PROCESS ANALYSIS OF CRITICAL VERSUS NONCRITICAL EVENTS IN THERAPY

RELATED TO THE CLIENT'S DEPTH OF EXPERIENCING

By

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ABSTRACT

This research study involved the process analysis of change events that occurred during the therapy session which the client perceived as having significant impact. The events surrounding a "critical" moment were compared with events of a "noncritical" moment. The behavioural components of particular interest were the client's depth of experiencing, vocal quality and levels of silence. Study was also directed at the client's evaluation of the therapist's helpfulness before and after a critical event.

Twelve 3-minute "critical" episodes in therapy were compared with twelve 3-minute "noncritical" episodes. The client's behaviour was measured under both conditions using the Experiencing Scale, Vocal Quality Classification System and the Speech Interaction System. The client's assessment of the therapist's helpfulness before and after a critical moment was measured on the Helpfulness Scale.

Using a dependent t-test, significant differences were found in the client's depth of experiencing and speaking pauses during a "critical" versus a "noncritical" episode. A Chi square test on vocal quality produced a significantly higher level of focused/emotional client responses under the "critical" condition. A dependent t-test of the helpfulness ratings of therapeutic interventions indicated a significant difference in the client's perception of helpfulness before the "critical" focal event than after the event. The nature of the change process was discussed from the perspectives of the client and the therapist.
These findings support the contention that the depth of client experiencing is a key component in the process of change and that internal focusing, an increase in client affect and a reduction of client dialogue accompany profound experiencing.
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CHAPTER I
Scope and Focus of the Study

Introduction

The current literature on process research indicated a revival of interest in the analysis of client and therapist insession behaviours as a means of understanding the change process resulting from psychotherapy (Kiesler, 1982). Outcome studies have largely focused on treatment effectiveness with minimal consideration of the nature of process. Kiesler (1982) and Hill (1982) claimed that a synthesis of both process and outcome studies is essential to explaining the change mechanism in terms of the influence of therapeutic interventions and external events.

Following the introduction of process research in the 1940's, as an outgrowth of psychoanalytic studies (Hill, 1982), attention shifted to client-centered variables in the 1950's with a particular interest in the effect of the therapist's level of empathy (Orlinsky & Howard, 1978). Findings were mixed and inconclusive, but the subsequent decline in process analysis was attributed to a "short-sighted, simplistic" perspective of change events occurring in the therapeutic sessions and to the limited utility of research evidence to practising clinicians (Elliott, 1983; Greenberg, 1983; Hill, 1982). In effect, the claim was made that therapists are determining the focus of research after the fact, rather than drawing on well formulated paradigms.
for direction. Additionally, the meticulous and painstaking efforts demanded of process researchers who invest substantial time and energy in a pursuit offering no predictable rewards may have inhibited its progress (Greenberg, 1983). Certainly, the practical limitations of current funding cutbacks have not enhanced its attractiveness as a field of study. In spite of these drawbacks, the importance of process in understanding client change remained apparent, and by the late 1970's, process research regained prominence with more sophisticated measurement instruments to strengthen its resources and new measurement units under consideration.

Elliott (1981) predicted that these promising new avenues of investigation would re-shape process research in the 1980's. He favoured sequential analysis of critical events, the mapping of significant trends and prediction based on a temporal ordering of significant moments in therapy across and within the interview sessions. Hill (1982) believed the lack of a contextual framework for critical incidents analysis might be resolved by post-session questionnaires, counsellor and/or client process recall testing or by a theoretical analysis of the events that led to change. Gottman & Markman (1978) suggested that new directions are required of research by which clinicians learn from past mistakes and predict the relative usefulness of a therapeutic intervention on the basis of a knowledge of the change process. A major development in the selection of research focus was a shift from single variable study to an examination of patterns emerging across the client-therapist interaction (Greenberg, 1983). The choice of the measurement unit then became crucial in process analysis, and various approaches were tested to capture the most comprehensive picture of the change.
elements in therapy.

Background of the Problem

An important issue in process research then is the selection of methods by which the largest number of important process variables may be analyzed within a manageable framework that produces the most significant findings on the nature of client change. Hill (1982) claimed that all research designs involved a "trade-off" of some kind, and the practical realities of time, economics and availability of participants must be considered. Hill felt that in the past, variables of lesser significance were chosen for study because of their suitability to mathematical calculation, producing results of minimal value.

Elliott (1983) and Hill, Carter & O'Farrell (1983) selected the case study as a means of gaining a more in-depth analysis of process which could be measured by more sophisticated instruments than were available to researchers of the past. Elliott (1983) used an existential-phenomenological approach which Valle & King (1978) viewed as an appropriate alternative to empirical designs. Hill et al. (1983) traced the progress of a single client in a time-limited treatment across twelve interview sessions. Elliott (1983) confined his attention to a brief episode evaluated as critical and demonstrated the range of process that could be examined from a short segment. The effectiveness of this method had been tested by Mintz & Luborsky (1971) who compared the ratings of four-minute segments with the ratings of whole sessions and achieved equivalent results. Hill et al. (1983) made comparisons of sessions identified as the "best" and the "worst" and found that the client's level of experiencing was more intense in the best sessions, while problem description and external concerns were higher in the worst sessions.
The evidence suggested therefore that the study of small portions of a therapy treatment provided valuable information on the larger context, and the nature of the change process can be effectively examined by comparisons of events classified as important with other events of lesser significance. The components of change may emerge as influential by virtue of their presence under one condition and their absence under another condition. It also appeared to be valuable to reduce the level of client dialogue and to facilitate an inward focusing that intensifies the depth of client experiencing in the pursuit of client change.

Elliott (1983) and Hill et al. (1983) concluded from their studies that the success of a process analysis could be measured by findings that answered the following questions: What changed in the event? What was the nature of the change process? and, What are the implications for the practice of psychotherapy?

Purposes of the Study

The purpose of this study is to examine whether change occurs in an event that has been evaluated as critical by the client and to compare the level of client experiencing, vocal quality and speech pauses in such events with another segment of equivalent length that has been rated as insignificant. Attention is also directed towards the client's perception of critical events, the value of therapist interventions and the possible recognition of signals that may alert the therapist to an imminent client shift. The main objective of this study, however, is to compare critical and noncritical events on the basis of the client's depth of experiencing. The second objective is to determine whether the client's voice quality and periods of silence that accompany client experiencing are different.
under such conditions.

Statement of the Problem

In order to meet the purposes of this study, the first problem was to secure sessions that were perceived by the therapist and the client as exceptionally meaningful and then to have the client identify events within the session that were critical and noncritical. The second problem was to convert the events to written and audiotaped forms for measurement on the appropriate rating scales. The third problem was to determine the client's perception of the therapist's helpfulness before and after a critical event. The fourth problem was to measure the client's in-session behavior in terms of the depth of experiencing, vocal quality and durations of silence under both conditions. The fifth problem was to compute the results of measurements statistically to test the accuracy of the hypotheses. The last problem was to interpret the findings and their implications and to recommend future studies that might replicate or expand on these results.

The means by which significant sessions were located involved a verbal presentation to counseling teams with an invitation to therapists to participate. When the session was identified by the therapist and confirmed by the client as important, the client rated interview segments across the session on the Interpersonal Process Recall Scale (Appendix A) at a 6 "greatly significant" or 7 "extremely significant." A noncritical event was specified by a mid-range score of 4 "I don't know" or 3 "some meaning" on the same scale. The moment of dialogue chosen by the client was called a focal event and served as the central point around which a 3-minute episode was transcribed. This episode was shifted to some degree to use a therapist intervention as a starting point and
to provide a logical sequence. Transcription was based on the standards set by Sacks, Schegloff & Jefferson (1978) (Appendix B).

The nature of the client's behaviour is operationally defined in terms of the level of experiencing, the quality of voice and the durations of silence that occurred in the client's speaking turns. The client evaluated the therapist's level of helpfulness on the basis of four interventions delivered before the focal event and two interventions after the event on the Helpfulness Scale (Appendix C).

Standard process rating systems used to evaluate client insession behaviour included the Experiencing Scale (Klein, Mathieu, Gendlin & Kiesier, 1970), the Client Vocal Quality Classification System (Rice, Koke, Greenberg & Wagstaff, 1979) and the Speech Interaction System (Matarazzo, Wiens, Matarazzo & Saslow, 1968) from which precise measurements of both conditions were achieved.

Definitions of Terms

Operational definitions of terms used in this study are as follows:

"Process" is defined as "behaviour in the counselling sessions focused on the counsellor, client and the interaction between both" (Hill, 1982). This includes "both observable behaviour and internal perceptions and experiences" (Greenberg, 1983).

A "critical moment" is conceptualized as "an event in the process of therapy in which the therapist confronted or interpreted some key set of feelings or behaviours to which the client is receptive and which results in the client having felt some significant emotional impact, having achieved a sense of mutual closeness with the therapist, having had some major cognitive reorganization, having achieved some important
insight in a way that is useful, and having shifted some of his/her dis­torted perceptions of the therapist more toward reality" (Rand, 1978).

A "critical session" refers to a therapy session identified by the therapist and confirmed by the client as particularly effective.

A "critical event" is the highest scale range on the Interpersonal Recall scale given to a segment and when required, the client's choice of the most meaningful segment rated at a 7 when more than one 7 score occurs.

A "noncritical event" is the midrange 4 "I don't know" or a 3 "no meaning" should the 4 rating not be used. In the event that more than one 3 or 4 score occurs, the rating furthest into the session is used to avoid the warm-up effect of the session's opening.

A "focal event" is the key client statement selected by the client for a critical and noncritical designation and is the central point from where the 3-minute episode is transcribed.

A "critical episode" refers to the 3-minute segment extracted from the entire session with the focal event centered with shifts to allow the therapist to be first speaker and logical sequence. High client rating.

A "noncritical episode" refers to the 3-minute segment extracted from the entire session with the focal event centered with shifts to allow the therapist to be first speaker and logical sequence. Low client rating.

"Depth of experiencing" refers to the quality of the client's participation in therapy as it relates to "the extent to which inner referents become the felt data of attention, and the degree to which efforts are made to focus on, expand and probe that data" (Klein, Mathieu-Coughlan & Kiesler, in press).
"Vocal quality" in this study represents a measure of the client's involvement and processing level (Rice et al., 1979) by a classification system that assesses productive and nonproductive processing styles (Rice & Gaylin, 1973). It is measured by four vocal categories: focused, emotional, external and limited, each containing six features: perceived energy, primary stress, regularity of stresses, pace, timbre and contours.

"Durations of silence" refers to the pauses occurring between the therapist's and the client's speaking turns and to pauses within the speaker's dialogue.

Research Hypotheses and Rationale

The following research hypotheses were tested in this study:

1. There will be a significantly higher depth of client experiencing in a critical episode than in a noncritical episode.

2. There will be a significantly higher incidence of focused plus emotional voice quality in the focal event of a critical episode than in the focal event of a noncritical episode.

3. There will be significantly longer durations of silence in a critical episode than in a noncritical episode.

4. There will be a significantly higher value placed on the therapist's level of helpfulness before a focal event of a critical episode than after the event.
For general interest but apart from the statistical claims of this study, the following questions were asked of the clients and therapists: What change occurred in this event? What was the nature of the change process?

Assumptions underlying this Study

A major assumption of this study was that critical events occur with a reasonable degree of frequency. Elliott (1983) contended that such moments were rare, but Rand (1978) identified critical sessions in eight of the ten dyads he studied based on criteria established by 46 practising psychotherapists with a mean experience level of 14.4 years.

Although research has failed to document the superiority of one treatment orientation over another (Orlinsky & Howard, 1978), the assumption was made that the client's depth of experiencing has applicability across therapeutic models (Rice & Greenberg, in press).

The third and last assumption was that the perception of the client was a valuable resource in the researcher's quest for understanding of meaningful process. The focus of this study on the client's appraisal of significant events was not intended to diminish the therapist's value but was designed to test the effects of tapping the resources of the client to learn more about the mechanism of change.

Delimitations of the Study

Twenty-four 3-minute segments of therapy sessions involving 12 subjects were transcribed and taped for analysis. It was recognized that
longer sequences within and across sessions involving larger populations would have enhanced the significance of results.

The subjects were restricted to individuals attending a cost-free counselling training center on an individual basis to resolve a personal problem issue. Their qualification depended on the therapist's identifying a critical session and confirming this evaluation with the client who was then required to rate a segment of the session at a 6 or 7 level on the Process Recall scale. This process created an imbalance of sexes (two male and ten female) and an age group with a mean of 26.58.

The therapists consisted of counsellors-in-training who responded to a verbal request for participation following a presentation of the research requirements. Their involvement also required a taped interview session that they regarded as exceptionally meaningful. An imbalance also occurred with the therapists' sexes (one male and seven female), the number of clients involved (four had two clients and four had one client) and variations in experience in counselling. Three therapists were in the doctoral program and five were in the master's program. It should also be noted that different treatment techniques were used across the twenty-four episodes.

