nonstatistical evaluation of client and therapist subjective comments about the treatments are presented.

Results of the Analysis on the Adjusted Posttest Scores for Between Treatment Group Differences

The results of the four MANOVA and two ANOVA computer runs on the adjusted posttest scores (free of pretest score differences) are presented here. Although there are both treatment and therapist main effects, the hypotheses are concerned with the treatment effects. These hypotheses are stated directionally in favor of the IPR treatment group. Significance testing was carried out at the .01 level for each of the six computer runs. Summary MANOVA and ANOVA tables are included as well as tables of raw score pre and post means and standard deviations, and adjusted posttest means.

POI MANOVA Results on
Adjusted Posttest Scores

H_1: Clients who receive personal counseling with IPR interventions will score higher on a measure of self-actualization, a correlate of mental health, as measured by higher adjusted posttest subscale scores on the POI than will clients who receive personal counseling without IPR.

Results: No significant difference in treatment effect between the IPR and traditional groups was found. Therefore, the null hypothesis was not rejected.

An F (12,29) value of 2.87 is needed to reject the null at the .01 level. The F obtained was 0.82, indicating very little between group differences on the POI and no chance of significance. The therapist and the interaction effects were nonsignificant.

The POI MANOVA summary information is presented in Table 5 below. Specific information about the raw score pre and post means and standard deviations, and about the adjusted posttest means for each group, is presented in Table 6, pp. 88-89.

Table 5: MANOVA of POI Adjusted Posttest Scores

Source	df	F	p
Treatment	12/29	0.8194	ns
Therapist	48/113.75	0.9018	ns
Interaction	48/113.75	0.9420	ns

Table 6: POI Raw Score Means, Standard Deviations, and Adjusted Means

Subscale	Treatment Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Mean Change	Group With Greatest Mean Change	Adjusted Posttest Mean
Time Competent	IPR	13.76	3.23	15.88	3.26	+ 2.12	Traditional	-.32
	Traditional	13.96	3.42	16.60	3.95	+ 2.64		+.32
Inner Directed	IPR	75.52	14.38	87.44	13.99	+11.92	Traditional	-.33
	Traditional	75.16	12.85	87.88	12.01	+12.72		+.33
Self-Actualizing Value	IPR	17.36	4.07	19.08	3.46	+ 1.72	Traditional	-.53
	Traditional	17.92	3.10	20.48	2.73	+ 2.56		+.53
Existentiality	IPR	19.64	4.29	23.04	4.34	+ 3.40	IPR	+.39
	Traditional	19.40	5.20	22.12	4.75	+ 2.72		-.39
Feeling Reactivity	IPR	14.40	3.51	17.20	3.24	+ 2.80	IPR	+.83
	Traditional	14.80	3.16	17.24	2.24	+ 2.44		-.83
Spontaneity	IPR	10.52	3.80	12.56	2.36	+ 2.04	Traditional	-.09
	Traditional	10.44	3.11	12.72	2.49	+ 2.28		+.09

Table 6: Continued

Subscale	Treatment Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Mean Change	Group With Greatest Mean Change	Adjusted Posttest Mean
Self-Regard	IPR	9.60	3.43	11.84	3.02	+2.24	Traditional	-.18
	Traditional	9.28	2.92	12.00	3.29	+2.72		+.18
Self-Acceptance	IPR	13.52	3.58	16.16	3.00	+2.64	Traditional	-.32
	Traditional	12.40	4.18	16.24	3.90	+3.84		+.32
Nature of Man, Constructive	IPR	10.76	2.15	11.40	2.06	+ .64	Traditional	-.10
	Traditional	11.12	2.46	11.80	2.04	+ .68		+.10
Synergy	IPR	6.28	1.67	6.84	1.21	+ .56	Traditional	-.06
	Traditional	6.28	1.43	6.96	1.24	+ .68		+.06
Acceptance of Aggression	IPR	14.60	3.49	16.96	3.16	+2.36	Traditional	-.13
	Traditional	15.08	3.71	17.44	2.92	+2.36		+.13
Capacity for Intimate Contact	IPR	17.08	4.21	20.40	3.22	+3.32	IPR	+.02
	Traditional	17.16	3.86	20.40	3.38	+3.24		-.02

COGS and DX MANOVA Results
on Adjusted Posttest Scores

H_2: Clients who receive personal counseling with IPR interventions will achieve a greater awareness of their feelings, a clearer motivation for growth-producing change, a more accurate ability to discriminate environmental stimuli, and a greater ability to engage in self-exploration in interpersonal situations as measured by higher adjusted posttest audiotape ratings on the scales of OF, CC, DS, and DX than will clients who receive personal counseling without IPR.

Results: No significant difference in treatment effect between the IPR and traditional groups was found. Therefore, the null hypothesis was not rejected.

An F (4,37) value of 3.88 is needed to reject the null at the .01 level. The F value obtained was 2.79, indicating no significant between treatment group differences on the four tape process ratings of OF, CC, DS, and DX. The therapist and interaction effects were nonsignificant.

The COGS and DX MANOVA summary information is presented in Table 7 below. Specific information about the raw score pre and post means and standard deviations, and about the adjusted posttest means for each group, is presented in Table 8, p. 91.

Table 7: MANOVA of COGS and DX Adjusted Posttest Scores

Source	df	F	p
Treatment	4/37.00	2.7907	ns*
Therapist	16/113.67	1.1344	ns
Interaction	16/113.67	0.4489	ns

*.025 < p < .05.

Table 8: COGS and DX Raw Score Means, Standard Deviations, and Adjusted Means

Subscale	Treatment Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Mean Change	Group With Greatest Mean Change	Adjusted Posttest Mean
Owning of Feelings	IPR	2.72	.56	2.58	.48	-.14	Traditional	-.13
	Traditional	2.54	.52	2.79	.45	+.25		+.13
Commitment to Change	IPR	1.77	.53	1.88	.48	+.11	Traditional	-.06
	Traditional	1.68	.33	1.95	.56	+.27		+.06
Differentiation of Stimuli	IPR	3.40	.33	3.39	.23	-.01	Traditional	-.01
	Traditional	3.35	.30	3.39	.32	+.04		+.01
Degree of Self-Exploration	IPR	3.22	.31	3.17	.24	-.05	Traditional	-.05
	Traditional	3.12	.33	3.23	.27	+.11		+.05

It should be noted that the F value for the treatments on the COGS and DX MANOVA is significant at the .05 level, but not at the .025 or .01 levels, and that the direction of the means favors the traditional group. Upon inspection of the univariate analyses of the four subscales, it was observed that most of the weight for this "trend toward significance" in the direction opposite that predicted came from the OF scale. The obtained OF scale ANOVA F (1,40) value was 4.41, which is significant at the .05 but not at the .025 or .01 levels. The F values for the ANOVAs on the CC and DS scales were both below 1.0, indicating no possibility for significance. And the F (1,40) value for the ANOVA on the DX scale was 1.69, which was nonsignificant at the .10 level.

TSR (Clients) MANOVA Results on Adjusted Posttest Scores

H_3: Clients who receive personal counseling with IPR interventions will be more satisfied with their experiences in counseling than will clients who receive personal counseling without IPR as measured by higher client adjusted subscale scores on the TSR.

Results: No significant difference in treatment effect between the IPR and traditional groups was found. Therefore, the null hypothesis was not rejected.

An F (6,35) value of 3.37 is needed to reject the null at the .01 level. The F value obtained was 0.47, indicating very little between group differences and no chance for significance on the client form of the TSR. The therapist and the interaction effects were nonsignificant.

The TSR (clients) MANOVA summary information is presented in Table 9 below. Specific information about the raw score pre and post means and standard deviations, and about the adjusted posttest means for each group, is presented in Table 10, p. 94.

Table 9: MANOVA of TSR (Client Form) Adjusted Posttest Scores

Source	df	F	p
Treatment	6/35	0.4675	ns
Therapist	24/123.31	0.8500	ns
Interaction	24/123.31	0.9589	ns

TSR (Therapists) MANOVA Results on Adjusted Posttest Scores

H_4: Clients who receive personal counseling with IPR interventions will have more satisfying and more productive counseling sessions than will clients without IPR as measured by higher therapist adjusted subscale scores on the TSR.

Results: No significant difference in treatment effect between the IPR and traditional groups was found. Therefore, the null hypothesis was not rejected.

An F (6,35) value of 3.37 is needed to reject the null at the .01 level. The F value obtained was 0.86, indicating very little between treatment group differences and no possibility for significance on the therapist form of the TSR. The therapist effect was significant at the .001 level, indicating that at least two of the therapists significantly differed on the ratings that they gave to the counseling experience of all their clients, including both IPR

Table 10: TSR (Client Form) Raw Score Means, Standard Deviations, and Adjusted Means

Subscale	Treatment Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Mean Change	Group With Greatest Mean Change	Adjusted Posttest Mean
1	IPR	4.60	.82	5.04	.74	+ .44	IPR	+.03
	Traditional	4.48	.71	4.92	1.04	+ .44		-.03
2	IPR	4.20	1.23	4.60	.76	+ .40	IPR	+.22
	Traditional	4.16	1.18	4.16	1.28	+ .00		-.22
3	IPR	3.44	1.08	4.68	.85	+1.24	IPR	+.08
	Traditional	3.24	.78	4.40	1.53	+1.16		-.08
4	IPR	3.40	.87	4.32	.75	+ .92	Traditional	-.05
	Traditional	3.36	.86	4.40	1.23	+1.04		+.05
5	IPR	3.68	.56	3.88	.60	+ .20	IPR	+.06
	Traditional	3.76	.60	3.88	1.09	+ .12		-.06
6	IPR	3.92	1.15	4.64	.86	+ .72	Traditional	-.03
	Traditional	3.76	1.27	4.52	1.19	+ .76		+.03

and traditional groups. The therapist effect does not relate to the above hypothesis (since there is no treatment x therapist interaction effect), which is concerned with between treatment group, not between therapist, differences.

The TSR (therapists) MANOVA summary information is presented in Table 11 below. Specific information about the raw score pre and post means and standard deviations, and about the adjusted posttest means for each group, is presented in Table 12, p. 96.

Table 11: MANOVA of TSR (Therapist Form) Adjusted Posttest Scores

Source	df	F	p
Treatment	6/35	0.8625	ns
Therapist	24/123.31	2.7801	<.001
Interaction	24/123.31	1.3340	ns

CDPS/PCRS (Clients) ANOVA Results on Adjusted Posttest Scores

H_5: Clients who receive personal counseling with IPR interventions will achieve a higher percentage of their goals in counseling than will clients who receive personal counseling without IPR as measured by higher client adjusted posttest scores on the PCRS.

Results: No significant difference in treatment effect between the IPR and traditional groups was found. Therefore, the null hypothesis was not rejected.