Another limitation was the necessary selection of critical and noncritical events from the same therapy session which had been categorized as a highly meaningful interview by the therapist and the client. Ideally, the noncritical events should be selected from a separate session identified as less significant and comparisons of episodes might be based on an equivalent position within the session.
A pre- and post-measurement of the client's level of progress would have enriched this design and contributed supportive evidence of the effects of perceived change on successful outcome. This study, however, was limited to the client and therapist reports of the nature of change from their perspectives.

In the past, the therapist's ratings on the Interpersonal Process Recall and Helpfulness scales were combined with the client's ratings (Hill et al., 1983; Elliott, 1983) but the therapist's evaluations were omitted from this investigation so as not to detract from the values of the client who has gained recognition as a relatively untapped source of knowledge on the change mechanism. Possibly, there was a tendency to give added weight to the therapist's perceptions of change, particularly when they conflicted with the client's opinions.

Justification of the Study

The process analysis of critical events has attracted considerable interest from process researchers who viewed this approach as an important means of measuring process and understanding how change occurs (Kiesler, 1982; Hill, 1982; Elliott, 1981). Such evaluations gave added credibility to its selection as a research topic by virtue of the experience of the investigators who recommended it. The comparison of aspects of therapy perceived as important by the client with other features regarded as nonproductive offered the potential discovery of meaningful patterns that were not only significant by their presence but conspicuous by their absence. Studies thus far have identified process variables which influence positive change during significant moments, but their prevalence under less significant moments has not been clearly determined. A reduced occurrence of such variables under
reverse conditions would greatly substantiate their importance in the change process. The use of the client as a source of information enabled the researcher to evaluate his contribution and also uncovered discrepancies between the participants' perceptions of the therapy session.

Attention to the client's depth of experiencing under the critical and noncritical conditions supported Hill et al.'s (1983) findings in comparing the best and the worst sessions of therapy that heavy dialogue by the client inhibits internal focusing and experiencing and the amount of problem description can predict outcome. In this study, it was found that deeper levels of experiencing occurred in the critical events than in the noncritical events and that more focused/emotional vocal quality and longer incidence of silence accompanied this experiencing.

The justification of this study was therefore based on the perceived need for an analysis of process to increase an understanding of its relationship to change and on the assumption that comparisons of opposite conditions provided the opportunity to assess significant variables by their presence or absence in a clinical interaction.

The following review of process literature demonstrates the complexity of this subject and the efforts that have been applied to the study of therapist and client and the characteristics each bring to the therapeutic session.
CHAPTER II
Review of the Literature

The intent of this literature search was to gain an overall appreciation for the nature of process research in terms of its historical past, current focus and future directions. This objective was achieved by a thorough investigation of the major psychological and psychiatric journals, doctoral dissertations and the comprehensive reviews of Orlinsky & Howard (1978) and Greenberg (1983).

Orlinsky & Howard (1978) brought order to a scattered body of literature by classifying studies into four main categories, i.e. Therapy as Activity, Therapy as Experience, Therapy as Dramatic Interpretation and Therapy as Association. These divisions were adopted for this survey, and their definitions and respective topics are explained later in this chapter. Attention was mainly focused on the perceptions and communications of the client and the therapist and their insession exchanges. Some extension occurred to give full coverage to the Orlinsky & Howard format. Following this evidence, the new theoretical approaches to process analysis were presented. The survey concluded with the research on critical events and basic principles of client experiencing on which this study was concerned. First, however, this review described some of the areas of controversy existing in this relatively new field.
Hill (1982) claimed that process research had come "full circle" which Kiesler (1973) also noted when he called for a convergence of various methods of analysis - regarded as marginally different - to serve the common objectives of all researchers interested in formulating a cohesive body of process literature from which both process investigators and practising clinicians might draw.

Greenberg (1983) confirmed that efforts along these lines were supported by more sophisticated methodology, the use of observers and third-party raters, video and audiotape devices and ongoing refinements to existing measurement instruments. Elliott (1983) developed a new model for process analysis which combined qualitative and quantitative interpretation, and Rice & Greenberg (in press) offered a new paradigm for understanding the mechanism of client change by classification of patterns that occur across therapy sessions and clients. Therefore, the renewal of interest in the issue of process was accompanied by fresh approaches to investigation but carried along with them some areas of confusion.

Controversial Issues

A review of process analysis studies was complicated by an apparent confusion between process research and outcome research; these terms are often used interchangeably (Kiesler, 1973). Distinctions also existed between process analysis and content analysis (Fine, 1979), particularly since process was largely examined on the basis of verbal content (Hill, 1982). However, nonverbal behaviour was also considered to be vital to understanding the meaning of cues passing between the client and the therapist (Orlinsky & Howard, 1978; Kiesler, 1982). Hill (1982) contended
that verbal response modes have been somewhat overworked, but verbal be-
behaviour was essential to understanding nonverbal messages. Other areas
of confusion in process studies involved the variations of definitions
used to describe the word "process", outcome studies without recogni-
tion of process variables as factors in the prediction of outcome,
the differences between process variables and input variables, and
an existing controversy regarding the reliability of analogue studies
as a legitimate measure of the real clinical setting (Elliott, 1979;
Fretz, Corn, Tuemmler & Bellet, 1979; Helms, 1976, 1978) and the use
of college students as representative of therapy patients.

Resolution of these questions have been attempted by some resear-
chers, but clarification varied from one issue to another.

Process Research versus Outcome Research

Process research has traditionally referred to changes that mani-
stall themselves in the counselling interview as a result of the insession
behaviour of the participants (Hill, 1982; Kiesler, 1982). Outcome re-
search concentrated on the differences between pre-test and post-test
measurement from which conclusions were drawn about specific variables
Orlinsky & Howard (1978) claimed that too much emphasis was placed on
successful outcome and felt a great deal of knowledge on process could
be learned from insignificant results. Cohen (1979) found that practising
clinicians were more critical in their judgments of scientific merit and
clinical relevance of studies that produced negative findings, instead
of viewing the results as one statement concerning treatment effectiveness.
Orlinsky & Howard (1978) implied that an absorption with client improvement
placed process in the shadows, while attention focused on the therapist's
characteristics and treatment orientation.
Process Analysis versus Content Analysis

Kiesler (1973) described content analysis as an outgrowth of process analysis and in his endeavour to systematize the literature as a common base for future research, the significance of the differences between content and process analyses was minimized. Fine (1979) defined content as the verbalized problem and process as the manner and sequence in which the content was presented. Gendlin (1979) defined content as the "what" of counselling and process as the "how". He felt that it was important to distinguish between the two because process is less subject to conscious control. Satir (1967) described the differences between content and process in the same terms as Gendlin (1979) and perceived content as one measure of process or a marker that differentiates some aspects of process. Other definitions appeared to be influenced by the researcher's particular area of interest.

Definitions of Process

Gendlin (1968, 1969) claimed, "I call process 'experiential focusing' ....Even if what was being talked about is very specific, the feel of it will be multiple. It is a feel of 'that whole thing' or 'whatever is still wrong'."

Hill (1982) called process "an analysis of behaviour in counselling session focused on counsellor, client and interaction between both."

Greenberg extended this definition to include the non-observable facets of behaviour that were necessarily arrived at by self-report.

Patton (1982) described process as "an inferred relation between or among client and counselor observations... In empirical terms, a process is a statement of relations between and among observation (e.g. a learning
curve, correlational coefficient, F ratio or a propositional statement." Patton felt that the term "process" was often a label applied vaguely to change or to cover inexplicable events.

Chaplin (1975) viewed process as "any change to any object or organism, particularly a behavioural or physiological change; the manner in which a change in an organism or a response is brought about; a sensation or other conscious content without reference to its context or meaning; a projection or outgrowth from an organ or cell."

Eisenberg & Delaney (1977) believed that process contained the essence of counselling and described it as "an identifiable sequence of events taking place over time. Usually there is the implication of progressive stages to the process. States are common to all human beings but what happens is uniquely different for each individual."

While Kiesler (1973) acknowledged the ambiguities and confusion associated with process, he defined it emphatically for his own purposes as "any research investigation that, totally or in part, contains as its data some direct or indirect measurement of patient, therapist or dyadic behaviour in the therapy interview. Process studies then are those assessing therapy interview behaviours in some fashion. If there is no measurement of interview behaviours, the study is not of process."

Satir (1967) distinguished between form and process by stating that "Process implies movement. It is dynamic, not static...Process focuses not on the activity per se, but on the carrying on of the activity."
In view of the different shades of meanings connected with process as a term, it was not too surprising to find that confusion existed between process and input variables which Hill (1982) attempted to distinguish for easy reference.

**Process Variables versus Input Variables**

Hill (1982) stated that the client input variables contain the problem issues, the client's personality and intellectual capabilities, modes of expression, attitudes and suitability to specific treatment modes. The therapist input variables are demographic data, historical and professional standing with respect to training, experience and social status, as well as personal expectations and treatment orientations. Situational input variables related to the environment and practical issues of treatment durations and payment of fees. Pre- and post-measurements of the client's condition are also examples of input variables. Process variables are perceived as the dynamics of the client/therapist association when all input ingredients are brought to the therapeutic exchange. Lambert & Bergin (1983) identified the therapist process variables as personal style, therapeutic interventions or operations and the relationship elements of both participants.

Kiesler (1973) referred to small pieces of process which were qualified as the characteristics of the therapist's conceptions and the client's preferences which formed "systems of indirect process analysis".

Orlinsky & Howard (1978) claimed that significant process occurred at an unconscious level that was barely perceptible to the participants.
in the therapeutic interaction and unavailable to independent observers. These underlying influences which are largely a mystery may partially explain the reluctance of some researchers to accept analogue studies as representative of the clinical setting. A related concern was the use of students as indicative of the client seeking therapeutic treatment.

**Analogue Studies and Students as Subjects**

Analogue studies might be described as one of the "trade-offs" referred to by Hill (1982) in her discussion of experimental alternatives. Orlinsky & Howard (1978) found the research evidence on analogue studies versus clinical investigation to be contradictory and excluded analogue designs from their literature review. Some findings indicated a strong similarity in therapists' behaviours under both conditions (Helms, 1978), but concerns were more strongly centered on the reactions of clients who are the "sensitive" members of the clinical interaction.

Studies that offered more promise of bridging the gap between the clinical client and the student were those that measured the subject's level of anxiety or other negative emotions (Kolko & Milan, 1983; Claiborn, 1983) that can be equated across both populations.

The controversy issues raised in this survey excluded the ongoing surveillance of studies in terms of the soundness of empirical designs and the scientific relevance of conclusions. New approaches that appeared to offer the potential for future controversy are the trends towards existential-phenomenological investigation which Valle & King (1978) viewed as a viable alternative to empirical methods. The
following studies, however, were mainly conducted on the basis of accepted scientific practices:

Therapy as Activity

Therapy as Activity incorporated studies of process from the perspectives of non-participating observers who interpreted meanings of the therapist/client interaction by observation of insession behaviours (Orlinsky & Howard, 1978). The major findings suggested that the qualities brought to the relationship by the therapist and by the client contributed more to successful outcome than the selection of treatment strategies (Lambert, DeJulio & Stein, 1978; Molner, 1983; Todd, 1981; Crohn, 1977; Schaffer, 1977; Stearns, 1980), and the client's level of involvement was a better predictor of outcome than the therapist's characteristics.

Orlinsky & Howard (1978) classified the therapist's behaviours as task-oriented or interpersonal. The task-oriented activity included instrumental and communicative strategies designed to facilitate the client's progress. Interpersonal behaviour reflected the therapist's personal style of relating to people and included physical appearance, likeability and overall presentation.

Therapist instrumental activity

In a single case study, Elliott (1983) analyzed transcribed dialogue from segments of a therapy session to determine the factors that led to a critical moment in therapy. A significant intervention was
selected on the basis of the client's profound reaction to the incident on replay and the high rating it received across a substantial number of observers. Elliott described such focal events as rare. He felt such moments should be seized upon with immediacy, although the power of the therapist statement was not anticipated. Based on the integration of an earlier insight by the client, the therapist translated the client's expression of thoughts and feelings on a particular issue to a major problem area. Elliott stressed the value of formulating vivid metaphors and well-timed analogies in an effort to bring new understanding to the client. Amira (1982) also endorsed the deliberate usage of metaphorical and figurative language in therapeutic interventions, although his results produced no significant differences by the use of such techniques. Amira concluded that his use of frequency counts and rates of production were inadequate measurements for determining the quality and impact of creative communications.

The nature of the interventions described by Elliott (1983) suggested a reframing element that impacted with profound meaning in a new context (Bandler & Grinder, 1982). In an analysis of the dialogue immediately preceding the critical moment, Elliott (1983) found that the client had ignored three therapist statements and had disagreed with another. This finding negated the likelihood of a predictable sequence and suggested that the therapist's influence was indirect.

Apparently, inaccurate interventions also contributed something useful to the process. One hypothesis implied that inaccuracy created a need for the client to rectify an error by a more indepth self exploration. Claiborn, Crawford & Hackman (1983) compared the effects of
discrepant interventions with active listening and congruent inter-
pretation. The discrepant statement proved to be the most consistent-
ly effective response, although the clients failed to gain a greater
understanding of their problem by having to strain for higher accu-
racy. The degree of new insight achieved with discrepant interven-
tions was equivalent to the therapist's active listening condition.
Greenberg (1983) referred to a single-session study conducted by
Strong, Wambach, Lopez & Cooper (1979) where the motivation of the
client was enhanced by interpretation, particularly when the inter-
vention spotlighted causes that were subject to the client's control.

Claiborn (1983), Hill (1978) and Spooner & Stone (1977) viewed
interpretation as valuable when it contained information that extended
beyond the client's expressed content. Gendlin (1968) claimed that
this broader perspective hovered below the client's immediate level
of awareness and encouraged a deeper experiencing. Rather than being
a concrete verbal proposition, Claiborn (1982) described interpreta-
tion as a method that can take the form of anecdotes, metaphors and
re-statement, as well as manifesting itself in a well-timed question
or movement of the client towards his/her own interpretation. Overlaps
on ratings of interpretation, confrontation and re-statement were
perceived as common occurrences attributable to differing perspectives
(Hill & Gormally, 1977). Interpretation, however, was not always re-
garded as beneficial.

Claiborn (1983) pointed to occasions when interpretation could
be inhibiting. If the therapist's tone was accusatory, the client was
intimidated, but if the interpretation was proposed tentatively, the client was receptive. When the interpretation provided the client with a new perception of the problem issue, it appeared to be more useful than an accurate statement. Spooner & Stone (1977) shared Claiborn's (1982) view of interpretation as having negative potential when it was presented without sensitivity. They found that the client read the interpretation as a hostile form of confrontation when it pointed to a discrepancy in the client's content. Hill & Gor- mally (1977) preferred the more direct technique of probing which produced more favourable results than restatement or reflection because it appeared to encourage the expression of feelings.

The identification of therapist responses was not found to be clearcut. Elliott (1983) defined the critical intervention in his study as reflective-interpretive but acknowledged the possibility that Goodman (1979) might regard the statement as a deep reflection and Shapiro, Barkham & Irving (1980) might qualify it as an exploration.

Kivlingham (1982) stressed the value of matched content between the client and the therapist and timing of interventions that were appropriate to intimacy and anger. He found that when the therapist's interventions were strategically timed, intimacy could be handled with a higher level of comfort. The client was less likely to respond inappropriately, appeared to be more flexible and self-ratings were more congruent with outside observations.

In an attempt to reduce resistance in clients, Kolko & Milan
(1983) combined paradoxical interventions with reframing when traditional behavioural methods failed. Results indicated a significant improvement in client performances which sustained over time. The administration of paradoxical directives was believed to lend itself to reframing techniques which Haley (1976) contended must change the meaning of an issue in a way that is compatible to the client's frame of reference. Reframing statements were also found to require originality but should not be so extreme as to throw question on the credibility of the therapist (Brehm, 1976).

Procedures for minimizing client resistance and for promoting compliance at early stages of treatment were also designed by Brehm (1976), Goldfried & Davison (1976) and Jan & Lichstein (1980). Utilization of paradoxical techniques had historically been limited to uncontrolled case studies (Jessee & L'Abate, 1980; Lamontagne, 1978) and although Orlinsky & Howard (1978) questioned the validity of such studies, Gombatz (1983) found that paradoxical directives were as effective as Client-Centered or Rational Emotive therapies in dealing with problem resolution. Ascher & Turner (1980) concluded that the underlying rationale of the therapist significantly affected the administration of a paradoxical strategy.

The therapist's level of empathy underwent substantial investigation as a therapeutic tool. Orlinsky & Howard (1978) cited 23 studies on this characteristic and claimed that empathy could be perceived as an interpersonal quality or as an instrumental activity projected to build rapport. Feldstein & Gladstein (1980) viewed it as subjective or
objective. In spite of its popularity as a research topic, Lambert & Bergin (1983) criticized the singlemindedness of researchers who examined empathy in isolation from other important variables. Lambert et al. (1978) limited its value to particularly sensitive moments when the client required strong emotional support or acceptance following a major disclosure. The reliability of ratings on empathy has also been open to conjecture (Hill & King, 1976; Fridman & Stone, 1978 and Feldstein & Gladstein, 1980). The perceived deficiencies of ratings were attributed to the poor material quality of recording instruments, the questionable proficiency of raters and the discrepancies that appeared to exist between empathy definitions and actual measures. Kohut (1978) called empathy a "vicarious introspection" which description carried connotations of an internal condition not easily observed or agreed upon.

In a study of schizophrenics and neurotics, Franco (1978) found that higher observer ratings of the therapist's empathy, warmth and genuineness could be secured by the use of "emotion" words and self-referents. High levels of facilitative conditions were negatively related to intellectual responses. Elliott (1983) found that responses of high impact were rated moderately on their empathic value. Gladstein (1983) reviewed the literature on empathy by analysis of social and developmental psychology studies. He distinguished two approaches on the definition and measurement of empathy which differed again from counselling/psychotherapy. The common denominators in these three
orientations related to an agreement that "affective empathy" meant
the ability to feel what another person feels and "cognitive empathy"
was the capacity to put one's self into another person's position.
Gladstein differentiated empathy in children from empathy experienced
by adolescents or adults and concurred with other findings that empathy
was no guarantee of effective helping. Bergin & Suinn (1975) restricted
the value of empathy to client-centered therapy under specific condi­
tions. The evidence suggested that its impact as an effective instru­
mental tool has yet to be verified (Lambert et al., 1978; Parloff,

**Therapist communicative activity**

Greenberg (1983) mentioned the need for nonverbal measurement in­
struments and the complexity of drawing conclusions from current studies
which are "often uninterpretable and even contradictory" (Graves & Robin­
son, 1976; Stragan & Zytowski, 1976; Smith-Hanen, 1977; Tepper & Haase,
1978; Young, 1980). Hill, Siegelman, Gronsky, Sturniolo, Frank & Fretz
(1981) conducted a study that indicated that verbal and nonverbal con­
gruence was significantly related to outcome. Mindies (1977) tested
nonverbal behaviour to determine whether the coordination of body move­
ment produced a higher perception of therapist empathy. The results
indicated no significant relationship, but it was evident that more
movement was associated with higher therapist ratings and co-ordinated
head nods and hand gestures correlated with these scores.

The therapist's level of experiencing in therapy appeared to have
a motivating influence on the client (Elliott, 1983). This internal
state of the therapist was conveyed to the client by vocal quality, words that reflected a deep involvement with the client's feelings and significant spans of silence. Hill et al. (1983) found that a higher level of client experiencing occurred after periods of silence and less experiencing resulted from the therapist's closed questions. Feldman (1978) correlated silence and speech latency with submissiveness in the presence of female therapists. This trend was associated with a "ladies first" courtesy in her particular study. Hill claimed that the client engaged in more problem description when the therapist focused on fact-finding. When interpretation, confrontation, ego-strengthening and reframing techniques were applied, the client moved to experiencing, self-exploration and insight.

The "Gloria" training film has been widely used to study the dynamics and impact of language (Meara, Pepinsky, Shannon & Murray, 1981), early moments in therapy (Nicholas, 1978) and the utility of verbal response categories across different treatment orientations (Hill, Thames & Rardin, 1979). Meara et al. (1981) compared verb usage with three therapists interacting in a dyad with the same client and their performances with other clients. Similarities of verb forms emerged between Rogers (Client-Centered) and Perls (Gestalt). The differences between Rogers and Ellis (Rational Emotive) were more in line with expectations of a Client-Centered therapy versus the highly directive Rational Emotive approach. The frequency of client dialogue was much higher with Rogers than with Ellis, demonstrating that active listening encouraged more client participation than the direct argument of cognitive treatment. Hill et al. (1983), however, found that passive listening of
a client with a proneness for excessive story-telling did nothing to inhibit this tendency. More directive measures were required to lead the client away from problem description.

Meara, Pepinsky, Shannon & Murray (1979) noted the consistency with which the client retained a personal language style in a single interview with three prominent therapists. Bieber, Patton & Puhriman (1977) claimed the independence of client conversational styles at intake was a temporary tendency that dissipated by the eleventh session, when the client's mode of speaking converged with the communication style of the therapist. Meara et al. (1979) also identified a tracking and convergence with the therapist's style and emphasized the instructional potential of language choices in the guidance of clients.

Hill et al. (1983) counted number of words spoken by therapist and client in her case study and classified the therapist's dialogue at 40% as an indicator of high activity and therapeutic involvement. Pope (1979) produced findings that indicated the positive reinforcing effects of an active therapist.

**Therapist Interpersonal Behaviour**

Hackney (1978) traced the changes in definitions of empathy over a 20-year span and identified a current shift of interest in empathy as a communications skill. He concluded, however, that emphasis was better placed on its emotional components in the study of process. Barrett-Lennard (1981) expressed a similar opinion and described empathy in terms of unconscious emotional links which strived on a conscious level to build a natural rapport between the therapist and the client.
Schaffer (1977) tested therapists on their drive levels and found that a significant correlation existed between perceived drive and accurate empathy. Expressive and deliberate therapists were also believed to be more empathic than inhibited or impulsive therapists. The high-drive group and those exhibiting more benign attitudes responded with less specificity, and the more modulated the expression of drive, the higher the therapists were rated on nonpossessive warmth. Bordin (1979) viewed empathy as an essential component of the "working alliance" which developed early in the client/therapist association. Ross (1983) failed to make a link between empathy levels and a client's decision to terminate treatment, but dropout occurred more frequently when the therapist was authoritarian than when he/she was democratic.

Hoffman & Spencer (1977) studied a characteristic described as "empathic distress" that developed when therapists formed too strong an emotional attachment with their clients. They found this condition occurred and created a barrier to effective treatment. Their recommendations involved the testing of the therapist's physiological reactions to specific clients by measuring skin responses during therapy. Schaffer (1977) also supported the measurement of therapists' personality traits by a battery of tests in order to predict their behaviour with clients.

Apparently, sexual intimacy between therapists and their clients was not unheard of. Friedeman (1983) studied the post-treatment attitudes of clients who had engaged in sexual intercourse with their
therapists and found the majority of clients regarded the experience as detrimental to treatment. There were significantly greater incidence of resentment and guilt in this group and three-fourths of the subjects rated outcome as "no change" or "change for the worse". There also appeared to be a lesser ability to work past the therapy stage. A small number of participants attributed improvement to this intimacy, indicating that sexual involvement did not inhibit the progress of all clients. Stricker (1977) viewed a sexual relationship between a male therapist and a female client as a serious abuse of his position. Delehanty (1979) took strong exception to this view which was classified as a sexist statement. She referred to equivalent impediments to successful treatment should the intimacy involve a female therapist and a male client.

Peterson & Bradley (1980) questioned whether the personal value systems of therapists related to their treatment orientations. Their results uncovered significant differences in beliefs and attitudes of practitioners of Behaviourism, Gestalt and Rational-Emotive therapies. In this study, the Gestalt therapists were the only group who demonstrated a strong endorsement for the values of warmth, congruence, genuineness and unconditional positive regard in creating a safe environment for the client. Brunink & Schroeder (1979), however, found Gestalt therapists to be more directive and less facilitative, while the Behavioural and Analytic therapists had strong similarities. Peterson & Bradley (1980) echoed the sentiments of Meara et al. (1979) that values and attitudes expressed verbally by therapists may differ significantly from the behaviour observed in the therapy session.
This behaviour appeared to be more strongly effected by the characteristics of the client than was previously thought, and the client has emerged as a strong participant in the therapeutic exchange.

Orlinsky & Howard (1978) viewed the client's role as task-oriented but encountered the largest body of literature in the areas of communicative activity and interpersonal behaviour.

Client communicative activity

Probably a communications device that is familiar to most clinical practitioners is the "flat affect" adopted by clients to reduce internal and external stimulation (Fosha, 1983). A study was conducted on psychotics to compare the improvement level of clients who had dropped this exaggerated monotone speaking style with clients who retained it. Fosha concluded that this tendency was a means of controlling emotionally charged material and should be respected as an effective defense that allowed more information to be processed and self-arousal to occur. Her findings denied that a "flat affect" was symptomatic of a higher level of pathology. Clients scored equally on improvement under both speaking conditions. In a sense, the "flat affect" bears some resemblance to the "externalizing" manner of speaking that Elliott (1983) noted in his client who used this device to keep sensitive material at arm's length until she was prepared to deal with it. It was described as a reporting style of self-interpretation which gave the client control of the communications and staved off intense experiencing until a state of readiness was reached. Elliott concluded that the client monitored progress by a sequential, contemplative style which proceeded on a course and ignored or challenged interventions that tended to interfere with the pattern set.
Hill et al. (1983) measured level of client participation by the number of self-referent statements that were verbalized. Carlson (1980) claimed that the desirability and productivity of self-learning increased with the quantity and explicitness of the self-referent data. Claiborn et al. (1983) believed that the verbal participation of the client contributed to a self-discipline over negative emotions which Gendlin (1979) preferred to hear expressed.