An F (1,40) value of 7.31 is needed to reject the null at the .01 level. The F value obtained was 0.10, indicating very little

Table 12: TSR (Therapist Form) Raw Score Means, Standard Deviations, and Adjusted Means

Subscale	Treatment Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Mean Change	Group With Greatest Mean Change	Adjusted Posttest Mean
1	IPR	3.76	.72	4.52	1.09	+ .76	IPR	+.13
	Traditional	4.00	.76	4.24	.83	+ .24		-.13
2	IPR	3.72	.54	3.92	.76	+ .20	IPR	+.14
	Traditional	3.56	.71	3.60	.87	+ .04		-.14
3	IPR	3.52	.71	4.56	1.19	+1.04	IPR	+.18
	Traditional	3.48	.65	4.20	1.00	+ .72		-.18
4	IPR	3.20	.87	4.44	.87	+1.24	IPR	+.11
	Traditional	3.44	.87	4.28	.84	+ .84		-.11
5	IPR	2.76	.93	3.60	1.08	+ .84	IPR	+.001
	Traditional	2.92	1.00	3.52	1.12	+ .60		-.001
6	IPR	3.08	.64	3.80	1.08	+ .72	IPR	+.06
	Traditional	3.12	.73	3.80	.87	+ .68		-.06

between group differences on the client form of the CDPS/PCRS and no possibility of significance. The therapist and interaction effects were nonsignificant.

The CDPS/PCRS client ANOVA summary information is presented in Table 13 below. Specific information about the raw score pre and post means and standard deviations, and about the adjusted posttest means for each group, is presented in Table 14, p. 98.

Table 13: ANOVA of CDPS/PCRS (Client Form) Adjusted Posttest Scores

Source	df	F	p
Treatment	1/40	.0995	ns
Therapist	4/40	.3399	ns
Interaction	4/40	.7698	ns

CDPS/PCRS (Therapists) ANOVA
Results on Adjusted Posttest Scores

H_6: Clients who receive personal counseling with IPR interventions will achieve a higher percentage of their goals in counseling than will clients who receive personal counseling without IPR as measured by higher therapist adjusted posttest scores on the PCRS.

Results: No significant difference in treatment effect between the IPR and traditional groups was found. Therefore, the null hypothesis was not rejected.

An F (1,40) value of 7.31 is needed to reject the null at the .01 level. The F value obtained was 0.10, indicating very little between group differences on the therapist form of the CDPS/PCRS and

Table 14: CDPS/PCRS (Client Form) Raw Score Means, Standard Deviations, and Adjusted Means

Subscale	Treatment Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Mean Change	Group With Greatest Mean Change	Adjusted Posttest Mean
Goals	IPR	.87	.18	.75	.20	-.12	Traditional	-.09
	Traditional	.87	.14	.77	.21	-.10		+.09

no possibility of significance. The interaction effect was nonsignificant. The therapist effect was significant at the .001 level, indicating that at least two of the therapists significantly differed on the ratings that they gave for goal achievement for all of their clients, including both the IPR and traditional treatment groups. This therapist effect does not relate to the above hypothesis (since there is no treatment x therapist interaction effect), which is concerned with between treatment group, not between therapist, differences.

The CDPS/PCRS therapist ANOVA summary information is presented in Table 15 below. Specific information about the raw score pre and post means and standard deviations, and about the adjusted posttest means for each group, is presented in Table 16, p. 100.

Table 15: ANOVA of CDPS/PCRS (Therapist Form) Adjusted Posttest Scores

Source	df	F	p
Treatment	1/40	.1037	ns
Therapist	4/40	14.9101	<.001
Interaction	4/40	1.6743	ns

Results of the Analyses on the Pre and Post Raw Scores for Pre to Post Differences Within the IPR and Traditional Treatment Groups

The hypotheses of this study were concerned with differences between the IPR and traditional treatment groups on the adjusted

Table 16: CDPS/PCRS (Therapist Form) Raw Score Means, Standard Deviations, and Adjusted Means

Subscale	Treatment Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Mean Change	Group With Greatest Mean Change	Adjusted Posttest Mean
Goals	IPR	.77	.14	.70	.19	-.07	IPR	+.06
	Traditional	.79	.13	.70	.19	-.09		-.06

posttest scores. Additional informal hypotheses were formulated predicting clients in both groups to improve from pre to post testing. That is, clients in both treatment groups were expected to improve on the POI, on the COGS and DX, and on the client and therapist forms of the TSR. Since the goal instrument (CDPS/PCRS) differs from the above instruments in that it has to do with predicting and then stating how many specific goals are achieved, no pre to post differences would be expected. This measure was important for the previous analysis in testing for between group differences, and, thus, the pre scores were important for adjusting the post scores for initial differences. Since the means for both client and therapist forms of this measure decreased pre to post, however, the results of the pre to post analyses are included here.

The pre and post data were analyzed by two three-way ANOVAs and four three-way MANOVAs (treatment x therapist x time) with repeated measures on the last dimension. These computer runs follow the division of instruments as used above for the between group analyses. The .01 level of significance was used with each of the six analyses.

The results of these analyses must be considered with some caution, however, because there was no nontreatment or attention placebo control group to compare the effects of counseling with no counseling. On the POI and TSR, test-retest issues could have been a problem, but not on the COGS and DX since they were ratings by independent judges of taped sessions. History and maturation effects could have been a threat to internal validity, since it is not known whether

clients would have improved over time with no treatments or an attention placebo.

POI Pre to Post Repeated Measures
MANOVA Results on Raw Scores

H_7: Clients in both the IPR and traditional treatment groups will score higher on a measure of self-actualization, a correlate of mental health, at the end of their counseling sessions than at the beginning, as measured by higher post POI subscale scores.

Results: A significant difference for both the IPR and traditional treatment groups was found on the POI (with post means higher than pre means). Thus, the null hypothesis was rejected and the alternative accepted.

An F (12,29) value of 2.87 is needed to reject the null at the .01 level. The obtained F value of 6.04 is significant at less than the .001 level. Since there was no treatment x time interaction effect, and since the means on each of the 12 subscales for both treatment groups were higher on the post scales (see Table 6, p. 88), it can be stated that both groups significantly improved over time. The therapist significant effect (p less than .001) and the therapist x treatment significant effect (p less than .001) are not important here, but it indicates that clients of at least two therapists in the two treatment groups had significantly different responses on the POI, which included both the pre and post data. As stated earlier and summarized in Table 5, p. 87, the therapist x treatment interaction effect and the therapist effect on the adjusted posttest scores MANOVA had no possibility of being significant since the F values are less than 1.00.

Each of the 12 subscale means on the POI for each treatment contributed to the significant time effect since all the means increased pre to post. When the univariate analyses were examined for each of the 12 subscales, each had a significant time difference at the .01 level or less except for scale 9 (Nature of Man--Constructive), which was significant at the .025 level. The POI pre to post MANOVA summary information is presented in Table 17 below.

Table 17: MANOVA of POI Pre- and Posttest Raw Scores

Source	df	F	p
Time	12/29	6.0364	<.001
Treatment	12/29	1.1102	ns
Therapist	48/113.75	2.8545	<.001
Time x Treatment	12/29	0.6926	ns
Time x Therapist	48/113.75	0.9250	ns
Treatment x Therapist	48/113.75	2.1111	<.001
Time x Treatment x Therapist	48/113.75	1.0165	ns

COGS and DX Pre to Post Repeated Measures MANOVA Results on Raw Scores

H_8: Clients in both the IPR and traditional treatment groups will achieve a greater awareness of their feelings, a clearer motivation for growth-producing change, a more accurate ability to discriminate environmental stimuli, and a greater ability to engage in self-exploration in interpersonal situations at the end of their counseling sessions than at the beginning, as measured by higher post subscale scores on the scales of OF, CC, DS, and DX.

Results: No significant pre to post differences in either the IPR or traditional treatment groups were found on the process

dimensions of the COGS and DX. Thus, the null hypothesis was not rejected.

An F (4,37) value of 3.88 is needed to reject the null at the .01 level. The obtained F value of 2.60 indicates no significant difference (neither was this value significant at the .05 level). There was no treatment x time interaction effect (at the .01 or .05 levels). Thus, even though all four traditional group means increased slightly pre to post, and only one of the IPR group means increased pre to post (see Table 8, p. 91), these differences were not significant as an interaction. The COGS and DX pre to post summary information is presented in Table 18 below.

Table 18: MANOVA of COGS and DX Pre- and Posttest Raw Scores

Source	df	F	p
Time	4/37	2.5970	ns*
Treatment	4/37	0.2279	ns
Therapist	16/113.67	1.9927	ns**
Time x Treatment	4/37	2.5449	ns***
Time x Therapist	16/113.67	1.0411	ns
Treatment x Therapist	16/113.67	0.8629	ns
Time x Treatment x Therapist	16/113.67	0.3066	ns

*.05 < p < .10.
**.01 < p < .05.
***.05 < p < .10.

TSR (Clients) Pre to Post Repeated Measures MANOVA Results on Raw Scores

H_9: Clients in both the IPR and traditional treatment groups will be more satisfied with their counseling sessions at the end than at the beginning of their counseling as measured by higher post client TSR subscale scores.

Results: A significant difference for both the IPR and traditional treatment groups was found on the client form of the TSR (with means higher on posttests). Thus, the null hypothesis was rejected and the alternative accepted.

An F (6,35) value of 3.37 is needed to reject the null at the .01 level. The obtained F value of 9.00 is significant at less than the .001 level of significance. Since there was no treatment x time interaction effect, and since the means increased for both treatments over time (see Table 10, p. 94), it can be stated that both treatment groups significantly improved over time.

Each of the subscales contributed to this overall significant time difference as revealed by the increase in means on all subscales (except for scale 2 in the traditional group, see Table 10, p. 94). When the univariate analyses were examined for each of the levels of the TSR, subscales 1, 3, 4, and 6 were found to be significant at the .01 level or less, and scales 2 and 5 were nonsignificant at the .10 level. These subscales were described under instrumentation in Chapter III. The client TSR pre to post MANOVA summary information is presented in Table 19, p. 106.

Table 19: MANOVA of TSR (Client Form) Pre- and Posttest Raw Scores

Source	df	F	p
Time	6/35	8.9962	<.001
Treatment	6/35	0.8132	ns
Therapist	24/123.31	0.8965	ns
Time x Treatment	6/35	0.2274	ns
Time x Therapist	24/123.31	1.0194	ns
Treatment x Therapist	24/123.31	1.5201	ns*
Time x Treatment x Therapist	24/123.31	1.0756	ns

*.05 < p < .10.

TSR (Therapists) Pre to Post Repeated Measures MANOVA Results on Raw Scores

H_{10}: Clients in both the IPR and traditional treatment groups will have more satisfying and more productive counseling sessions at the end of their treatment than at the beginning as measured by higher post therapist TSR subscale scores.

Results: A significant difference for both the IPR and traditional treatment groups was found on the therapist form of the TSR (with post means higher than pre means). Thus, the null hypothesis was rejected and the alternative accepted.

An F (6,35) value of 3.37 is needed to reject the null at the .01 level. The obtained F value of 13.79 is significant at less than the .001 level. Since there was no treatment x time interaction effect, and since the six subscale means increased for both treatment groups, it can be stated that both groups significantly improved over time. The therapist significant effect is not important here, but it indicates that at least two of the therapists significantly differed

on the ratings that they gave to the pre and post counseling experiences of all their clients.

Each of the subscales for both groups contributed to the overall significant time difference (see Table 12, p. 96). When the univariate analyses were examined for each of the six levels, subscales 1, 3, 4, 5, and 6 were found to be significant at the .01 level or less, and scale 2 was nonsignificant at the .10 level. These subscales are described under instrumentation in Chapter III. The therapist TSR pre to post MANOVA summary information is presented in Table 20 below.

Table 20: MANOVA of TSR (Therapist Form) Pre- and Posttest Raw Scores

Source	df	F	p
Time	6/35	13.7866	<.001
Treatment	6/35	1.7414	ns
Therapist	24/123.31	4.2212	<.001
Time x Treatment	6/35	1.3148	ns
Time x Therapist	24/123.31	1.8311	ns*
Treatment x Therapist	24/123.31	1.5222	ns**
Time x Treatment x Therapist	24/123.31	1.3476	ns

*.01 < p < .05.

**.05 < p < .10.

CDPS/PCRS (Clients) Pre to Post Repeated Measures ANOVA Results on Raw Scores

As stated at the beginning of this section, the CDPS/PCRS goal instrument can not properly be viewed as a measure of pre-post

improvement. The pretest was most suitable for adjusting posttest scores for initial pretest score differences. The pretest measured the degree to which clients (and therapists) hoped to achieve their goals, and the posttest measured the degree to which clients (and therapists) believed they actually reached their goals in counseling at the time of the final research sessions. The results of the pre to post ANOVA analyses on the client and therapist forms of the CDPS/PCRS are included here for additional information, with informal hypotheses predicting no pre to post differences.

H_{11}: No difference will be observed in either the IPR or traditional treatment groups between the clients' prediction of how much they hope to achieve their goals at the beginning of counseling on the CDPS and the degree to which they rate that they actually achieve their goals at the end of their counseling sessions on the PCRS.

Results: A significant difference for both the IPR and traditional treatment groups was found on the CDPS/PCRS (with post means lower than pre means for both groups). Thus, the null hypothesis was rejected.

An F (1,40) value of 7.31 is needed to reject the null at the .01 level. The obtained F value of 7.45 was significant at this level. Since there was no treatment x time interaction effect, and since the means on this scale for each of the treatment groups dropped pre to post (see Table 14, p. 98), it can be stated that clients in both groups predicted the achievement of their goals to a significantly higher degree than they rated their final achievement of their goals. The CDPS/PCRS (clients) pre to post ANOVA summary information is presented in Table 21, p. 109.

Table 21: ANOVA of CDPS/PCRS (Client Form) Pre- and Posttest Raw Scores

Source	df	F	p
Time	1/40	7.4530	<.01
Treatment	1/40	0.0258	ns
Therapist	4/40	1.6720	ns
Time x Treatment	1/40	0.0716	ns
Time x Therapist	4/40	0.8267	ns
Treatment x Therapist	4/40	0.7636	ns
Time x Treatment x Therapist	4/40	0.6519	ns

CDPS/PCRS (Therapists) Pre to Post Repeated Measures ANOVA Results on Raw Scores

H_{12}: No difference will be observed in either the IPR or traditional treatment groups between the therapists' prediction of how much they believe their clients will achieve their goals at the beginning of counseling on the CDPS and the degree to which they rate their clients as actually achieving their goals at the end of their counseling sessions on the PCRS.

Results: A significant difference for both the IPR and traditional treatment groups was found on the CDPS/PCRS (with post means lower than pre means for both groups). Thus, the null hypothesis was rejected. This statement must be made with caution, however, as described below.

An F (1,40) value of 7.31 is needed to reject the null at the .01 level. The obtained F value of 13.07 was significant at less than the .001 level. The means for both the IPR and traditional groups dropped pre to post (see Table 16, p. 100). There was, however, a therapist effect (.001 level) and a therapist x time interaction

effect (.001 level) but no treatment x time interaction effect. An investigation into the cell means revealed that one therapist rated both IPR and traditional treatment clients as having actually achieved their goals higher than he predicted they would on the pretest. Each of the other four therapists rated both groups of clients lower on the post. Overall, however, it can be stated that the therapists rated a significantly lower degree of achievement of their clients' goals than they predicted they would achieve at the beginning. The CDPS/PCRS (therapist) pre to post ANOVA summary information is presented in Table 22 below.

Table 22: ANOVA of CDPS/PCRS (Therapist Form) Pre- and Posttest Raw Scores

Source	df	F	p
Time	1/40	13.0677	<.001
Treatment	1/40	0.1767	ns
Therapist	4/40	15.0289	<.001
Time x Treatment	1/40	0.1767	ns
Time x Therapist	4/40	11.5658	<.001
Treatment x Therapist	4/40	0.8304	ns
Time x Treatment x Therapist	4/40	1.6750	ns

Subjective Client Comments

In addition to the formal instruments which provided quantifiable data that could easily be analyzed, an informal "Comments" page was included in the posttesting for clients to make any statements about the treatments or the counseling process on an optional basis. Of

the 25 IPR treatment clients in the research program, 19 chose to respond on this "Comments" page, and of the 25 traditional treatment clients, 18 chose to respond.

A nonstatistical inspection of these comments revealed no differences between the IPR and traditional treatment clients concerning their satisfaction with their counseling experiences. This correlates with the objective data on the TSR and on the CDPS/PCRS which showed no significant differences in degree of satisfaction with counseling and goal attainment between clients in the two treatment groups. Almost all of the 37 clients who responded highly accentuated the positive aspects of their counseling experiences.

Most of the comments were global rather than specific. Representative statements are: "The counseling sessions have been a great help to me," and "I think the Counseling Center is one of the best things about this University and provides a needed service." Three clients in each of the treatment groups stated that they would have preferred their sessions to continue for a longer period of time. One client stated that he wished his counselor had been more knowledgeable of the situation with which he was dealing, but he did not clarify this.

Of the 19 IPR clients who responded on the "Comments" sheet, eight clients made at least one reference to the videotape and two clients made a reference to the stimulus films. One of the latter clients replied, "The most helpful and self-rewarding sessions were those in which we used the films as a basis for interaction and communication." The other client stated, "For my counselor the movie

clips seemed to be helpful, however they weren't very applicable to myself."

Of the eight clients who made statements on the use of videotape feedback in their sessions, six were very positive, one was mixed, and one was negative. The negative comment was nonspecific about the videotape:

> "Several great people work at the Counseling Center that really 'vibrate' with happiness. The people here do much more than the machines, i.e., the biofeedback machine and the TV monitor. It is the discussions that are the most bright and not the machine."

The mixed comment was:

> "Sometimes I felt that the videotaping was an interference with my sessions with [my therapist]. I held back most of what I wanted to say--dealt with generalities rather than specifics. Sometimes it was helpful to review the tapes to better understand how [my therapist] was seeing me and to clarify things."

Of the six clients who made positive comments on the use of videotape, one client said she "enjoyed the videotape sessions and felt that they were very revealing." She went on to say that she would have appreciated more feedback from the inquirers. Another client stated, "I feel as though the video sessions were very good and very helpful," and then went on to say that he wished he could have reviewed the tapes at a later date. The other four comments were as follows:

> "I found the sessions in which videotaping was used very helpful. I would have liked it to have been used more."

> "Taping of sessions eliminated the need to repeat information previously discussed and helped me believe that the counselor understood and was interested."

"I have wondered if the videotaping techniques have caused any changes that could be considered global as opposed to isolated behaviors. I think seeing myself on videotape made me realize how obnoxious my intellectualizing is and how hard and scattered I appear. And that led directly to my allowing myself to feel vulnerable which allows me to feel more of everything and, I think, appear softer and more real."

"I found the video-taping quite helpful in underlining communication. I had never really thought much about what happens (goes on) with myself or the person I'm interacting with, particularly wants, needs, and feelings in general."

Subjective Therapist Comments

A discussion was held with the research therapists after the completion of their final research sessions about the use of the IPR techniques. These discussions were audiotaped and then reviewed for writing the following subjective therapist comments.

All of the therapists believed that the IPR videotape and stimulus film intervention techniques were helpful with their clients. They each stated that they were pleased to add the techniques to their repertoire of therapeutic skills, and that they planned to use them occasionally with their clients in the future.

Three of the therapists, in fact, used the videotape recall technique with some of their nonresearch clients, and a fourth therapist used the stimulus films two times with an IPR research client after the final 15th research session when the posttests were taken. The client told her therapist that the films were important in helping her to share her feelings more openly with her friends, and that she no longer became "upset" at her friends when they did not simply know what she was feeling without her telling them.

Each of the therapists stated that they found the videotape recall to be helpful to themselves in improving their therapeutic styles. One therapist said the tapes helped him focus more on process and not get so caught up in content. Another therapist commented that he became more self-disclosing with his IPR clients through the use of the inquirer and the recall, and that he found this to be beneficial. He said that the videotape recall made it easier to convey to his clients that he did in fact understand them.

Four of the therapists said they found the mutual recall technique to be most effective because they could actively participate in the recall process, learn from it, and express themselves more openly with their clients. The fifth therapist found client recall to be most useful, and he said that he used it the most because it provided the best therapeutic intervention for the specific research clients that he saw. Four of these clients were women who had difficulties with men, and he wanted to give them a period of distance from him by viewing the videotape with the help of an inquirer but without his being in the room or watching through a one-way mirror. He noted that this brought up the issue of fears of abandonment and it proved to be a stimulus for therapeutic work on this underlying dynamic.

Each of the therapists believed that the stimulus films were more effective with some clients and the videotape with others. One therapist in particular found no therapeutic value in using the videotape with one client, but found that the stimulus films were very beneficial in assisting her to talk about and label her feelings. Two of the

therapists noted that the therapeutic value of the videotape was in direct proportion to the extent that the clients wanted to see themselves and to actively engage in learning about their interactions with their therapist. One client refused to look at herself on the videotape. Her therapist initially feared that this form of self-confrontation might have been harmful at that stage in her therapy, but the therapist reported that this client made a great deal of improvement in relating to her openly and in raising her self-concept. Two of the therapists said they found the films and videotape valuable as an assessment tool, both for themselves and for their clients.

The main criticism of the IPR techniques was that therapists did not like having to use them on a regular basis with their IPR clients (50% of the sessions during the first 10 sessions and once in the next 5). Two of the therapists believed that the techniques were occasionally intrusive and detracted from the sessions because they had to use them when they did not want to do so. As an example, one therapist said his client refused to get deeply involved in her painful feelings when she knew the session would be interrupted with an inquirer entering to do recall. Although the therapists recognized the need for the structure of the interventions due to the controlled research, they also were aware that this need for internal validity control detracted from their ability to be as effective with their clients at all times as they could have been without the structure.