Staples, Sloane, Whipple, Cristol & Yorkston (1976) found the highest rate of improvement amongst clients who spoke for long durations during treatment. In a study of the verbal and nonverbal behaviour of violent and nonviolent adolescents, Hassell (1983) noted that the violent groups spoke frequently in short segments and engaged in a lot of hand and arm movements. The nonviolent group spoke less often but for longer periods, were more open and relaxed in discussions, smiled more frequently and leaned forward during communication exchanges.

McDaniel (1981) linked verbal response modes with levels of disturbance and found that more self-disclosures and less "demonstrations of edifications" occurred in the disturbed group, but a better quality of participation accompanied improvement which was unrelated to the percentage of self-disclosures.

Client interpersonal behaviour

Holden & Quan (1983) found that improvement in short-term therapy related to the client's ability to struggle through negative transference and the working through depended on the presence of "active anger" rather than a "passive anger". "Passive anger" suggested the more withdrawn and reluctant client whose prognosis is poorer than the motivated client (Gomes-Schwartz, 1978). Staples et al. (1976) viewed the client's
personal characteristics as more instrumental in producing positive change than the therapist's interventions. Gomes-Schwartz (1978) related successful outcome to the client's level of involvement which Kolb (1982) confirmed was the best indicator of success. The degree to which the client was liked by the therapist appeared to serve as a motivator (O'Malley, Chong, Suh & Strupp, 1983). This relationship was confirmed by the Vanderbilt Process Scale measurement which found no correlation in the first session, a weak indication in the second and a clear connection by the third interview. This finding supported Bordin's (1979) concept of the "working alliance" as an early development in therapy.

**Behaviour interaction and therapeutic outcome**

Orlinsky's & Howard's (1978) coverage of studies related to the therapist and client behaviour interaction focused on group dynamics and the quality of performances resulting from a facilitative but permissive environment. Positive results were attributed to the independence encouraged by therapists in group and dyad situations. High therapist expectations and the complementarity of client and therapist characteristics were related to successful outcome. Research also involved the influence of the participants' genders on the therapeutic interaction and outcome and attention was given to the early terminations of clients from treatment.

In a study of patient-to-patient interactions in a group treatment program, Ellsworth, Casey, Hickey, Twemlow, Collins, Schoonover, Hyer & Nesselroade (1979) produced significant evidence that a higher level of improvement could be achieved by mixing acute ward patients with chronic
patients, rather than assigning them on the basis of similar pathology. The introduction of a "buddy" system in a six-week program for chronic schizophrenics also produced some dramatic effects (Otteson, 1979). Participants worked harder to facilitate the discharge of one of their counterparts than would be expected in negotiating their own release. Patients with up to 14 years consistent hospitalization were eligible for discharge on the basis of this partnership support. It was concluded that the effectiveness of caring for another individual exceeded the direct threat imposed by acting on one's own behalf in this setting. This finding also supported the strength of the collaborative bond that exists between therapist and client and intensified its meaning as an equal partnership.

Crohn (1977) produced divergent results in two studies aimed at examining the interaction between client and therapist. In one study, the interaction was symmetrical and in the other, a strong polarization occurred based on the pattern set by the therapist. A controlling type of behaviour in the therapist produced a docile response from the client which modified proportionately when the directive approach was reduced. Schaffer (1977) felt this tendency created an opportunity to increase the client's initiative by adopting a less active role as therapist.

Petro & Hansen (1977) confirmed substantial evidence that both male and female therapists are equally as sensitive to the needs of the client. However, previous claims that male and female therapists show more empathy to male clients than female clients were also supported in this study. Paster (1982) could find no indications that therapists held a
bias for clients on gender or sex role. Stearns (1980) also found that sexual stereotyping was not an issue in therapy, and the paramount factors were the client's presenting problem, personal history, occupational satisfaction and reactions to stress. Helms (1978) concluded that vocational confusion was rated as more serious than personal problems when clients were under 25 years old. Female therapists were also inclined to perceive female clients as having more problems than male therapists did. This discrepancy was tentatively attributed to the higher level of encouragement that clients received from female therapists to verbalize certain problems. Feldman (1978) found that therapists of both sexes tended to talk more to female clients than to male clients and that male therapists engaged in a higher volume of "small talk" in their interviews. Clients of both sexes tended to be more dependent with male therapists and more compliant with female therapists, although not to a level of significance.

The ratings of clients and therapists by observers were significantly correlated to the therapist's feelings about the clients (Sharf & Bishop, 1979). LaCrosse (1977) had clients, therapists and observers rate the therapist's behaviour on expertness, attractiveness, trustworthiness, empathic understanding, congruence and unconditional positive regard. The results indicated that clients rated therapists higher than observers and therapists. Observers' ratings of therapists were lower than therapists' self-ratings, and a higher correlation existed between clients and observers than between clients and therapists. Schwartz
(1983) found higher agreement between observer ratings of the therapeutic alliance than between the ratings of clients and therapists. The perceptions of these participants are covered in the following classifications.

**Therapy as Experience**

Therapy as Experience was defined by Orlinsky & Howard (1978) as a process viewed internally by the client and therapist engaged in an interaction that can be measured or reported on in an empirically sound way.

The client's involvement in therapy was described as a reenactment of experiences with the external world. In this social world, the individual's attention shifts from the self to others. In treatment, the client focuses on the therapist for understanding of the environment and his/her relationship to it.

**Client perceptions**

Process research studies suggested that client self-perceptions were influenced by the therapist's perception of him/her. The greater a therapist's optimism and degree of respect, the higher the client's level of confidence (Tovian, 1977), and this tendency grew when the therapist encouraged independence (Cooley & Lajoy, 1980).

Pratt (1978) designed a behavioural model that allowed therapists to test the effects of noncongruent patterns on the client's perceptions. He found that the significance of nonverbal cues accelerated when combined with conflicting verbal messages. The extent to which the client was aware of deliberate incongruence has not been examined, but it is apparent that the client is finely attuned to the degree to which the therapist is experiencing legitimately (Elliott, 1983).
Peterson & Bradley (1980) found that the therapist's level of experience did not affect client responses, and Pratt (1978) found no significant influence on the client's perception of the therapist's congruence as a result of the level of experience, but significant differences occurred in evaluating congruence when the level of experience was disregarded.

Dye (1983) studied the effects of the therapist's touch on the client's perception of the therapist's expertise, attractiveness and advice-giving skills. No significant differences emerged as a result of touching the client nor did this physical contact increase the likelihood of continued attendance. Belcore (1983), however, found a positive link between the patient's attitude toward a physician and medical care in general as a result of being touched during treatment visits. Stockwell & Dye (1980) discovered a higher level of self-reported satisfaction amongst clients who were not touched, although no main effect emerged as significant in the touched and untouched groups.

In a study on the client's perception of the therapist based on the influence of talking levels, Kleinke & Tully (1979) found that low level talkers were evaluated more favourably on the liking scale, and high level talkers were rated as high on domineering. The quieter therapist was also viewed as more experienced. Contrary to other research, spans of silence were reacted to negatively by the clients in this study even though they were brief. Possible causes for this discomfort were not determined. Barrett-Lennard (1981) found that the client's perception of the therapist's level of empathy was related to successful
perception of the therapist's level of empathy was related to successful outcome. LaCrosse (1977) and Beard (1983) claimed that the client perceived the therapist as attractive when the levels of empathy and positive regard are high. Beard (1983) also confirmed that a high rating on trustworthiness and expertness was a by-product of perceived warmth and empathy. Kubinski (1983) found that the value the client placed on the therapist's quality depended on the nature of the presenting problem. Attractiveness was important when the issue was a personal problem, but expertness took precedence in a vocational guidance situation. Barak & LaCrosse (1975) suggested that expertness and trustworthiness might be two components in the client's perception of credibility. Of these three qualities, expertness was most predictive of outcome (LaCrosse, 1980).

Meara et al. (1981) confirmed the client's recognition and appreciation of an empathic therapist but contended that the discomfort of confrontation was highly valued by the client intent on improvement. An analysis of a single client who was treated by three therapists independently indicated that empathy produced more client dialogue and experiencing of deep feelings, but the client perceived the therapist who challenged her as offering the potential for greater learning. Bieber, Patton & Fuhriman (1977) and Meara et al. (1981) suggested that the intensity of the client's efforts could be measured by the strength of the therapist's demands. However, Meara et al. warned against an overloading of the client, if the therapist neglects to pace himself/herself according to the client's capacity to keep up with the process. Meara et al. (1979) discovered a strong willingness on the part of the client to meet therapeutic expectations and a sense of responsibility
for a substantial share of effort when the therapist is perceived as involved (Elliott, 1983).

On the negative side, the client's needs can be transferred to the therapeutic relationship in terms of unrealistic demands (Hill et al., 1983). Hill found that the client's loneliness created a longing to perceive the association as a personal friendship. The client's eventual termination in advance of her willingness to discontinue heightened a sense of rejection and feelings of hostility which may have contributed to a return to the baseline established before treatment. The client's agreement to a short-term contractual arrangement did not lessen the impact of termination which Hill contended must be determined by the nature of presenting problems.

Hawes (1983) investigated client and therapist similarities as a measure of client satisfaction and found that both participants evaluated the relationship negatively when their personal characteristics were extremely different. A relationship existed between the extent of these differences and early termination. Hawes also found that the personality traits of therapists and clients differ substantially from members of the general population.

In a study of clients who terminate therapy after one session, King (1983) found their perceptions of treatment was positive. Clients rated the experience as useful and expressed an intention to return when another problem arose. Clients attributed their success from one interview to their ability to present their concerns well and the therapist's personality and the quality of the clinical environment were not factors in their decisions to discontinue.
Gruder (1983) related successful outcome to therapeutic conditions where both the client and the therapist were in agreement as to the client's capability of developing and maintaining an intense involvement in a trusting, collaborative relationship. A sense of commitment to an active process, a recognition of the value of insight, receptivity to the open expression of feelings, an ability to confront problems and act upon new solutions and confidence in the therapist's skills were all prerequisites to improvement.

Striano (1982) surveyed clients who had interacted with more than one therapist. He found that warmth, friendliness and self-disclosures were not perceived by clients as sufficient to carry the therapeutic relationship, if other skills were lacking. Many clients had found their therapists to be too active and authoritarian and perceived treatment as a negative and unrewarding experience. Schaffer (1977) suggested that a more self-effacing character style on the part of the therapist allowed the client to develop a more prominent role in the therapeutic interaction.

Discrepancies apparently occurred in the client's perceptions of events and the therapist's perceptions of the same events. Stiles (1980) related treatment effectiveness to the client's degree of comfort and found that both the therapist and client were in agreement on the benefits occurring in the first half of the therapy session. At the end of the second half, however, the therapist felt positive about events that carried deep and rough client experiences, while the client felt shaken and vulnerable. The client viewed these experiences negatively and
felt more positively about sessions that ran smoothly and easily. Stiles concluded that pleasant feelings in session do not necessarily demonstrate good therapy. The clients and therapists agreed in principle that the powerful sessions may be more valuable, even when they are accompanied by uncomfortable moments.

Orlinsky & Howard (1978) reported that the largest body of process research on the therapist's experiencing deals with his/her views of the client, few studies related to the therapist's self-perceptions and a slight number focused on the therapist's view of the therapeutic relationship. The following outlined some of the results of these investigations:

**Therapist's Perceptions**

Sharf & Bishop (1979) believed that the therapist's feelings about a client are established at the intake interview, and a positive attitude is based on the client's degree of motivation and the extent to which his/her goals seem realistic.

Vaccaro (1981) related successful outcome to the therapist's high expectations of a client's potential for improvement. The client's physical appearance also played a significant part in the therapist's evaluations (Sharf & Bishop, 1979), while the client's level of anxiety and problem severity did not. A high rating on physical attractiveness tended to increase the likelihood of favourable ratings on other characteristics. When the client expressed confidence in his/her own ability to resolve inner conflicts, the therapist's positive feelings towards him/her increased and a higher correlation occurred when the
clients were members of the opposite sex. Shullman & Betz (1979) discovered a tendency for the therapist conducting intake interviews to refer clients to therapists of the same sex. It was not known whether this practice reflected the client's expressed preference or whether the therapist favoured an interaction based on matched genders.

Rouse (1983) found that the therapist's predictions of progress were significantly higher with well-educated clients, but no significant discriminations occurred between white collar workers over blue collar workers.

The age of the client apparently had an influence on the therapist's perception of client prognosis. Ingalls (1983) compared the clinical psychologist's evaluations with the geriatrics specialist and found the psychologist was more pessimistic in his predictions about elderly clients. It was not apparent that this tendency affected the clinical evaluation process. Taboada (1983) anticipated a negative bias towards elderly clients and found that the reverse occurred. Sixty-five year-olds were rated significantly higher than thirty-year-olds on social desirability in this study, and were perceived as more powerful, more active and mentally healthier. It was concluded that a dramatic reverse discrimination occurred wherein the therapist was accused of ignoring pathology in the elderly client because of a lack of interest in administering treatment to this population. Ponzo (1981) confirmed the prevalence of age prejudices as they related to restrictions placed on the elderly client. Ponzo contended that therapist's perceptions were distorted on this issue and developed a list of cognitive, affective and behavioural objectives designed to reduce this tendency.
Gaffin (1981) found a positive correlation between the self-rated complementarity of therapists and clients and successful outcome, but the similarities were not apparent at selected phases of treatment.