One therapist said that he found a couple of his clients to be distracted and more anxious during the initial videotaping sessions

due to the presence of the equipment. But he went on to say that they became much more focused and less anxious during recall when they were allowed to see themselves on tape. He also said that this distraction effect occurred only during the initial videotape sessions.

Summary

In the initial section of this chapter, the results of the analyses on the adjusted posttest scores for between group differences were presented. Six hypotheses were stated predicting that higher adjusted posttest scores would be found with IPR treatment clients than with traditional treatment clients on the POI, the COGS and DX, the client form of the TSR, the therapist form of the TSR, the client form of the CDPS/PCRS, and the therapist form of the CDPS/PCRS. Significance testing was carried out at the .01 level. The results of the six 2 x 5 (treatment x therapist) MANOVA and ANOVA computer runs indicated that there were no significant differences between treatment groups on any of the six measures. Thus, none of the null hypotheses were rejected.

In the second section of this chapter, the results of the analyses on the pre and post raw scores for pre to post differences within the IPR and traditional treatment groups were presented. Four informal hypotheses were stated predicting that higher posttest over pretest raw scores would be found within both the IPR and traditional treatment groups on the POI, the COGS and DX, the client form of the TSR, and the therapist form of the TSR. Significance testing was carried out

at the .01 level. The results of the four three-way MANOVAs (treatment x therapist x time) with repeated measures on the last dimension indicated that there were pre to post significant differences in both the IPR and traditional treatment groups on the POI and on the client and therapist forms of the TSR, but not on the COGS and DX. Thus, the null hypotheses for the POI, the client form of the TSR, and the therapist form of the TSR were rejected and the alternatives accepted. For the COGS and DX, however, the null hypothesis was not rejected.

Two informal hypotheses were stated predicting no pre to post differences on the client form of the CDPS/PCRS and the therapist form of the CDPS/PCRS. Significance testing was carried out at the .01 level. The results of the two three-way ANOVAs (treatment x therapist x time) with repeated measures on the last dimension indicated that there were pre to post significant differences in both the IPR and traditional treatment groups (with the means decreasing pre to post) on both the client and therapist forms of the CDPS/PCRS. Thus, the null hypotheses were rejected. This means that both clients and therapists (in both treatment groups) predicted at the beginning of counseling that they (the clients) would achieve their goals in counseling to a significantly higher degree than they rated that they actually achieved their goals at the end of counseling.

In the third section of this chapter, a nonstatistical evaluation of client subjective comments was presented. Nineteen of the 25 IPR clients responded on a "Comments" form and 18 of the 25 traditional clients responded. Almost all of the 37 clients made

statements stressing the positive benefits that they received from counseling. A nonstatistical evaluation between the two treatment groups showed no differences concerning their satisfaction with their counseling experiences. Most responses were global rather than specific, such as "The counseling sessions have been a great help to me." Of the 19 IPR clients who responded on the "Comments" form, 2 made references to the stimulus film techniques and 8 made references to the videotape techniques. Of these 10 references to IPR interventions, 1 was slightly negative, 2 were mixed, and 7 were positive statements.

In the fourth section of this chapter, an informal evaluation of therapist subjective comments about the use of IPR techniques was presented. Each of the therapists believed that the IPR videotape recall and stimulus film techniques were helpful to their clients, and each was pleased to add the techniques to their repertoire of therapeutic skills. Therapists found that the stimulus films worked better with some clients and the videotape recall better with others. Their primary criticism was in having to use the techniques on a regular basis (due to the structure of the research design) with each of their IPR clients. This, they believed, was not helpful at times and occasionally resulted in less effective treatment sessions. Thus, although therapists were positive in their statements about the use of IPR techniques, they believed that the most effective use of the interventions would require a great deal of therapeutic flexibility and freedom.

CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

The purpose of this study was to evaluate the effectiveness of using the Interpersonal Process Recall (IPR) model in counseling and psychotherapy. IPR videotape and stimulus film techniques were used as therapeutic interventions in combination with traditional dyadic treatment methods and compared with the use of the traditional treatment methods without IPR techniques. The basic question underlying the research project was whether clients who experienced IPR interventions would improve more (as evidenced by higher scores on process and outcome measures) than clients who did not experience IPR techniques in a therapy series of 4 to 15 sessions.

A review of the literature on controlled research studies in counseling and psychotherapy indicates that there is adequate evidence that clients who receive psychological treatment improve more than do untreated controls. Studies reveal (Smith & Glass, 1977) that the typical therapy client is better off than 75% of untreated controls. The research has not demonstrated, however, that any one form of psychotherapy treatment is better than another. Researchers are turning from the question of whether or not counseling and psychotherapy works to the question of what works best with whom under which conditions. The current study is a step toward further specificity in

that it examines the effects of a particular treatment model when integrated into traditional dyadic counseling methods. It is hoped that this research will stimulate further investigations toward more specificity, such as examining which IPR techniques work best with what types of clients at which stages in the therapeutic process.

The IPR model as used in this study was a modified replication of the model used in studies by Schauble (1970) and Van Noord (Van Noord, 1973; Van Noord & Kagan, 1976) which had inconsistent results. Schauble found that IPR interventions did result in significant positive changes in client growth and outcome when compared to control clients, whereas Van Noord found no significant differences. The major recommendations from these previous studies that were incorporated into the current study were as follows: (a) The sample size was increased from 12 to 50 clients, (b) The number of sessions was changed from a fixed 6 sessions to an allowable range of 4 to 15 sessions, and (c) Therapists were allowed more flexibility in the use of the IPR techniques according to individual client needs as determined by the therapists. The range of these sessions represents short-term counseling and psychotherapy, which reflects the growing trend across the country to use more shortened forms of treatment in university counseling centers and in community mental health clinics.

The sample for this study consisted of 50 volunteer undergraduate and graduate clients who had requested help with personal concerns from the staff of the Georgia State University Counseling Center during the 1976/1977 academic year. Therapists were three counseling and

clinical psychology staff interns and two staff therapists, all of whom regularly saw clients at the Center.

The experimental design used was a pretest-posttest control group design. The experimental group consisted of 25 clients who received traditional counseling in combination with IPR videotape feedback and stimulus film techniques. The control group consisted of 25 clients who received traditional counseling alone. Each therapist saw 10 clients, 5 in each group. Therapists retained control over which clients they saw, but not over the assignment of clients to treatment groups. Clients were matched according to sex and time of entry into treatment and then randomly assigned to the treatment groups. The number of 50-minute treatment sessions for each client ranged from 4 to 15. Of the total 462 counseling sessions completed in this study, 260 were for IPR treatment clients and 202 were for traditional treatment clients. The mean number of sessions completed per client was 10.4 for IPR clients and 8.1 for traditional clients. Nine clients in the IPR group and two clients in the traditional group continued counseling beyond the 15th session after completing the posttests.

For the IPR treatment clients, therapists were allowed to select the IPR techniques which they believed best suited their clients' individual needs. During the first 10 sessions, IPR techniques had to be used in a minimum of 50% of the sessions, and they had to be used in at least every other session or in two consecutive sessions followed by two traditional sessions. During the 10th through the 14th sessions, an IPR technique had to be used at least once. The techniques could have been used more if desired. Therapists were allowed to

choose from the following five IPR techniques: stimulus films, videotape recall of stimulus films, client recall, mutual recall, and significant other recall. Of the 107 interventions that were completed in this study, 65 were mutual recalls, 24 were stimulus films, 10 were client recalls, 6 were significant other recalls, and 2 were videotape recalls of stimulus films. For the mutual and client recalls, third-person inquirers were used to facilitate recall in the traditional IPR style.

The measures used as criteria for this study were the Personal Orientation Inventory (POI), the client and therapist forms of the Therapy Session Report (TSR), the client and therapist forms of the Client Description of Problem Scale/the Progress of Counseling Rating Scale (CDPS/PCRS), the Characteristics of Client Growth Scales (COGS), and the Depth of Self-Exploration Scale (DX). Data from the first three instruments were collected after the first and last sessions as written instruments. Data from the last two instruments were collected from audiotape samples of the first and last counseling sessions and then rated on four subscales by two independent judges.

The six, specific, primary research hypotheses predicted more client growth and satisfaction for IPR clients than control clients as evidenced by higher adjusted posttest scores on the above instruments. The data were analyzed for differences between treatment groups by four 2 x 5 (treatment by therapist) MANOVA and two 2 x 5 ANOVA computer analyses. Prior to these analyses, bivariate linear regression analyses for each subscale of each instrument were performed in order to obtain the adjusted posttest scores free of pretest

score differences. Significance testing was carried out at the .01 level. The results of the analyses indicated no significant differences between treatment groups on any of the six measures. Thus, the primary hypotheses were not confirmed.

Informal hypotheses were also formulated predicting pre to post positive raw score differences for both treatment groups on the POI, on the COGS and DX, and on the client and therapist forms of the TSR. Significance testing was carried out at the .01 level. The results of the four three-way MANOVAs (treatment x therapist x time) with repeated measures on the last dimension indicated that there were pre to post significant positive differences on the POI and on the client and therapist forms of the TSR for both groups, but not on the COGS and DX. Two additional informal hypotheses predicted no pre to post differences for either treatment group on the client and therapist forms of the CDPS/PCRS. The results of the two three-way ANOVAs (treatment x therapist x time) with repeated measures on the last dimension indicated that there were pre to post negative significant differences (with the means decreasing pre to post) on both the client and therapist forms of the CDPS/PCRS.

A nonstatistical evaluation of subjective client comments indicated no differences between treatment groups. Clients who responded on the optional "Comments" form stressed the positive benefits that they received from counseling. Of the IPR clients who made statements about the IPR techniques, one was slightly negative, two were mixed, and seven were positive. All of the therapists made positive statements about the use of the IPR techniques with their clients,

and all said they planned to continue using the techniques occasionally. Their primary criticism was in having to use the techniques on a regular basis (due to the research design). They believed this was not always helpful with their clients, and they stated that a great deal of therapeutic flexibility with individual clients would be required to result in a maximum degree of effectiveness from the use of the stimulus film and videotape recall techniques.

Conclusions

The following conclusions relate to the primary hypotheses of the study:

1. The integration of IPR videotape and stimulus film techniques with traditional treatment methods did not result in clients scoring higher on a measure of self-actualization, a correlate of mental health, than was observed in control clients treated with traditional methods alone.

2. The integration of IPR videotape and stimulus film techniques with traditional treatment methods did not result in clients evidencing more client growth as measured by in-therapy process dimensions than was observed by control clients treated with traditional methods alone.

3. The integration of IPR videotape and stimulus film techniques with traditional treatment methods did not result in clients becoming more satisfied with their experiences in counseling than was observed in control clients treated with traditional methods alone.