Frank (1982) found significant differences between the client's expressed needs and the therapist's perceptions of the client's needs. Therapists tended to believe the client wanted more supportive reality-oriented treatment than he/she did, and expected less a preference for expressive insight-oriented therapy than was wanted. There was no apparent recognition of the point of treatment when the client wanted less help and more independence. These findings suggested that the therapist may be lagging behind the client's actual state of readiness to move forward.

From a study of the therapist's ratings regarding a liking for the client, Peiser (1982) was able to predict the number of sessions the client would attend or miss, and measurement of the client's improvement significantly correlated to the therapist's degree of liking, the therapist's perception of their similarity. The highest success rates were correlated to dyads where both participants were female.

Schuh (1981) investigated the qualities of the clients that influenced the therapist's choice of an appropriate treatment model. He found a high level of discrimination in the selection of clients for group therapy on the basis of their diagnosed condition. Reactive paranoid schizophrenics and phobic clients were rarely recommended for
group interaction. Single people were referred more often than married people, particularly when the married clients fell into hysterical or obsessive/compulsive categories. The alcoholics' need for group support, however, was generally accepted across the range of therapists under study. Schuh also found that therapists tended to favour their own specialization when referring clients, i.e. a family therapist tended to refer clients for family therapy and a group specialist rarely recommended individual treatment when group options were available. In the group situation, it might be natural to select people who are most likely to interact favourably in a joint effort and one might expect therapists to favour their own mode of treatment.

Conjoint experience and therapeutic outcome

In his analysis of a critical moment in therapy, Elliott (1983) reported on the discrepancies between the therapist's perception of client change and the client's perception of the same event. When the client reacted to a strategic intervention, the therapist viewed it as an integration of an earlier insight, and the client described the "moment" as a sudden recognition of progress to a new plateau in her therapeutic struggle which Sarbin & Mancuso (1980) called a "positive transvaluation of personal identity". Elliott (1983) experienced no apparent difficulty in incorporating both client and therapist perceptions into an explanation of the change process. The important issue was the collaborative effort that successfully produced a major shift for the client.

Church (1982) also identified a collaborative exchange in client and therapist statements in a sequential analysis of moment-by-moment
responses. Church believed that good process could be recognized across sessions by examining the impact of each participant's response to the previous response. Successful therapists appeared to react more spontaneously to their clients, while successful clients made more comments of an exploratory or pondering nature. The intensity with which they worked their way through difficulties and the wider variety of response types were also apparent.

Stiles (1980) found discrepancies between the perceptions of the therapist and of the client as to what constituted an effective therapy session. The participants were in agreement on the first half of the treatment interview. At the end of the second half, the therapist felt positive about the interaction when the client had undergone some deep and rough experiences. The client felt shaken and vulnerable and viewed the experience negatively, preferring the sessions that ran smoothly and easily. Stiles concluded that pleasant feelings in session are not necessarily indicators of good therapy, and the clients tended to agree that progress related to uncomfortable moments.

Rouse (1983) and Stiles (1979) found a positive correlation between the therapist's ratings of patient's progress and self-ratings of activity and advice-giving. No such significant relationship emerged from the client's perceptions of progress and the therapist's degree of activity and advice-giving. Both parties agreed, however, that the therapist's activity exceeded his/her advice-giving, and the therapist's participation surpassed the client's initial expectations.

Bieber et al. (1977) confirmed Meara et al.'s (1979) findings that a tracking and convergence developed over repeated sessions which also
resembled the interaction that Patton, Fuhriman & Bieber (1977) called a "concerted activity". May (1977) noted a convergence which Pepinsky & Karst (1977) attributed to the client's natural inclination to follow an implied treatment direction communicated by the therapist indirectly and possibly unconsciously.

Wexler & Butler (1976) examined ways that the therapist might effect a higher expressiveness rate from clients by his own example, since the client's lack of verbal proficiency had been linked to poor prognosis. In a single case study with an inarticulate client, the therapist projected a high level of expressiveness in an early session. An increase in the client's expressive behaviour was noted, and reinforcement was not required as treatment progressed. Wexler & Butler felt that timing might be critical in establishing an expressive pattern.

Fessler (1978) investigated the therapist and client perceptions of particular events, the intentions of the participants and the nature of their respective experiencing. The findings suggested that the therapist and client experience an event differently and congruence related to the accuracy of the therapist's understanding of the client's experience. Fessler commented that the full complexity of interpretation could not be measured by studying recall or observations independently.

The following studies attempted to understand the underlying meanings contained in the client's and the therapist's communication systems.

**Therapy as Dramatic Interpretation**

Therapy as Dramatic Interpretation involved the interpretation and
understanding of client and therapist messages. It is perceived as a symbolic process that reflects the mutual contributions of participants engaged in a reciprocal bond that has explicit and vague components. Meanings are not apparent to observers and their subtleties may be more often sensed than qualified by the client and therapist.

**Client messages**

Stiles (1979) suggested that the client's quality of self-disclosure and expressions of immediate experiencing were good indicators of effective counselling. When the client's experiencing level was superficial, the therapist recognized that substantial change was unlikely to occur. Schenken (1978) endorsed the analysis of conversational styles as a means of interpreting underlying messages. Narrative content, topic switches and the specific new themes that were introduced were clues to unconscious reactions. Hill et al. (1983) found a tendency for the therapist to indulge the client in early sessions until sufficient rapport had been developed and attention could be directed to self-exploration. Mahrer, Fellers, Burak, Gervaize & Brown (1981) interpreted topic switches as a signal of client discomfort, as Elliott's (1983) "externalizing" indicated a client move into safer channels.

**Therapist messages and therapeutic outcome**

Mahrer et al. (1981) claimed an exhaustive search of the research literature uncovered only one study on the therapist's self-disclosure. This single piece of evidence involved a verbatim transcript of an actual in-counselling session (Jourard, 1976). The findings failed to support a contention that the therapist's willingness to self-disclose would accelerate the rate of client's self-disclosing statement and
that the therapist would be perceived in a more favourable light. Their analysis of the dialogue indicated no increase in client self-disclosure and no improvement in the client's perception of the therapist or their relationship. On the contrary, there was a tendency for the client to withdraw to external topics as a consequence of the therapist's self-disclosure. A negative view of the association was intensified when the client perceived the self-disclosure as a reaction to unfavourable behaviour. Malan (1979) recommended that the therapist restrict attention to a specific central theme in his communications with the client, in order to facilitate a structured and manageable plan of therapeutic activity. Silverberg (1982) found that client satisfaction was not dampened by the therapist's failure to meet expectations.

**Symbolic interaction and therapeutic outcome**

Lewis (1983) studied symbolic processes as a means of communications with clients who suffered perceptual and linguistic dysfunctions that prohibited an effective communication exchange between therapist and client. This condition was apparently magnified when the client experienced an increase in anxiety. Lewis contended that the use of metaphors and the development of symbolic messages with the client might counteract the barriers of such disabilities and reduce the threat of direct confrontation.

Amundsen (1981) found that the client tended to adopt the therapist's values, and the therapist influenced the client-therapist similarity in terms of equality and self-respect. Lichtenberg & Barke (1981) failed to find communication similarities and common relationship
patterns across orientations in which the therapist maintained a control position. Cox (1978) found similar communications patterns of therapists and clients using the medical, behavioural and systems models. The medical model was identified as the prevailing favourite in the practice of psychotherapy when distinguishing health from pathology.

**Therapy as Association**

Therapy as Association involved process developing from recurring contact, physical presence and temporal continuity and reflected the practical issues of fees, length of treatment and orientation.

**Normative organization and therapeutic outcome**

Janesh (1982) investigated the effects of objective evidence of expertness and nonverbal behaviour that projected an image of confidence and professionalism on the client's perception of the therapist's competence. The display of university degrees and the therapist's adoption of a professional stance enhanced the client's acceptance of the therapist as an "expert".

**The therapeutic role system**

Considerable attention has been paid to the possible benefits of pre-training clients for an effective participation in therapy. Hogan, Beck, Kunce & Heisler (1983) found predischarge training interventions to clients who were transferred to a community aftercare program produced more knowledge and greater congruence with therapist expectations. The pre-trained clients had an 82% rate of transfer success as compared to 59% in the control groups. McCraine & Mezill (1978) and Winston,
Pardes, Papernik & Breslin (1977) studied clients who returned to treatment after failure to make a satisfactory adjustment to after-care facilities and concluded that in-patient units do not facilitate re-entry into the community. Barton (1977) reported a 37% base rate for successful transfer from state hospitals to outpatient follow-up clinics. Craigie & Ross (1980) felt that relatively minor alterations in the referral system would improve after-care effectiveness.

Robertson (1982) gained more realistic expectations from clients by simply showing them a training film in advance of treatment. Inaccurate expectations about therapy were correlated with premature termination and outpatient dropout rates (Horenstein & Houston, 1976). Fraps, McReynolds, Beck & Heisler (1982) found that events occurring in the first session determined the level of persistence that would be applied to treatment. The factors that encouraged client enrollment were different to those that motivated continuation.

**Temporal aspects of therapeutic association**

Ross (1979) surveyed 100 clients attending the private practices of seven therapists to define the durations of treatment in terms of long- and short-term therapy. Long-term was qualified as visits extending beyond 25 sessions. Short-term was seen as any number under 25. The median length of treatment involved eight visits, and 80% of clients terminated before 25 sessions. Horn-George (1981) compared the client-therapist relationship in long- and short-term treatments.
and found significant differences in the participants' perceptions of therapy. Long-term treatment produced a higher degree of client-therapist similarities in how interviews should be conducted and the nature of goals to be achieved. In the long-term association, a higher value was placed on the independence of the client. Short-term participants perceived a greater need for conformity and interpersonal support.

Summary of Process Studies

A summary of the studies presented in this thesis confirmed the importance of a positive reciprocal bond between the therapist and the client. Progress appeared to be linked to the development of the "working alliance" and the client's perceptions of his/her level of participation. Successful outcome was connected to effective communications between the participants, the client's focus on feelings with immediacy and specificity and the therapist's attention to his/her own inner experiences in a genuine, congruent way which tended to produce more evidence of sharing behaviour. In addition, the effects of pre-training and the client's advance knowledge of what is expected in therapy enhanced insession performance.

Greenberg (1983) qualified these process research findings in terms of their fundamental purposes which were predictive, explanatory or descriptive. The predictive studies confirmed the strength of the mutual participation of client and therapist. The major feature of the explanatory category was the move from single-variable study towards a focus on the relationship of meaningful patterns. The descriptive
element related to the measurement instruments required to capture an accurate picture of process variables from the perspectives of the participants and independent observation.

New Theoretical Approaches to Process Analysis

Rice & Greenberg (in press) developed a new paradigm for the analysis of process variables in terms of a classification system of patterns that have meaning outside the context in which they occur. They suggested the identification and description of significant change events that are manifested in the client's insession behaviour will help in accumulating recurring patterns in client change performances that relate to individual styles and therapeutic strategies which can also be categorized. The comprehensive process analysis of these events and a detection of their common elements that match the classifications would be helpful in the construction of definitive models of change. Rice & Greenberg claimed that if understanding the mechanisms of client change is the goal, then the client should be the focus of study. Past absorption with the characteristics of the therapist has left the client's participation in therapy largely unexplored, although it is the client who is performing therapeutic tasks of substantial complexity in order to change. Klein, Mathieu-Coughlan & Kiesler (in press) related significant change events to the experiential therapy originated by Gendlin (1969) and to the various stages of the Experiencing scale (Klein et al., 1970). The focal change moment was described as a major client shift to a higher plateau in the pursuit of a "new state of cognitive-affective awareness". Focusing inward to a deeper level of experiencing was viewed as a client operation that could attend any treatment orientation.
Research into this new theoretical approach to process proposes to address the following questions: What actually takes place in a particular class of change phenomena? and, do clients for whom a successful performance on a particular change event is clearly documented tend to have more successful eventual outcome on certain change measures than do others?

Rice & Greenberg (in press) stated "It is not the amount of a given client process during the episode that is important but the pattern of the client process that is under study." The possible variations that determine the mechanisms of client change relate to the client’s personality characteristics and the environmental influences that encourage or inhibit its occurrence. Differences relate to the client’s state of readiness to change and the natural propensity for change, and to the skills of the therapist. Rice & Greenberg suggested that "therapists as well as researchers might benefit from greater use of clients as guides in the discovery and mapping of new territories of therapeutic process." The new paradigm emerged from Greenberg’s (1975) task analytic approach to the study of significant events.

The task-analytic approach began with the formulation of an explicit framework in which significant events were isolated by observations of behaviour. The investigator conceptualized a task situation with a recurring theme of high potency and measured the change process it effected. The potency of the hypothesized event was then verified by analysis of the ingredients (task plus task instruction plus client performance) that qualified it for intensive study. The
behaviour and its possible alternatives were compared on the basis of its practice realities versus the hypothetical version. The final step in this paradigm related to an outcome measurement correlating successful treatment with therapeutic interventions.

Elliott (1983) developed a Comprehensive Process Analysis model based on three dimensions: (a) the person being studied (i.e. client or therapist); (b) the aspect of process measured, i.e. content, interpersonal action, style as reflected in vocal quality and timing, and response effectiveness of interventions; (c) the perspective from which the measure is taken, i.e. client, therapist, third-party rater or observer.

The five stages of this process analysis procedure included the identification of the event, definition of context and episode, transcription of dialogue, measurement of process variables and integration of the analysis.

Elliott (1983) tested this model on a case study involving a critical moment in therapy which was selected on the basis of the highest combined ratings of the therapist and the client on an intervention distinguished from 200 therapist statements. The client's change process was explained in terms of Gendlin's (1979) experiential concepts by relating the client's reaction to a private felt shift that was followed by a public felt shift. These hypothesized shifts represented a signal of new client awareness at a deep experiencing level. Other indications of a significant event were manifested by the client's tearful response on recall and the need to explain content to observers because it was
Hill (1982) identified six levels of process analysis, i.e. ancillary components of an extralinguistic, linguistic, nonverbal and physiological nature, verbal response modes that measure the quality and timing of interventions and other speech, the manifest or latent properties of content, overt behaviour such as empathy, covert behaviour accessed by self report on process recall and strategies associated with treatment orientations.

Critical Events

Research studies that focused on critical events in psychotherapy were scarce, although Elliott (1983) contended that their significance was central to understanding the nature of change. His analysis of the sequence of dialogue before and after the key moment suggested a collaborative effort between the therapist and the client. The therapist's influence was facilitative but indirect, in that the client ignored three interventions and disagreed with one. The critical event was influenced by a well-timed, vivid metaphor that related the client's description to a key problem issue. Elliott claimed that the full significance of the analysis could only be understood by testing interpretations in other contexts. This conclusion reflected a basic principle of the Rice & Greenberg (in press) classifications of change mechanisms.

Rand (1978) also viewed critical sessions or events as a "turning point in therapy". He surveyed experienced psychotherapists for confirmation of their occurrence and for a set of criteria that exemplified such events. 46 respondents classified their experiences
with critical moments into three types of insights: "(a) some conflict that the client has been dealing with in a less direct or less affect-laden manner gets confronted directly; (b) some material that the client was previously unaware of is brought into the client's awareness in a way that is useful to him or her; and (c) some cognitive reordering occurs in the client so that he perceives the therapy situation, the self, the therapeutic relationship or his world view in a different way; important insight is obtained." Rand studied ten consecutive sessions in their entirety for ten clients. The therapist chose the client and the starting point in the therapy process. Rand hypothesized that a relationship existed between the sessions identified by the client as critical and the criteria provided by the therapists which he converted to five components. Depending on the scores on client affect before and after a critical session, Rand failed to support his hypotheses. The significant finding in this study was the difference in client ratings of critical sessions versus the total group of sessions measured. Rand concluded his study with the observations that choices must be made in studying critical events in the selection of large populations or extensive measurement scales, since realistically he found the co-operation of busy practitioners and "tired" clients after administration of only three scales was strained at a point well below researchers' recommendations. Rand also questioned the reliability of clients' appraisals of critical moments which often gained significance over time.

The nearest equivalent to "critical event" studies was an investigation conducted on the "goodness" of a therapy session (Mintz, Auerbach,
Luborsky & Johnson (1973) as determined by the Therapy Session Report (Orlinsky & Howard, 1967) which was rated by the client, the therapist and an observer. The findings produced a high correlation between the value of the session and the helpfulness of the therapist. The quality of treatment was significantly tied to the "active experiencing" of the client.

Auerbach & Luborsky (1968) classified sessions as "good" and "poorer" by taking the top 18% and the low 18% of scores on a measurement scale of limited description, entitled Therapist Responds Effectively to Patient's Main Communication. A comparison of 60 sessions by independent raters provided significant differences in the therapists' skills but no apparent distinctions could be found on the clients' characteristics. Orlinsky & Howard (1967) studied the "good" therapy hour, using 17 experienced therapists and 60 female clients in sessions ranging from 8 to 26. Results were based on the Therapy Session Report administered to the therapist and the client. No independent ratings were involved. "Good" sessions were those rated high on a single item on the Session Report. Both the clients and the therapists considered a session successful when the client displayed friendly, affective and motivated behaviour and when the therapist was perceived as effective, optimistic and interested. The differences in perception of an interview session related to the level of client affect. The clients valued sessions highly when their affect was positive, while the therapists valued a display of both positive and negative client affect. These results are similar to Stiles (1980)
findings that therapists placed significance on client in-session discomfort while the clients preferred a smooth session.

An alternative approach to critical events involved the grouping of subjects in terms of opposite personal characteristics for comparison. Greenberg & Webster (1982) divided clients into resolvers and nonresolvers of conflict situations. Using the Gestalt two-chair technique, one part of the person expressed criticism while another part expressed feelings and desires. The expression of these contradictory aspects of the self tended to soften the authority of the critical part. By termination of treatment and at the time of follow-up, the resolvers had gained the ability to resolve their conflicts, to make more effective decisions and to accept themselves as people with a measure of power. The nonresolvers were unable to achieve this level of resolution, but they experienced a new awareness of the effects of their behaviours and a reduction of the discomfort that naturally accompanied indecision.

An analysis of nine recurring events identified from the performances of three subjects engaged in the resolution of conflict issues was conducted by Greenberg (1980) using the Gestalt two-chair method and measurement by the Experiencing Scale (Klein et al., 1970) and Vocal Quality Classification System (Rice et al., 1979). Results indicated that performance patterns associated with the resolution of conflict splits depended on the softening of the internal critic and an integration of opposing conflict elements.
Current interest in key events occurring in therapy appeared to be extensive (Elliott, 1981; Hill, 1982; Elliott, 1983; Greenberg, 1983) and strongly linked to experiential therapy. Klein et al. (in press) have claimed that experiential theory of treatment can be used to define critical moments of change and progress in therapy" by relating significant events to the progression stages of the Experiencing Scale. Based on Gendlin's (1979) Experiential Psychotherapy and Rogers' (1979) Client-Centered theories, experiencing was described as "the extent to which the ongoing bodily, felt flow of experiencing is the basic datum of an individual's awareness and communications about the self and the extent to which this inner datum is integral to action and thought" (Klein et al., in press). At the low end of the Experiencing Scale, the client's dialogue was impersonal and superficial. Indications of progress were marked by expressions of feelings and an increase in self-understanding. Moving along a continuum, a knowledge of beliefs and values were clarified and integrated, contributing to a "new state of cognitive-affective awareness" which moved the individual to new behaviour.

Another perspective of a critical event was qualified by Rice & Greenberg (in press) as a moment in client experiencing when a felt shift occurred as an "insight event" and was described as an "experiential-behavioural" process:

"On the one hand, the insight event unfolds in the client's experience. Thus, the client's energy is turned inward (focused voice, posture) towards the experience of newness,
relief and cognitive stimulation—connection. At the same
time, however, this experience 'spills over' behaviourally
and becomes manifest both in the characteristic sequence
of agreement — insight marker — unfolding and in enhanced
task performance (experiencing and working). Thus shifts in
experience and behaviour occur together."

Rice & Greenberg suggested that insight events may not all achieve
this ultimate stage of experiencing and perhaps a major felt shift
occurs only with ideal cases. Hence, the concepts of a critical event
as presented by Elliott (1983), Rand (1978) and Rice & Greenberg (in
press) — although sharing common features — appeared to differ in
some important ways that may need clarification in terms of the cri-
teria used to identify them. Elliott (1983) conceptualized a critical
moment as a rare occurrence of substantial magnitude, Rand (1978)
linked a more frequent event with client affect and Rice & Greenberg
(in press) introduced a category of events on a graduating continuum
that raised the question of how critical is "critical".

On the basis of this extensive literature review, the critical
event was selected as a challenging area of study utilizing the
measurement scales that have been designed for process analysis and
have been refined by the efforts of a considerable number of process
investigators.

The following chapter outlined the methodology that was used
in this study.
Chapter III

Methodology

Selltiz, Wrightsman & Cook (1976), in an introduction to research methods in social relations, suggested:

"One of the functions of social research is to develop and evaluate practices, concepts, and theories - in short, to know the limits of one's knowledge and keep pressing against them. Yet social research may be entirely practical in its functions; the desire may be to know for the sake of being able to do something better or more efficiently" (p.7).

These principles reflected the objectives of scientific investigation and the requirements of the clinical practitioners who are "concerned with the social and psychological meaning of one's findings as well as their statistical significance" (p.489).

With these thoughts in mind, the intent of this investigation rested on the application of systematic process methodology to the comparisons of patterns of client behaviours under critical and noncritical in-therapy conditions. Several process measurements were used to illuminate the clinically relevant qualities of client performances during periods regarded as significant in impact, and to identify operationally the sequential patterns. The following methodology outlined the parameters in detail.
Population and Sampling Procedure

The 24 therapy episodes in this study were drawn from actual sessions conducted with 12 clients attending a cost-free community counselling training center. The subject sample consisted of two male and ten female adults, ranging in age from 19 to 46 years (M = 26.58) who sought individual counselling on a personal problem issue. The sample was therefore composed of subjects who were broadly representative of a population of people in this particular age group which experiences discomfort at some time with personal problems and attempts to resolve such issues by voluntarily applying for cost-free counselling services.

The focus of this study was on the experiencing behaviour of clients during a therapy session at points that they perceived as critical and noncritical. The actual client performances chosen were dependent on the therapist and client meeting a set of predetermined criteria. First, the therapists were invited to identify sessions that they considered highly meaningful and to confirm that the client concurred with this opinion. When agreement was reached and an interview chosen, the client was asked to participate in the research project. After signing a consent form, the client selected an appropriate time for an interview with the researcher. In advance of the appointment, taped segments of the interview session were made. These tapes were played for the client who was asked to rate their significance on an Interpersonal Process Recall Scale. If the client rated at segment at a 6 or 7 point on the scale, it was classified as a critical event.
the higher of the two ratings were used. When more than one rating occurred at the highest point, these segments were replayed and the client assigned the highest priority rating. To be considered as a noncritical event, the client had to assign a 3 or 4 rating to a segment of the taped dialogue. The rating occurring furthest into the session was as a noncritical point to avoid the early warm-up stage of the therapy session. Eleven of the twelve subjects rated a 7 on the Process Recall Scale and one subject gave the highest rating at a 6. Nine subjects rated segments at the 3 point of the scale with no 4 ratings occurring. Three subjects rated at the 4 point of the scale. One client failed to qualify for the study when his highest rating occurred at a 5 on the Process Recall Scale.

**Therapists**

Eight counsellors-in-training, one male and seven female, contributed to this study on the basis of a two-client maximum per counsellor. Three counsellors were in a doctoral program and five were in a master's program. Four counsellors provided two clients each and four provided one client each. All counsellors had a minimum of 100 hours of training in the Carkhuff/Egan model of counselling and varying levels of experience in the use of other therapy treatments. Three counsellors had specialized training in the Gestalt model and one had substantial experience with this method. All counsellors were selected on the basis of their ability to produce a therapy session that they and their respective clients regarded as exceptionally significant. All counsellors responded to a questionnaire on their perceptions of the change and change process, after reading the transcribed episodes selected from the client's ratings on the Process Recall Scale.
Raters

Three independent raters were engaged in this study and two were involved in each measurement instrument scale. One rater was a university professor in the Counselling Psychology department, one rater was a Master's student and one was a counsellor at a crisis center. The raters were chosen on the basis of their familiarity with a particular rating scale.

Description of Measuring Instruments

- The Experiencing Scale

The measurement of the client's depth of experiencing was made on the Experiencing Scale (Klein et al., 1970) and covered twelve 3-minute episodes that surrounded each event classified as critical and twelve 3-minute episodes that surrounded each event classified as noncritical. This scale is a seven-point rating instrument that evaluated the level of client involvement as determined by seven phases that increase in expressiveness and self-referents, from a starting point of impersonal and superficial dialogue to a graduated sequence of increased involvement to an ultimate level where self-awareness and personal integration lead to discussions of thoughts and action.

Based on Gendlin's (1979) experiential theory of an internal shift achieved by inward focusing and Rogers' (1973) concept of the "communication of self" in Client-Centered Therapy, the Experiencing Scale has undergone considerable development and modification by the contributions of many people (Gendlin & Zimring, 1955; Gendlin, 1962;
The Experiencing Scale was designed for direct application to audiotaped segments of the therapy session when measuring the client's depth of experiencing from insession dialogue. This study used the Experiencing Scale on tapes and typed transcripts of the 3-minute segments. A two-volume research and training manual is available to raters and requires 16 hours of practice. One rater in this study had considerably more experience and one rater trained by the use of this manual.