4. The integration of IPR videotape and stimulus film techniques with traditional treatment methods did not result in clients achieving

a higher percentage of their goals in counseling than was observed in control clients treated with traditional methods alone.

The following conclusions relate to the additional informal hypotheses of the study:

5. Both clients who received the IPR interventions and clients who received only traditional interventions scored higher on a measure of self-actualization, a correlate of mental health, at the end of their counseling experiences.

6. Both clients who received the IPR interventions and clients who received only traditional interventions were more satisfied with their counseling sessions at the end than at the beginning of their counseling.

7. Neither clients who received the IPR interventions nor clients who received only traditional interventions evidenced more growth on in-therapy process dimensions at the end of their counseling sessions than at the beginning.

8. Both clients who received the IPR interventions and clients who received only traditional interventions predicted that they would achieve a higher percentage of their goals at the beginning of their counseling sessions than they actually did achieve. Clients said they achieved approximately 76% of their goals (and predicted 87%) and therapists said their clients achieved approximately 70% of their goals (and predicted 78%).

All of the above conclusions resulted from an examination of the formal measurement data that came from the study. The following

conclusions resulted from an examination of client and therapist subjective comments about the study:

9. Clients who received the IPR interventions found the IPR videotape and stimulus film techniques helpful in their growth and problem solving.

10. Therapists found the use of the IPR videotape and stimulus film techniques beneficial in helping clients, but they believed that maximum effectiveness from using these interventions can be achieved only with a great amount of therapeutic freedom and flexibility.

11. Both clients who received the IPR interventions and clients who received only traditional interventions viewed their counseling sessions as satisfying and helpful in making changes.

Discussion

In reviewing the literature on the use of videotape feedback as a therapeutic tool in counseling and psychotherapy in Chapter II, it was noted that many therapists have reported that videotape feedback can be effective in helping clients change. It was also noted, however, that controlled studies have not, on the whole, demonstrated that the use of videotape adds appreciably to client growth and outcome when compared to the treatment of clients without the aid of videotape. It was stated that there is a great deal of evidence to support the claim that counseling and psychotherapy does in fact help clients change, but that there is little or no evidence to support the claim that any one form of psychotherapeutic treatment is better than another. The results of the present study do not contribute any

major new findings, but rather they support these observations from previous research.

Therapists and clients in this study reported that IPR videotape and stimulus film techniques were beneficial, but the use of these interventions did not result in any significant differences on any of the outcome measures between the IPR and traditional treatment groups. The analyses revealed that clients in both treatment groups made gains on a measure of self-actualization at a significant level ($p < .001$), and that clients were more satisfied with their sessions at the end of counseling than at the beginning ($p < .001$). Clients in both groups rated that they achieved approximately 76% of their goals in a mean of about nine sessions per client. Therapists rated their clients in both groups as achieving 70% of their goals in this amount of time. Both these percentages appear rather remarkable considering the fact that effective short-term therapy is often viewed as requiring at least 24 sessions (6 months). Thus, whereas growth was evidenced on all of the written outcome instruments for clients in both treatment groups, neither group demonstrated more growth than the other. It should be noted that the pre to post research design was not as valid as it would have been if there had been an untreated or placebo-attention control group to rule out the effects of history, maturation, and test-retesting. But the fact that pre to post differences on the POI and on the client and therapist forms of the TSR were highly significant, and that clients and therapists rated a mean achievement of 73% of client goals in such a short number of sessions, adds a great deal of weight to the probability that client growth did

occur over time and that clients and therapists found the sessions to be beneficial. It should be noted here that Hathaway's "hello-goodbye" effect predicts a certain degree of biased client ratings because clients may initially exaggerate symptoms and then exaggerate improvement at the end of therapy. This is perhaps due to a need on the part of clients to rationalize their investment of time and effort, as well as to present favorable results to make their therapists feel like they accomplished something. Even allowing for a certain amount of this, however, clients and therapists still rated a fairly high achievement percentage of client goals.

It was stated earlier that clients and therapists both predicted that clients would achieve a higher percentage of their goals at the beginning of counseling than they were perceived to have achieved at the end of counseling. Clients in both treatment groups predicted that they would achieve 87% of their goals. Therapists predicted 77% for traditional clients and 79% for IPR clients. The final client ratings for goal achievement were 75% for the IPR group and 77% for the traditional group. The final therapist ratings were 70% for both groups. Although these pre to post differences were significant, the size of the pre-post difference really is not large. It is not uncommon, perhaps, that clients and even therapists would be somewhat optimistic about the possibilities for change. A moderate amount of optimism may be helpful, in fact, for as Luborsky et al. (1971) pointed out, studies have shown that the amount of expectation and/or motivation tends to be positively related to outcome. The short number of sessions ($\underline{N}$ = 10.4 for IPR clients and 8.1 for traditional clients)

would certainly be a factor in clients not achieving as many goals as they had planned. It is not surprising, then, that clients predicted that they would achieve a higher percentage of goals than they finally achieved. What is surprising is that both clients and their therapists said they achieved such a high percentage of their goals in such a short number of sessions. This suggests that client growth can occur in short-term counseling and therapy.

The group of subscales on which no significant pre to post movement was found was on the three subscales of the Characteristics of Client Growth Scales (COGS) and the Depth of Self-Exploration Scale (DX). These scales were somewhat different than the other measures in that they were ratings by two independent judges of audiotape samples of client verbal behaviors from the first and last sessions. Although they were used as outcome measures in this study, they can more properly be considered to be process measures of what actually happens within therapy. The written measures, however, can more clearly be thought of as outcome measures. The hypothesis which related to the pre to post analysis of the COGS and DX raw score data predicted that clients in both the IPR and traditional treatment groups would achieve a greater awareness of their feelings, a clearer motivation for growth-producing change, a more accurate ability to discriminate environmental stimuli, and a greater ability to engage in self-exploration of interpersonal situations at the end of counseling than at the beginning, as measured by higher posttest scores on the scales of Owning of Feelings (OF), Commitment to Change (CC), Differentiation of Stimuli (DS), and Depth of Self-Exploration (DX).

This hypothesis was not confirmed. Neither was the primary hypothesis confirmed predicting higher adjusted posttest scores on the OF, CC, DS, and DX scales for IPR clients than for traditional clients. The mean changes on pre to post raw scores were very small for clients in both treatment groups (see Table 8, p. 91). The means for the IPR group dropped slightly for the OF, CC, and DX scales, whereas the means for the traditional group increased slightly on all four scales. These differences in the direction of mean changes between treatment groups were not large enough to cause a treatment by time interaction effect (see Table 18, p. 104). Nor were they large enough to cause a significant difference on the adjusted posttest scores between the treatment groups (see Table 7, p. 90). Thus, the within session verbal behaviors of the clients did not change for either group pre to post.

It is unclear why no significant pre to post movement was found on the COGS and DX for clients in either of the treatment groups. One possible answer is that the clients in this study began their initial sessions with a fairly high degree of owning of feelings, commitment to change, differentiation of stimuli, and self-exploration (pre-COGS = 2.58 and pre-DX = 3.17), suggesting a more intense involvement in the initial sessions than occurred during the final sessions. This could have resulted because final sessions included termination topics which were more superficial than initial presenting problems, particularly due to the fact that this was short-term therapy without the development of an in-depth client-therapist relationship. As a comparison, both pre and post scores (post-COGS = 2.66 and post-DX = 3.20)

in this study were higher than post scores in Van Noord's (Van Noord, 1973; Van Noord & Kagan, 1976) study (post-COGS = 2.37 and post-DX = 2.28). The average age of clients in this study was higher than in Van Noord's study (25 years compared to 21 years), which may have contributed to clients in this study speaking of their problems in more depth during the first sessions, while "winding down" and becoming less involved during the last sessions. This comparison also holds true for Schauble's (1970) study (pre-COGS = 2.25 and pre-DX = 2.13; post-COGS = 2.76 and post-DX = 2.69), with Schauble's average client age of 20 years, although Schauble's average post-COGS score was higher than in this study. The fact that different raters were used in these studies means that these comparisons must be made with caution.

It is quite possible that the COGS and DX were not the most suitable instruments for use as posttest measures in this study. It is reasonable to think that a client's verbal behaviors will reveal lower ratings on owning of feelings, commitment to change, differentiation of stimuli, and depth of self-exploration during the termination session than during ongoing sessions, which are likely to include verbal behaviors indicating more involvement with more intense issues than those covered in the termination session. An investigation which would include several periodic ratings on the COGS and DX scales for several sessions of the same client from beginning to end would offer solutions to this problem.

Also, in this study 22% of the clients continued beyond the 15th session, but it is possible that they behaved less openly knowing that

their final research session was being taped and would be listened to by someone else for rating. What is more important, perhaps, is that pre to post written measures demonstrated client growth and client satisfaction with the counseling experiences. The main purpose of the within-therapy process measures (COGS and DX) was to see if there were any between group differences at the end of the treatments.

There were no significant between treatment group differences on these process measures at the .01 or .025 levels. This is similar to the results of the other five outcome measures. The analyses of the data from the five written outcome measures for treatment effects resulted in F values that were all less than 1.00, indicating very little differences and no possibilities for significance. Although the level of significance was set at .01 for all analyses, and the COGS and DX MANOVA of adjusted posttest scores resulted in a treatment effect that was not significant at this level, it was significant at the .05 level, and, therefore, deserves some discussion.

An inspection of the pre and post means of the OF, CC, DS, and DX scales (see Table 8, p. 91) reveals that the traditional treatment clients made slight gains on all four scales whereas the IPR clients made slight losses on three of the four scales. An inspection into the univariate analyses of these four scales, however, indicates that it was the OF scale which gave most of the weight for the overall MANOVA to be significant at the .05 level. A further inspection of the pre and post means on this scale for the clients of each of the five therapists revealed that for four out of the five therapists the

means decreased slightly for the IPR treatment clients and increased slightly for the traditional treatment clients. For the fifth therapist the means of clients in both treatment groups increased slightly.

It is unknown why the IPR clients decreased on the OF scale means (mean change = -.14 on a scale of 1 to 5) whereas the traditional treatment clients increased (mean change = +.25) with a very small but similar trend on two of the other three process scales. As mentioned earlier, nine of the IPR clients continued counseling beyond the 15th session, whereas only two of the traditional clients continued beyond the 15th session. Perhaps the posttest audiotapes caused more of a negative effect on the clients who were continuing, and, since there were more of such clients in the IPR group, this could be one cause for the lower IPR group means. Gelso (1974) has demonstrated that audiotaping, when not used as a therapeutic tool, can indeed have an inhibiting effect on clients.

It is interesting to note than Van Noord's IPR clients also scored slightly lower (but not significantly lower) on the COGS and DX posttest scores than did the traditional clients in his study. Perhaps the use of media techniques in the initial stages of therapy does contribute to some negative effects which showed up on the in-therapy process measures. This suggestion, however, conflicts with the results of Schauble (1970) and Kingdon (1975), for in their studies the IPR clients scored significantly higher than traditional clients on similar process measures. It is obvious that no definitive statements can be made about this issue based on the controlled research up to this point in time.

The final and most important question that must be addressed here is why the IPR treatment clients did not score significantly higher on the adjusted posttest scores on any of the six measures than the traditional treatment clients as predicted. One possible answer is that therapists need to have previous experience with the IPR model before it can be implemented by them with the degree of clinical skill required to cause significant treatment differences. Although all of the therapists stated that they felt comfortable with the IPR techniques after reading about them and then going through a 5-hour training course, it can not be expected that they were as comfortable with these interventions or were as therapeutically skillful with them as they were with their traditional treatment methods. Although one of the therapists had previous experience with the IPR model in other settings, none of the therapists had ever used the techniques in therapy prior to these research sessions. Under more ideal conditions, therapists would have had the opportunity to experiment with the IPR techniques with their regular clients for a year or so before beginning the research sessions.

An argument can be made that with therapists who were relatively inexperienced in IPR interventions, it is significant that IPR treatment clients did not score any worse than traditional treatment clients on the adjusted posttest scores. And it is certainly important that the use of IPR techniques did not result in any negative treatment effects. It should be noted that one of the advantages of the IPR model is that it can easily be taught to therapists in a relatively short period of time. After the initial training, however, therapists

need to practice using the techniques to become familiar with them and to integrate them into their own therapeutic styles.

Did clients of one or more of the research therapists benefit from the IPR techniques more than clients of the other therapists? The results of the MANOVAs and ANOVAs of the adjusted posttest scores indicate that the answer is no, for there were no significant therapist by treatment interaction effects on any of the six measures. Even though the mean number of treatment sessions varied for therapists and treatments (see Table 2, p. 58), no significant differences were found as a result of these variations. Nor were there differences found in client and therapist subjective comments.

The average IPR client was seen for 10.4 sessions with an average of 4.3 IPR interventions. Was this too little or too much to cause significant positive differences? Therapists had the opportunity to use the techniques more often than required, but none of them elected to do so. When therapists were asked why they did not use the techniques more, they responded that they needed time alone with their clients without videotapes, films, and inquirers. And they suggested that they would have preferred to have used the techniques somewhat less than required, particularly during sessions when there was a great deal of intense client involvement, when, they believed, no additional techniques were needed beyond the traditional methods. This suggests that IPR (and particularly the stimulus film technique) may be most helpful during those sessions when clients are not highly disclosing, or with clients who have difficulty expressing feelings.

There is always the possibility of regional differences in the approach that clients take to counseling. Perhaps typical southern clients need more time to test out their therapists and develop trust. Could the videotape and stimulus films have interfered with this initial trust development rather than aid it as predicted? If so, it is likely that these interventions would have been more effectively used later on in therapy, particularly in longer term therapy, to assist clients in learning more about their eliciting behaviors, their ways of relating to their therapists, and in trying out new behaviors after several initial sessions of trust building have elapsed without the use of the techniques.

It needs to be noted that clients in the IPR group had sessions that went on longer than those in the traditional group (10.4 sessions per IPR client compared to 8.1 sessions per traditional client), and that nine IPR clients continued counseling after the final 15th research sessions, whereas only two traditional clients went beyond this number with their therapists. Research studies, on the whole, have not determined any average set number of sessions needed to cause change in clients, and it is likely that this varies a great deal for different clients and treatments. Meltzoff and Kornreich (1970), in their review of several relevant studies, stated that an optimal point was found to range anywhere from the 5th to the 65th interview, depending on the type of patient and the mode of therapy. They concluded that about half of the studies showed a positive relationship between outcome and the number of client sessions (that is, the more sessions, the better the outcome), with the remaining studies

showing either no relationship or a curvilinear relation with improvement fading when treatment continues for hundreds of hours. The fact that seven more IPR clients than control clients continued therapy beyond the 15th session can be seen as a positive indication that IPR techniques contributed to clients becoming more involved with their therapeutic issues and working on them in more depth. Although it seems probable that for several types of clients more treatment sessions are likely to lead to more positive and lasting personality changes, it is also probable that IPR intervention techniques can assist therapists by helping their clients in working on issues over a longer period of time with the result that positive therapeutic changes are more lasting.

It should also be noted that four clients in the control group dropped out of counseling before the fifth session, whereas only two dropped out in the IPR group. This suggests, at least, that the IPR techniques did not scare clients away in the initial sessions.

An important observation made from this study was that therapists believed that the mutual recall technique was by far the most useful, whereas the stimulus films technique was the second most useful intervention. The client and significant other recalls were also found to be useful, but with a more limited range of clients. And the video recall of stimulus films was believed to be the least useful technique, in large part, perhaps, due to the complicated media operations involved. Another observation was that therapists believed that flexibility in using both the videotape and stimulus films is an absolute

necessity for maximum effectiveness. This was also a conclusion in Van Noord's and in Schauble's studies.

Although the therapists in this study showed an interest in learning and using the IPR techniques, they were not committed to them as proven effective change interventions. This was as it should have been, in that the therapists were not biased in favor of IPR, and they were, therefore, less likely to bias the outcome measures. However, it is probable that therapists who use the techniques regularly, are comfortable with them, and are committed to them will be more effective in using them. It is also probable that therapists will function most effectively with IPR techniques when they do not have to use them on a regular schedule or when they are forced to follow certain guidelines. Resistance to structured sessions is as common to therapists as it is to clients, and such resistance probably was a factor in this study, although there were no major complaints by therapists other than the ones already mentioned.

It appears that what Luborsky et al. (1975) have termed the "dodo bird verdict" (a term from Alice in Wonderland) was upheld in this study: "Everybody had won and all must have prizes." Previous research has, on the whole, found insignificant differences between different forms of therapy. One reason for this is that when all clients improve to a significant degree, as demonstrated by the analyses of the written outcome pre to post change scores in this study, it is statistically difficult for one form of treatment to show any advantage over another because there is less room at the top of the scales used for significant differences to occur between

treatments. Another possible reason for no treatment differences in this study is that a major common element in both forms of treatment, such as the basic helping relationship with a therapist, may have contributed the most to client changes, with the IPR techniques contributing only small amounts of variance to change scores resulting in small effects rather than large effects.

Finally, controlled research as carried out in this study has some basic drawbacks. As Bergin (1971) has pointed out, process and outcome studies do not give us information about the individual differences which tend to be averaged out in the group means. It was predicted that IPR clients would make greater gains than traditional clients; that is, on the average, IPR clients would do better than traditional clients. It is quite possible that some clients benefited from the IPR techniques, perhaps to a large extent, whereas for other clients the effects of the techniques were either neutral or even detrimental, and that overall the differences were averaged out to result in no apparent differences. Therapists reported that the techniques were indeed helpful, but not at all times with all of the IPR clients. Further research needs to be done to investigate the effects of the IPR model with more specificity, thus giving us more accurate information concerning which of the techniques work best with what types of clients at which stages in the therapeutic process.

Implications for Future Research

1. Because inconsistent results have been obtained from studies on the use of IPR videotape and stimulus film techniques in counseling

and psychotherapy, further investigations into the use of these interventions in short-term and in long-term therapy are recommended.

2. Since past IPR research has indicated that subjective comments about the use of the IPR model in therapy are beneficial to some clients at certain stages, attention should be focused more on individual differences. This would be a move toward specificity concerning which IPR techniques work best with what types of clients at which stages in counseling.

3. To implement recommendation number 2, a major effort should be invested into the intensive study of single cases in which specific client, therapist, technique, and socio-environmental variables can be examined.

4. Ideally it would be best if, in future research on the IPR model in therapy research, therapists could have a year or more experience using the techniques with their regular clients prior to beginning the research in order to become as comfortable and skillful with the techniques as they are with their traditional methods of intervention.

5. Studies should examine the effects of using the model at the initial stages of therapy compared to using the model at later stages in therapy to see if the techniques have more effect when used beyond a certain number of initial trust-building sessions.

6. It would be advantageous to look at the effects of the model on different personality types, for example, introverts compared to extroverts, high-esteem clients compared to low-esteem clients, or

clients with a poor body image compared to clients with a good body image.

7. The "significant other" mutual recall technique should be examined further with couples and families since there is a growing trend toward using videotape as a therapeutic tool in couples and family therapy.

8. Because many therapists believe the use of an outside inquirer to facilitate the videotape recall is not practical in terms of scheduling and heavy caseloads, the use of the therapists as their own inquirers should be examined and compared to the use of third-person inquirers to see if there are differential effects.

APPENDICES

APPENDIX A

THERAPY SESSION REPORT ITEMS

APPENDIX A

THERAPY SESSION REPORT ITEMS*

This booklet contains six questions about the counseling session or sessions which you have just completed. These questions have been designed to make the description of your experiences in the session(s) simple and quick.

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

BE SURE TO ANSWER EACH QUESTION.

Counselor Identification _____

Client Identification _____

Date _____

*These items were selected and modified from the Therapy Session Report, copyright by Psychotherapy Session Project, 1966. All property rights reserved by the Psychotherapy Session Project, 907 South Wolcott Avenue, Chicago, Illinois, U.S.A.

CLIENT FORM (PRE) OF THERAPY SESSION REPORT

Circle the one answer which best applies.

1. HOW DO YOU FEEL ABOUT THE SESSION WHICH YOU HAVE JUST COMPLETED?

   This session was:

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

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

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

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

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

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

   I am getting along:

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

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

   My counselor:

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

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

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

CLIENT FORM (POST) OF THERAPY SESSION REPORT

Circle the one answer which best applies:

1. THE LAST FEW SESSIONS HAVE BEEN?

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

2. HOW DID YOU FEEL ABOUT COMING TO THE LAST FEW SESSIONS?

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

3. HOW MUCH PROGRESS DO YOU FEEL YOU MADE IN DEALING WITH YOUR PROBLEMS DURING THE LAST FEW SESSIONS?

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

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

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

5. HOW WELL DID YOUR COUNSELOR SEEM TO UNDERSTAND WHAT YOU WERE FEELING AND THINKING DURING THE LAST FEW SESSIONS?

    My counselor:

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

6. HOW HELPFUL DO YOU FEEL YOUR COUNSELOR WAS TO YOU DURING THE LAST FEW SESSIONS?

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

COUNSELOR FORM (PRE) OF THERAPY SESSION REPORT

Circle the one answer which best applies:

1. HOW DO YOU FEEL ABOUT THE SESSION WHICH YOU HAVE JUST COMPLETED?

   This session was:

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

2. HOW MOTIVATED FOR COMING TO COUNSELING WAS YOUR CLIENT THIS SESSION?

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

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

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

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

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

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

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

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

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

COUNSELOR FORM (POST) OF THERAPY SESSION REPORT

Circle the one answer which best applies:

1. THE LAST FEW SESSIONS HAVE BEEN:

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

2. HOW MOTIVATED FOR COMING TO COUNSELING WAS YOUR CLIENT DURING THE LAST FEW SESSIONS?

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

3. HOW MUCH PROGRESS DID YOUR CLIENT SEEM TO MAKE IN THE LAST FEW SESSIONS?

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

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

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

5. HOW MUCH WERE YOU LOOKING FORWARD TO SEEING YOUR CLIENT DURING THE LAST FEW SESSIONS?

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

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

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

APPENDIX B

CLIENT'S DESCRIPTION OF PROBLEM SCALE AND PROGRESS OF COUNSELING RATING SCALE

APPENDIX B

CLIENT'S DESCRIPTION OF PROBLEM SCALE AND PROGRESS OF COUNSELING RATING SCALE

Client's Description of Problem Scale
Client Form (A)

Below are listed a number of areas which people sometimes mention as goals in counseling. Each goal is followed by numbers 1-9. After each possible goal you are to place two ratings. FIRST, place the letter "G" above the number which indicates how important this particular area is a goal for you in counseling at this time. For example, if the particular goal has nothing to do with you, place a "G" over number 1. If it is a very important goal for you, place the "G" over number 8 or 9. If it is moderately important, place the "G" somewhere in the middle.