The validity of the scale has been confirmed across experimental conditions where experiencing is a focus of attention, and reliability figures range from 0.79 to 0.91 on modes and 0.85 to 0.92 on peaks using the Ebel inter-class reliability method. A short form (Appendix D) of the Experiencing Scale used in this study is attached, along with reliability figures of ratings on individual therapy segments (Appendix E).

The Client Vocal Quality Classification System

The manual for Client Vocal Quality required the use of taped and transcribed segments and qualified training on this instrument as analogous to developing an ear for music. The Client Vocal Quality Classification System (Rice et al., 1970) is frequently used to supplement the Experiencing Scale (Hill et al., 1983; Elliott, 1983). This system has four voice patterns - focused, emotional, external and limited. Each voice pattern has six features:

(a) perceived energy, (b) primary stress, (c) regularity of stress, (d) pace, (e) timbre and (f) contour. This classification system has been successfully used to measure the quality of the client's voice
(Rice & Gaylin, 1973) and has been a reliable predictor of therapeutic outcome (Rice & Wagstaff, 1967) on the basis of voice quality and expressive stance. Rice & Wagstaff reported reliability figures at 0.70 to 0.79 on the correlations of independent judges on the four voice patterns with a percentage agreement of 70. A brief description of each category of measurement by pattern type is shown in Appendix F.

**The Speech Interaction System**

The Speech Interaction System (Matarazzo et al., 1968) measured three speech variables: (a) the mean speech duration, i.e., the total time in seconds the client or the therapist speaks divided by the total number of respective speech units; (b) mean speech latency; i.e., the total latency time which consists of periods of silence separating two different speech units, divided by the number of respective client and therapist speaking pauses; (c) percentage interruptions, the total number of times the client or therapist speaks divided into the number of these same speech units which were interruptions of the other participant.

Since this study was mainly concerned with the periods of silence that occurred, only the speech pauses were statistically measured. The speech interaction and speech interruptions were excluded.

The reliability figures on the Speech Interaction are high at 0.90 but reliability drops to 0.55-0.75 for measurements of silence because of variations in raters' response times. Matarazzo et al. (1968) claim high reliability on 15-minute segments and evidence has shown a drop in reliability with reduced time periods.
Training of raters required several hours of practice time to achieve the reliability levels of judges of extensive experience. Nine speech scores for inexperienced observers produced a reliability of 0.71 to 1.00 with eight of the nine variables having coefficients above 0.94 (Kiesler, 1973).

Periods of silence included speech pauses between speaker turns and within the dialogue sequence of a speaker. It excludes pauses for breathing, choosing words and reflection when it is apparent that the speaker has not yet completed the utterance. The silence following a therapist's statement is included in the client's latency time and vice versa. Refer to Appendix G for further description.

Matarazzo et al. (1968) developed a recording aid which electronically measures the components of this system by attachment to a recording unit. The use of a stopwatch or other chronographic device is claimed to be as effective. This study employed a stopwatch.

**Transcription System**

The transcription system developed by Sacks, Schegloff & Jefferson (1978) supplemented the Speech Interaction System by identifying and recording breathing patterns, latching of speaking turns and recording time throughout the dialogue. The description of sounds in terms of volume and pacing increased its usefulness to vocal measurement along with the taped segments. The period selected for transcription after identification of the focal event involved running the tape-recorder back approximately a minute and a half from this central point and transcribing the dialogue for three minutes. Some shifting was necessary to start with a therapist
interventions and to achieve a balance of dialogue between client and therapist with a logical sequence that could be understood by nonparticipating observers. By this transcription method, uncertain hearings are typed in parenthesis and changes in sound are identified by symbols. Appendix B provided an outline of symbols used. Typing and editing of transcripts required four to five replays of audiotaped dialogue.

Audio Process Recall

The audio process recall used in this study was a process classification procedure adapted from Elliott's (1979) Interpersonal Process Recall. Elliott's 9-point scale divided the figure points into a plus and minus split, representing both helpful and hindering aspects of the session. However, this study utilized this scale solely for the purpose of identifying the significance the client attached to particular segments of the session which have been complicated by the evaluation of negative features. The scale was therefore changed to a 7-point scale starting from 1 "no meaning" to a mid-point of 4 "I don't know" to a maximum of 7 "extremely significant".

The procedure recommended by the process recall instructions was to view the whole sessions and select a cut-off point when the client is called upon to rate the segment. Elliott (1979) mentioned the skill required in determining an appropriate length of a segment and to avoid causing the client confusion or undue loss of time, it was decided to select consecutive segments in advance of the client's arrival. Each segment was numbered and presented on audio equipment with logical cut-off points for rating. The segments varied in length to present sufficient
material to understand a piece of the interaction. Fifteen segments were extracted in sequence across the session.

The same recall consultant was used to review all of the segments after training for the purposes of this study in accordance with the procedures set out in Elliott's (1979) manual. The revised format for the Interpersonal Process Recall is shown in Appendix A.

**The Helpfulness Scale**

The Helpfulness Scale is a 9-point Likert scale. The lower end of the scale starts with a point called "extremely hindering". It moves to a central "neutral" rating and up to an "extremely helpful" point at the reverse end of the scale. This scale can be used to measure the therapist's level of helpfulness as perceived by the client, the therapist or independent observers. In this study, it was used to determine the client's perception of the helpfulness of interventions before and after the focal event. As in the Process Recall Scale, the words "use sparingly" is placed at the extreme ends of the scale. The recall consultant may ask the client to elaborate on the scoring.

Elliott (1979) reported rather low reliability coefficients on the Helpfulness Rating Scale on a rate-rerate method at 0.38 to 0.71. Internal consistency between the Helpfulness Scale and measures of therapist empathy produced a 0.49 correlation which increased to 0.66 when ratings were pooled. Studies comparing the Helpfulness Scale to a Global Helpfulness measurement by clients only, correlated at 0.61 and 0.63.
The Helpfulness Rating Scale used in this study is shown in Appendix C.

Change Process Questionnaire

The Change Process Questionnaire was administered to both the client and the therapist and simply asked two questions. The first question was "What changed in this event?" The second question was "What was the nature of the change process?" When some clients did not appear to understand the second question, it was replaced with "How did change come about?" All responses to these questions were recorded and transcribed verbatim. The client and therapist statements were typed in parallel form which was provided in Tables 6 and 7 (pp.82-83).

Data Collection and Rating Procedures

The Experiencing Scale

An analysis of twenty-four 3-minute episodes was conducted by rating the clients' behaviour on the Experiencing Scale for mode and peak by two independent raters. A separate rating was made of the twenty-four focal events identified by the clients. These ratings were listed under categories called critical and noncritical.

Vocal Quality

Ratings were taken on the Client's Vocal Quality Classification System at the critical and noncritical focal points of the twenty-four episodes by two independent raters.
Speech Interaction System

Two independent raters calculated the durations of silence using the formula contained in the Speech Interaction System and these figures were listed for subjects #1 to #12 under the two conditions, critical and noncritical.

Transcription System

A separate tally of speech pauses in seconds across the 24 episodes was calculated from the Sacks, Schegloff & Jefferson (1978) transcription system using a common rater and a second independent rater.

Helpfulness Scale

When the focal event was established by the client on a 7 rating or the highest priority 7 item, this point was located on the taped whole session. Then the audiotape was run back to cover two therapist's statements in advance of the critical moment and two statements after its occurrence for rating by the client on the Helpfulness scale. Comparisons were then made of the therapist's statements leading up to and following the focal moment.

Change Process Questionnaire

The clients and therapists were asked to respond to two questions on the change process. Their responses were labelled with the letters A to E which correspond to Rand's (1978) five sets of criteria reflecting
the responses of 46 psychotherapist as to the ingredients of a critical event. Where the change process responses appeared to overlap into two classifications, such as new insight and cognitive reordering, both were included to represent the client's or therapist's perceptions of change. Appendix G specified the five categories by letters A to E, and Table 8 (p.86) showed a breakdown of responses by letter designation.

The change process questions were addressed to the clients after they had heard the taped episode, and to the therapist after they had read the 3-minute transcriptions of the critical episodes. The designation of categories was determined by the researcher merely for interest's sake, and no claims are made on their significance.

Process Recall

The Process Recall Scale was completed by the client to isolate events as critical and noncritical. The words "use sparingly" appeared on the rating scale at the outer end of the scale at the 6 and 7 scores.

The positions of the focal events on the critical and noncritical conditions were times to establish the points of their occurrence in the interview session in order to select noncritical events most representative of involvement, i.e. furthest away from the warm-up stage, and to determine at what point all events occurred within the session.

Reliability Scores of Ratings

Reliability scores were high across most ratings. On the Experiencing Scale for the 3-minute episodes, agreement was reached on the mode at 0.93 and the peak at 0.75, using a Pearson product moment correlation coefficient. This statistic also correlated on the focal events at \( r = 0.84 \).
On client vocal quality, the raters obtained a Cohen's kappa of 0.75 for each of the conditions rated. On the durations of silence, the Pearson product moment correlation produced a statistic of \( r = 0.68 \) using the Speech Interaction System formula and 0.91 using the Sacks et al. (1978) transcription method which provided a means of recording the pauses in seconds.

**Statistical Analysis**

The dependent t-test for correlated means was used on the data. This method was recommended by Ferguson (1981) "when a single group of subjects are studied under two separate experimental conditions and ... the data are composed of pairs of measurements". The Experiencing Scale produced two figures, peak and mode, and each were computed separately. The dependent t-test was also administered to the combined scores of two Helpfulness ratings before the critical focal event and two ratings after the event. The t-test was calculated by Minitab computer.

The Client Vocal Quality Classification System scores are in the form of frequencies, and the Chi square was chosen as an accepted means of measuring differences in frequency data. In general, restrictions on its use related to the independence of the scores from one another, some logical or empirical basis for the way the data are categorized and frequency of data should be higher than 5 for each cell. When results on this measure were marginally significant and it was recognized that all data did not exceed 5, the scores were combined to reduce the df from 3 to 1 and produced a higher level of significance.

Greenberg (1983) claimed that "Measurement is the core issue in process research and any research is only as good as the measurement system
used." Efforts to find appropriate process instruments were rewarded by rating scales with a long history of development and refinement and well-documented reliability figures. The statistical procedures selected for this study were appropriate to the values of the data, the size of the sample population and accounted for the variance of the paired measurements.

The following chapter presented the results of this investigation in terms of the four hypotheses proposed.
CHAPTER IV

Results

This chapter presents the results of client performances under Conditions #1 (critical episode/event) and #2 (noncritical episode/event) and the statistical significance of between-group comparison which are made in terms of the process variables selected for investigation. Also presented is a tentative or speculative approach to the meaning of the change process from the perceptions of both participants in the therapeutic interaction and the factors they view as having produced change. Discussion and implications of these results are covered in Chapter V.

Comparison of Client Performances under Conditions #1 and #2

The Experiencing Scale

Results of this comparison are shown in Table 1 (p.76). The mode scores for the 3-minute episodes indicated a t value of 4.31, p<.01, peak scores yielded a t value of 7.29, p<.01 and focal event scores a t of 5.20, p<.01. It is therefore concluded that the behaviour component of depth of experiencing is distinctly greater in a critical event than in a noncritical event.