SECOND, place the letter "A" on the number which indicates the degree to which you hope to achieve this goal in counseling. Thus, for example, if you hope to make a great deal of progress toward a very important goal, place an "A" on or near the high number above which you have placed the "G." An "A" on number 1 indicates that you do not plan to make progress toward that goal. And if, for example, you hope to make a moderate degree of progress on a very important goal, place an "A" on one of the middle numbers.

Client identification_____ Date_____
Counselor identification_____ Client Form A

Place the letter "G" above the number which indicates how important a goal this particular area is for you in counseling at this time. AND, place the letter "A" on the number which indicates the degree to which you hope to achieve this goal in your counseling sessions.

1.	Improving my ability to have close relationships with the opposite sex	1	2	3	4	5	6	7	8	9
2.	Dealing with unhappiness and depression	1	2	3	4	5	6	7	8	9
3.	Becoming more aware of the true nature of my feelings	1	2	3	4	5	6	7	8	9
4.	Relieving tension and anxiety	1	2	3	4	5	6	7	8	9
5.	Discovering "who I am"--my identity	1	2	3	4	5	6	7	8	9
6.	Dealing with panic reactions to such things as tests	1	2	3	4	5	6	7	8	9
7.	Improving my relationships with people in general	1	2	3	4	5	6	7	8	9
8.	Changing specific behavior (what behavior)_____	1	2	3	4	5	6	7	8	9
9.	Resolving problems with my parents	1	2	3	4	5	6	7	8	9
10.	Dealing with sexual problems	1	2	3	4	5	6	7	8	9
11.	Improving my ability to control my emotions	1	2	3	4	5	6	7	8	9
12.	Dealing with feelings of embarrassment	1	2	3	4	5	6	7	8	9
13.	Making new and/or real friends	1	2	3	4	5	6	7	8	9
14.	Dealing with self-blame or self-criticism	1	2	3	4	5	6	7	8	9
15.	Dealing with how to be a better conversationalist	1	2	3	4	5	6	7	8	9
16.	Dealing with my feelings of inadequacies	1	2	3	4	5	6	7	8	9

17.	Improving my ability to sleep	1	2	3	4	5	6	7	8	9
18.	To become less lonely	1	2	3	4	5	6	7	8	9
19.	Other (specify) _____ _____	1	2	3	4	5	6	7	8	9
20.	Other (specify) _____ _____	1	2	3	4	5	6	7	8	9
21.	Other (specify) _____ _____	1	2	3	4	5	6	7	8	9

Progress of Counseling Rating Scale
Client Form (B)

We would like to have you rate your progress or lack of progress in the following specific areas which people sometimes mention as goals in counseling. Each goal is followed by numbers 1-9. After each possible goal, you are to place two ratings. FIRST, place the letter "G" above the number which indicates how important this particular area has, at any time in your counseling sessions, been one of your goals. For example, if the particular goal had nothing to do with you, place a "G" over number 1. If it was a very important goal for you, place the "G" over number 8 or 9. If it was moderately important, place the "G" somewhere in the middle.

SECOND, place the letter "A" on the number which indicates the degree to which you feel you have achieved this goal in counseling. Thus, for example, if you have made a great deal of progress toward a very important goal, place the letter "A" on or near the high number above which you have placed the "G." An "A" on number 1 indicates no progress toward that goal.

Client identification_____ Date_____
Counselor identification_____ Client Form B

Place the letter "G" above the number which indicates how important this particular area has at any time in your counseling sessions been one of your goals. Place the letter "A" on the number which indicates the degree to which you feel you have achieved this goal in your counseling sessions.

1.	Improving my ability to have close relationships with the opposite sex	1	2	3	4	5	6	7	8	9
2.	Dealing with unhappiness and depression	1	2	3	4	5	6	7	8	9
3.	Becoming more aware of the true nature of my feelings	1	2	3	4	5	6	7	8	9
4.	Relieving tension and anxiety	1	2	3	4	5	6	7	8	9
5.	Discovering "who I am"--my identity	1	2	3	4	5	6	7	8	9
6.	Dealing with panic reactions to such things as tests	1	2	3	4	5	6	7	8	9
7.	Improving my relationships with people in general	1	2	3	4	5	6	7	8	9
8.	Changing specific behavior (what behavior)_____	1	2	3	4	5	6	7	8	9
9.	Resolving problems with my parents	1	2	3	4	5	6	7	8	9
10.	Dealing with sexual problems	1	2	3	4	5	6	7	8	9
11.	Improving my ability to control my emotions	1	2	3	4	5	6	7	8	9
12.	Dealing with feelings of embarrassment	1	2	3	4	5	6	7	8	9
13.	Making new and/or real friends	1	2	3	4	5	6	7	8	9
14.	Dealing with self-blame or self-criticism	1	2	3	4	5	6	7	8	9
15.	Dealing with how to be a better conversationalist	1	2	3	4	5	6	7	8	9

16.	Dealing with my feelings of inadequacies	1	2	3	4	5	6	7	8	9
17.	Improving my ability to sleep	1	2	3	4	5	6	7	8	9
18.	To become less lonely	1	2	3	4	5	6	7	8	9
19.	Other (specify) _____ _____	1	2	3	4	5	6	7	8	9
20.	Other (specify) _____ _____	1	2	3	4	5	6	7	8	9
21.	Other (specify) _____ _____	1	2	3	4	5	6	7	8	9

Client's Description of Problem Scale
Counselor Form (A)

Below are listed a number of areas which clients sometimes mention as goals in counseling. Each goal is followed by numbers 1-9. After each possible goal you are to place two ratings. FIRST, place the letter "G" above the number which indicates how important you believe this particular goal is for your client in counseling at this time. For example, if the particular goal has nothing to do with your client, place a "G" over number 1. If it is a very important goal, place the "G" over number 8 or 9. If it is moderately important, place the "G" somewhere in the middle of the scale.

SECOND, place the letter "A" on the number which indicates the degree to which you think your client will achieve this goal in counseling. Thus, for example, if you believe your client will make a great deal of progress toward a very important goal, place an "A" on or near the high number above which you have placed the "G." An "A" on number 1 indicates that you do not expect your client to make any progress in that goal. And, for example, if you believe your client will make a moderate degree of progress on a very important goal, place an "A" on one of the middle numbers.

Client Identification_____ Date_____
Counselor Identification_____ Counselor Form A

Place the letter "G" above the number which indicates how important this particular goal is for your client in counseling at this time. AND place the letter "A" on the number which indicates the degree to which you expect your client to achieve this goal in your counseling sessions.

1.	Improving my ability to have close relationships with the opposite sex	1	2	3	4	5	6	7	8	9
2.	Dealing with unhappiness and depression	1	2	3	4	5	6	7	8	9
3.	Becoming more aware of the true nature of my feelings	1	2	3	4	5	6	7	8	9
4.	Relieving tension and anxiety	1	2	3	4	5	6	7	8	9
5.	Discovering "who I am"--my identity	1	2	3	4	5	6	7	8	9
6.	Dealing with panic reactions to such things as tests	1	2	3	4	5	6	7	8	9
7.	Improving my relationships with people in general	1	2	3	4	5	6	7	8	9
8.	Changing specific behavior (what behavior)_____	1	2	3	4	5	6	7	8	9
9.	Resolving problems with my parents	1	2	3	4	5	6	7	8	9
10.	Dealing with sexual problems	1	2	3	4	5	6	7	8	9
11.	Improving my ability to control my emotions	1	2	3	4	5	6	7	8	9
12.	Dealing with feelings of embarrassment	1	2	3	4	5	6	7	8	9
13.	Making new and/or real friends	1	2	3	4	5	6	7	8	9
14.	Dealing with self-blame or self-criticism	1	2	3	4	5	6	7	8	9
15.	Dealing with how to be a better conversationalist	1	2	3	4	5	6	7	8	9

16.	Dealing with my feelings of inadequacies	1	2	3	4	5	6	7	8	9
17.	Improving my ability to sleep	1	2	3	4	5	6	7	8	9
18.	To become less lonely	1	2	3	4	5	6	7	8	9
19.	Other (specify) _____ _____	1	2	3	4	5	6	7	8	9
20.	Other (specify) _____ _____	1	2	3	4	5	6	7	8	9
21.	Other (specify) _____ _____	1	2	3	4	5	6	7	8	9

Progress of Counseling Rating Scale
Counselor Form (B)

We would like to have you rate your client's progress or lack of progress in the following specific areas which people sometimes mention as goals in counseling. Each goal is followed by numbers 1-9. After each possible goal, you are to place two ratings. FIRST, place the letter "G" above the number which indicates how important this particular area has been, at any time in your counseling sessions, one of your client's goals. For example, if the particular goal had nothing to do with your client, place the "G" over number 1. If it was a very important goal for your client, place the "G" over number 8 or 9. If it was moderately important, place the "G" somewhere in the middle.

SECOND, place the letter "A" on the number which indicates the degree to which you feel your client has achieved this goal in counseling. Thus, for example, if your client made a great deal of progress toward a very important goal, place the letter "A" on or near the high number above which you have placed the "G." An "A" on number 1 indicates no progress toward that goal.

Client identification_____ Date_____
Counselor identification_____ Counselor Form B

Place the letter "G" above the number which indicates how important this particular area has been, at any time, one of your client's goals in your counseling sessions. Place the letter "A" on the number which indicates the degree to which you feel your client has achieved this goal in your counseling sessions.

1.	Improving my ability to have close relationships with the opposite sex	1	2	3	4	5	6	7	8	9
2.	Dealing with unhappiness and depression	1	2	3	4	5	6	7	8	9
3.	Becoming more aware of the true nature of my feelings	1	2	3	4	5	6	7	8	9
4.	Relieving tension and anxiety	1	2	3	4	5	6	7	8	9
5.	Discovering "who I am"--my identity	1	2	3	4	5	6	7	8	9
6.	Dealing with panic reactions to such things as tests	1	2	3	4	5	6	7	8	9
7.	Improving my relationships with people in general	1	2	3	4	5	6	7	8	9
8.	Changing specific behavior (what behavior) _____	1	2	3	4	5	6	7	8	9
9.	Resolving problems with my parents	1	2	3	4	5	6	7	8	9
10.	Dealing with sexual problems	1	2	3	4	5	6	7	8	9
11.	Improving my ability to control my emotions	1	2	3	4	5	6	7	8	9
12.	Dealing with feelings of embarrassment	1	2	3	4	5	6	7	8	9
13.	Making new and/or real friends	1	2	3	4	5	6	7	8	9
14.	Dealing with self-blame or self-criticism	1	2	3	4	5	6	7	8	9
15.	Dealing with how to be a better conversationalist	1	2	3	4	5	6	7	8	9

16.	Dealing with my feelings of inadequacies	1	2	3	4	5	6	7	8	9
17.	Improving my ability to sleep	1	2	3	4	5	6	7	8	9
18.	To become less lonely	1	2	3	4	5	6	7	8	9
19.	Other (specify) _____ _____	1	2	3	4	5	6	7	8	9
20.	Other (specify) _____ _____	1	2	3	4	5	6	7	8	9
21.	Other (specify) _____ _____	1	2	3	4	5	6	7	8	9

APPENDIX C

CHARACTERISTICS OF CLIENT GROWTH SCALES AND DEGREE OF SELF-EXPLORATION SCALE

APPENDIX C

CHARACTERISTICS OF CLIENT GROWTH SCALES AND DEGREE OF SELF-EXPLORATION SCALE

Owning of Feelings in Interpersonal Processes: A Scale for Measurement

Level 1

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

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

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

Level 2

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

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

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

Level 3

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

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

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

Level 4

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

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

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

Level 5

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

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

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

Commitment to Change in Interpersonal Processes: A Scale for Measurement

Level 1

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

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

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

Level 2

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

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

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

Level 3

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

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

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

Level 4

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

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

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

Level 5

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

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

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

Differentiation of Stimuli in Interpersonal Processes: A Scale for Measurement

Level 1

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

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

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

Level 2

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

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

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

Level 3

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

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

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

Level 4

The client is almost always aware of the differences between stimuli in his world, and he responds to them in a differential manner. He actively attempts to become more aware of his various emotions and their sources.

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

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

Level 5

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

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

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

DEGREE OF SELF-EXPLORATION SCALE

Helpee Self-Exploration in Interpersonal Processes: A Scale for Measurement*

Level 1

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

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

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

Level 2

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

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

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

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*This scale is derived in part from "The Measurement of Depth of Intrapersonal Exploration" (Truax & Carkhuff, 1967), which has been validated in extensive process and outcome research on counseling and psychotherapy. In addition, similar measures of similar constructs have received extensive support in the literature of counseling and therapy. The present scale represents a systematic attempt to reduce ambiguity and increase reliability. In the process, many important delineations and additions have been made. For comparative purposes, level 1 of the present scale is approximately equal to stage 1 of the earlier scale. The remaining levels are approximately correspondent: level 2 and stages 2 and 3; level 3 and stages 4 and 5; level 4 and stage 6; level 5 and stages 7, 8, and 9.

Level 3

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

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

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

Level 4

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

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

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

Level 5

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

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

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

APPENDIX D

CLIENT CONSENT FORM

APPENDIX D

CLIENT CONSENT FORM

I, _____, understand that various counseling techniques such as videotaping and stimulus films may be used in some of my counseling sessions. I understand that some of my sessions will be audiotaped and that some of these tapes will be analyzed for research purposes. I understand that my counselor and I will be asked to complete a few short questionnaires and that these will be analyzed for research purposes. Permission to use this information is given with the understanding that all information will be used in a professional manner, that adequate safeguards will be taken to insure anonymity, and that my name will not be used in any reports.

Signed _____

Date _____

APPENDIX E

BIOGRAPHICAL DATA SHEET

APPENDIX E

BIOGRAPHICAL DATA SHEET

Client identification number _____

Date _____

Male _____ Female _____

Age _____

Grade Point Average _____

Level in School:

Freshman _____
Sophomore _____
Junior _____
Senior _____
Masters _____
Ph.D. _____
Other _____

APPENDIX F

CLIENT COMMENTS FORM

APPENDIX F

CLIENT COMMENTS FORM

Comments

Sometimes multiple-choice inventories do not provide an opportunity to express opinions or comments in exactly the way that a person would like to express them. Please feel free to use this space to indicate any impressions, reactions, or opinions you may have had to the counseling research project which you have completed. Any such comments that you make will be appreciated.

Thank you very much for your cooperation and participation in this project.

Client identification _____
Counselor identification _____
Date _____

APPENDIX G

PROCEDURAL MEMOS TO THERAPISTS

APPENDIX G

PROCEDURAL MEMOS TO THERAPISTS

September 16, 1976

MEMO TO: Therapists involved in client research project

FROM: Bob Tomory

Counseling with IPR

During the first 10 sessions, an IPR technique must be used in a minimum of 50% of the sessions; the techniques must be used in at least every other session or in two consecutive sessions followed by two traditional sessions. The techniques can be used in more than 50% of the sessions if desired. During the 10th through the 14th sessions, an IPR technique must be used at least once. You may select the IPR technique which you believe is most suitable to facilitate each individual client's growth at a particular moment in time. One possible sequence of techniques is presented below. You are encouraged to use as many of the techniques as possible, but there is no requirement that each of the techniques be used. Also, any particular technique may be used as much as is desired. In summary, techniques will be selected according to individual client needs.

Clients used in this study must complete at least four sessions with at least two sessions of IPR techniques. If a client is terminated for any reason without meeting these minimal requirements, the next client on the waiting list of the same sex will be asked to participate to replace the terminated client. For those clients who

continue therapy beyond the 15th session, posttests will be taken during the 15th session. Clients, therefore, may terminate at any time, but in order to be used in this study they must complete at least four sessions.

Traditional counseling without IPR will be used for the first and the last sessions. If a session continues beyond the 15th session, a traditional session will be used on the 15th session. Audiotapes will record the first and the last, or the first and the 15th sessions. Sessions will last for 50 minutes in accordance with normal session length at Georgia State. You will be asked to complete a minimum of 50 minutes in each session in order to control for an equal amount of time in both IPR and traditional counseling sessions.

Traditional Counseling Without IPR

The five clients who receive the traditional treatment alone will have sessions that are unstructured and are conducted using your normal, eclectic, dyadic treatment methods. Each session will last 50 minutes. Audiotapes will be collected from the first and last, or first and 15th sessions.

IPR Techniques and Session Procedures

Stimulus films. Clients view at least five filmed vignettes which are selected by you according to individual client problem areas. After viewing each vignette, the client discusses with you those thoughts, feelings, images, memories, etc., that he had while watching the vignette. The client's reactions to the vignettes become the focus of the counseling session. This process can take up the whole

session or part of it, with any remaining portion of the 50 minutes being spent in traditional counseling procedures.

Videotape recall of stimulus films. Clients view at least five vignettes and are videotaped while watching them. The videotape is played back for the client and you for a recall of the client's reactions to the film. You facilitate the client's recall of the tape, and this recall becomes the focus of the counseling session. This process can take up the whole session or part of it, with any remaining portion of the 50 minutes being spent in traditional counseling procedures.

Client recall. A traditional counseling session is taped for 10 to 15 minutes. An inquirer then facilitates the client in his recall of the session for a period of 20 to 30 minutes while you watch the recall from an unobtrusive position in the room, through a one-way mirror, or you may leave the session completely and wait in another location until the inquiry time has elapsed. If you watch the recall, the client is aware that you are doing so. During the final 10 to 20 minutes of the session, the inquirer leaves the room and you return for a final period of traditional counseling.

Mutual recall. A traditional counseling session is videotaped for 10 to 15 minutes. An inquirer then facilitates the recall for both you and the client for 20 to 30 minutes. The inquirer then leaves and a traditional session follows for the remainder of the hour.

Significant other client or mutual recall. The client and significant other are both videotaped while talking about something that

is meaningful to their relationship for 10 to 15 minutes. You then enter the room and act as an inquirer to facilitate the recall of the tape by either the client alone or by both the client and the significant other for 20 to 30 minutes. The remainder of the session is a traditional counseling session with either the client alone or both the client and the significant other.

September 16, 1976

MEMO TO: Therapists involved in client research project

FROM: Bob Tomory

Following the initial session:

1. Collect an audio tape (which I have supplied) of the session
2. Have client sign consent form
3. Ask client to go to the testing office to fill out questionnaires before the next session (preferably immediately following the first session)
4. Fill out the Counselor Form (Pre) of the Therapy Session Report and the Counselor Form (A) of the Client's Description of Problems Scale
5. Return the audio tape, consent form, and two inventories to me

Following the final or the 15th session:

1. Collect an audio tape (which I have supplied) of the session
2. Ask client to go to the testing office to fill out questionnaires
3. Fill out the Counselor Form (Post) of the Therapy Session Report and the Counselor Form (B) of the Progress of Counseling Rating Scale
4. Return the audio tape, client schedule sheet, and two inventories to me

APPENDIX H

CLIENT CONTROL SHEETS

APPENDIX H

CLIENT CONTROL SHEETS

Traditional Treatment Clients

1. Client identification number _____
   Beginning date _____
   Termination date or date of 15th session _____
   Number of sessions _____
   Comments concerning the treatment of this client:

2. Client identification number _____
   Beginning date _____
   Termination date or date of 15th session _____
   Number of sessions _____
   Comments concerning the treatment of this client:

3. Client identification number _____
   Beginning date _____
   Termination date or date of 15th session _____
   Number of sessions _____
   Comments concerning the treatment of this client:

4. Client identification number _____
   Beginning date _____
   Termination date or date of 15th session _____
   Number of sessions _____
   Comments concerning the treatment of this client:

5. Client identification number _____
   Beginning date _____
   Termination date or date of 15th session _____
   Number of sessions _____
   Comments concerning the treatment of this client:

IPR Treatment Clients

Name of Counselor _____
Client Identification _____

Please record the date of the session in the appropriate box plus name of inquirer and vignette numbers if appropriate: TREATMENT	SESSIONS (1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
1. Traditional Only															
2. Client Recall (include name of inquirer)															
Did you observe the inquiring? YES/NO															
3. Mutual Recall (include name of inquirer)															
4. Stimulus Films (include film # from typescript)															
5. Videotape Recall of Stimulus Films (include film # from typescript)															
6. Significant Other Recall															

Additional information pertaining to the treatment of the client (optional):

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REFERENCES

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