Comparison of Client Performances under Conditions #1 and #2

Client's Vocal Quality

Results of this comparison are shown in Table 2 (p.77). A Chi square value of 9.33, p<.05 was yielded on a full table and 8.71, p<.01 for a reduced table. Table 3 (p.77) shows distribution of frequencies. It is
TABLE 1

Comparison of Client Performances under Conditions #1 and #2
The Experiencing Scale

<table>
<thead>
<tr>
<th>Subject</th>
<th>Mode</th>
<th>Peak</th>
<th>Mode</th>
<th>Peak</th>
<th>Critical</th>
<th>Noncritical</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>3</td>
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<tr>
<td>2</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
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<td>5</td>
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<td>3</td>
<td>3</td>
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</tr>
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<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>11</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>12</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

Dependent t-test indicates the following:

For MODES, \( t \text{ value} = 4.31, p < .01, M = 1.17, \text{S.D.} = 0.94 \)

PEAKS, \( t \text{ value} = 7.29, p < .01, M = 1.08, \text{S.D.} = 0.52 \)

FOCAL, \( t \text{ value} = -5.20, p < .01, M = 1.50, \text{S.D.} = 1.00 \)
### TABLE 2
Comparison of Client Performances Under Conditions #1 and #2 - Client's Vocal Quality Classification

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>CRITICAL</th>
<th>NONCRITICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3</td>
<td>E</td>
<td>X</td>
</tr>
<tr>
<td>4</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>X</td>
</tr>
<tr>
<td>6</td>
<td>L</td>
<td>X</td>
</tr>
<tr>
<td>7</td>
<td>E</td>
<td>X</td>
</tr>
<tr>
<td>8</td>
<td>E</td>
<td>L</td>
</tr>
<tr>
<td>9</td>
<td>E</td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>L</td>
</tr>
<tr>
<td>11</td>
<td>E</td>
<td>X</td>
</tr>
<tr>
<td>12</td>
<td>F</td>
<td>F</td>
</tr>
</tbody>
</table>

**FOCAL EVENTS**

**NOTE:**
- F = Focused
- E = Emotional
- X = External
- L = Limited

### TABLE 3
Chi Square Alternatives based on Full Table (df = 3) and Reduced Table (df = 1)

**FULL TABLE**

<table>
<thead>
<tr>
<th></th>
<th>F</th>
<th>E</th>
<th>X</th>
<th>L</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3.0</td>
<td>5.0</td>
<td>3.0</td>
<td>1.0</td>
<td>12.0</td>
</tr>
<tr>
<td>2</td>
<td>2.0</td>
<td>2.5</td>
<td>6.0</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.0</td>
<td>0</td>
<td>9.0</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2.0</td>
<td>2.5</td>
<td>6.0</td>
<td>1.5</td>
<td>12.0</td>
</tr>
<tr>
<td>Tot.</td>
<td>4.0</td>
<td>5.0</td>
<td>12.0</td>
<td>3.0</td>
<td>24.0</td>
</tr>
</tbody>
</table>

Chi Square = 9.33, p < .05, df = 3

**REDUCED TABLE**

<table>
<thead>
<tr>
<th></th>
<th>F + E</th>
<th>X + L</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8.0</td>
<td>4.0</td>
<td>12.0</td>
</tr>
<tr>
<td>2</td>
<td>4.5</td>
<td>7.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.0</td>
<td>11.0</td>
<td>12.0</td>
</tr>
<tr>
<td></td>
<td>4.5</td>
<td>7.5</td>
<td></td>
</tr>
<tr>
<td>Tot.</td>
<td>9.0</td>
<td>15.0</td>
<td>24.0</td>
</tr>
</tbody>
</table>

Chi Square = 8.71, p < .01, df = 1
concluded that the behaviour component of voice quality is significantly different in a critical event than in a noncritical event.

**Comparison of Client Performances under Conditions #1 and #2**

**Durations of Silence**

Results of comparisons are shown in Table 4 (p.79). The 3-minute episodes yielded a t value of 4.65, p<.01 for the count of scores recorded on the Sacks et al. (1978) transcription system. The Speech Interaction System (Appendix H) yielded a t value of 5.89, p<.01 on the 3-minute segments and a t value of 2.69, p<.01 on the focal events. It is therefore concluded that the durations of silence are significantly different in a critical event than in a noncritical event.

**Comparison of Interventions Before and After the Focal Event**

**Client Ratings on Helpfulness Scale**

Results of comparisons of Helpfulness ratings before and after the critical focal events are shown in Table 5 (p.80). A dependent t test measuring two interventions before the event and two interventions after the event in terms of the Helpfulness Scale ratings produced a t value of 2.66, p<.05. Graph 1 (p.80) illustrated the sequential score means which suggested a peak immediately preceding the focal event with a descent after the event. It is therefore concluded that the client's perception of the therapist's level of helpfulness before a focal event is higher than after the event.

These results ended the statistical portion of this study. The following data covered comparisons of the therapist and client perceptions of the
<table>
<thead>
<tr>
<th>Ss.</th>
<th>3-min. Episodes - Sacks Transcription Count</th>
<th>3-min. Episodes - Speech Interaction</th>
<th>Focal Events - Speech Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Critical</td>
<td>Noncritical</td>
<td>Critical</td>
</tr>
<tr>
<td>1</td>
<td>81.5</td>
<td>45.5</td>
<td>2.037</td>
</tr>
<tr>
<td>2</td>
<td>38.5</td>
<td>32.0</td>
<td>0.786</td>
</tr>
<tr>
<td>3</td>
<td>87.5</td>
<td>40.5</td>
<td>1.620</td>
</tr>
<tr>
<td>4</td>
<td>64.0</td>
<td>51.0</td>
<td>1.422</td>
</tr>
<tr>
<td>5</td>
<td>66.5</td>
<td>32.5</td>
<td>1.511</td>
</tr>
<tr>
<td>6</td>
<td>55.5</td>
<td>63.0</td>
<td>2.921</td>
</tr>
<tr>
<td>7</td>
<td>56.5</td>
<td>30.5</td>
<td>0.958</td>
</tr>
<tr>
<td>8</td>
<td>71.0</td>
<td>57.5</td>
<td>1.614</td>
</tr>
<tr>
<td>9</td>
<td>73.0</td>
<td>49.0</td>
<td>2.920</td>
</tr>
<tr>
<td>10</td>
<td>66.5</td>
<td>40.0</td>
<td>2.463</td>
</tr>
<tr>
<td>11</td>
<td>72.0</td>
<td>10.5</td>
<td>1.756</td>
</tr>
<tr>
<td>12</td>
<td>66.0</td>
<td>49.0</td>
<td>1.119</td>
</tr>
</tbody>
</table>

T values = 4.65, p < .01  5.89, p < .01  2.69, p < .05
### TABLE 5
Comparison of Client Perceptions of the Helpfulness of Therapist Interventions before and after a Critical Focal Event

<table>
<thead>
<tr>
<th>Subject</th>
<th>Helpfulness Ratings Before Event</th>
<th>Helpfulness Ratings After Event</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st</td>
<td>2nd</td>
</tr>
<tr>
<td>1</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>4</td>
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</tr>
<tr>
<td>5</td>
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<tr>
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<tr>
<td>7</td>
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<tr>
<td>8</td>
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<tr>
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<td>9</td>
</tr>
<tr>
<td>12</td>
<td>8</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subject</th>
<th>Helpfulness Ratings Before Event</th>
<th>Helpfulness Ratings After Event</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st</td>
<td>2nd</td>
</tr>
</tbody>
</table>

**Means**
- Helpfulness Ratings before Event: 7.30, 7.67, 6.67, 5.91

**t value** = 2.66, *p* < .05.

### GRAPH 1
Sequential Order of Score Means before and after a Focal Event

- Indicates peak before focal event

Order of Interventions
Comparison of Client and Therapist Perceptions of Change

Change Process Questionnaire

The client and therapist responses to the question, What changed in this event? were abbreviated and outlined in Table 6 (pp.82 and 83). These statements are verbatim and identified in categories A to E as shown in Appendix G. These letters correspond to Rand's (1978) five classifications as determined by the researcher for interest only, and are open to conjecture.

Table 7 (pp.84 and 85) show answers to question, What was the nature of the change process?

Table 8 (p.86) and Graph 2 (p.86) indicated that the client most frequently recognized change as D "some important insight that is useful", followed by A "having felt some significant emotional impact", C "cognitive reordering", B "emotional closeness with therapist" and lastly, E "a shift in distorted perceptions of therapist" which was unique to one client. The therapist most frequently chose C "cognitive reordering" as the nature of change, followed by A "significant emotional impact" and D "important insight that is useful" and made no reference to B "emotional closeness" or E "distorted perceptions" relating to the therapist. One client and one therapist from different dyads perceived no client change as a result of the critical event, while their partners in the interaction found a significant change.

Table 9 (p.87) listed responses by client and therapist and Graph 3 (p.87) presented a frequency distribution of answers to the second question, What was the nature of the change process? In responses, change was
<table>
<thead>
<tr>
<th>Ss.</th>
<th>Client Statement</th>
<th>Classification</th>
<th>Therapist Statement</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>If I wanted to gain from counselling, I'd have to do it myself.</td>
<td>D + E</td>
<td>Client faced herself and learned the game of self-pity was something she had control and choice over.</td>
<td>C</td>
</tr>
<tr>
<td>2</td>
<td>When she took my husband, she also took my family. A move back home (England) would recover half the loss.</td>
<td>C + D</td>
<td>Client came to terms with discrepancies between goals set in counselling and the results.</td>
<td>C</td>
</tr>
<tr>
<td>3</td>
<td>A clear understanding of what she wanted to do to resolve problem.</td>
<td>D</td>
<td>A recognition of how she contributed to her husband's helplessness.</td>
<td>D</td>
</tr>
<tr>
<td>4</td>
<td>Nothing changed as a result of the event.</td>
<td>-</td>
<td>Client's realization that change would only come from himself.</td>
<td>D</td>
</tr>
<tr>
<td>5</td>
<td>Recognition of powerful feelings towards grandmother whom I thought I didn't care anything about. Got rid of anger by putting myself in her shoes.</td>
<td>A+C+D</td>
<td>Client was able to forgive her grandmother and see her as a person who did the best she could.</td>
<td>A+C+D</td>
</tr>
<tr>
<td>6</td>
<td>My own behaviour kept my family seeing me as a child. I used this to get love from them.</td>
<td>C + D</td>
<td>Recognition of her misguided way of getting what she needed from her family.</td>
<td>C + D</td>
</tr>
<tr>
<td>7</td>
<td>By reliving the pain and guilt from husband's infidelity was able to move on the problems now.</td>
<td>A</td>
<td>No change.</td>
<td>-</td>
</tr>
<tr>
<td>8</td>
<td>Talking about my fear of causing violence</td>
<td></td>
<td>Movement towards a higher self-sufficiency.</td>
<td></td>
</tr>
<tr>
<td>Ss. Client Statement</td>
<td>Classification</td>
<td>Therapist Statement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>when I'm frustrated and seeing it wasn't inherited.</td>
<td>A+C+D</td>
<td>A + C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Able to express feelings without feeling ashamed.</td>
<td>A + D</td>
<td>Able to get in touch with feelings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Recognized I had no intention to change if I had to do something in particular.</td>
<td>D</td>
<td>Cogitively separating self from performance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Ability to admit sorrow regarding breakup and move beyond it.</td>
<td>A + B</td>
<td>A heightened ability to get in touch with her deeper affect.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Recognition that I can't make everything right. I can't be a father and find a father purely for that reason.</td>
<td>A+C+D</td>
<td>Able to express deep feelings by accessing through children, and then moving beyond this block.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### TABLE 7

**Client and Therapist Responses to Question, "What was the Nature of the Change Process?"**

<table>
<thead>
<tr>
<th>Ss.</th>
<th>Client Statement</th>
<th>Attributed to</th>
<th>Therapist Statement</th>
<th>Attributed to</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I felt that the counsellor took my mother's side, so I had to take responsibility for my own progress.</td>
<td>self</td>
<td>Rejection by the therapist of client's &quot;empty&quot; content by confrontation that fixed client on a direction.</td>
<td>counselling strategy</td>
</tr>
<tr>
<td>2</td>
<td>By exploring past events in terms of their meanings now.</td>
<td>self</td>
<td>By creating an environment that facilitated expression of feelings.</td>
<td>counselling strategy</td>
</tr>
<tr>
<td>3</td>
<td>By showing me how I was being manipulated by a sense of guilt. Words &quot;unfulfilled promises&quot;.</td>
<td>interventions</td>
<td>An awareness that she kept husband helpless and then disliked his weakness.</td>
<td>client's self exploration.</td>
</tr>
<tr>
<td>4</td>
<td>No change.</td>
<td>-</td>
<td>Persistent confrontation on how he was viewing himself.</td>
<td>interventions</td>
</tr>
<tr>
<td>5</td>
<td>By putting myself in other person's shoes.</td>
<td>counselling technique</td>
<td>By experiencing her grandmother's position.</td>
<td>counselling technique</td>
</tr>
<tr>
<td>6</td>
<td>By thinking seriously about therapist's comments and exploring own behaviour.</td>
<td>interventions</td>
<td>Interpretation of conflicting statements and confrontation on discrepancies between goals and behaviour. interventions</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Counsellor's reference to pain center.</td>
<td>interventions</td>
<td>No change.</td>
<td>-</td>
</tr>
<tr>
<td>8</td>
<td>By linking patterns with parents' situation.</td>
<td>interventions</td>
<td>Clarifying client's perceptions of self.</td>
<td>interventions</td>
</tr>
<tr>
<td>Ss.</td>
<td>Client Statement Attributed to</td>
<td>Therapist Statement Attributed to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------</td>
<td>-----------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>By adopting role of feelings interacting with intellect.</td>
<td>By experiencing what it was like to be pure feelings. counselling technique.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Pressure and confrontation from counsellor. interventions</td>
<td>Clarifying client's perceptions of the self. interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Support of counsellor and concentration on feelings interventions</td>
<td>Creating strong rapport that encouraged internal exploration. Keeping client away from surface issues and returning her to feelings. interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Going through process of feeling things at &quot;gut level&quot; and letting go of guilt. interventions</td>
<td>Focusing on emotions indirectly by connecting through client's counselling strategy children strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject</td>
<td>Client's Responses</td>
<td>Therapist's Responses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
<td>-----------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>D + E</td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>C + D</td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>D</td>
<td>D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>-</td>
<td>D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>A + C + D</td>
<td>A + C + D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>C + D</td>
<td>C + D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>A</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>A + C + D</td>
<td>A + C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>A + D</td>
<td>A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>D</td>
<td>C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>A + B</td>
<td>A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>A + C + D</td>
<td>A + C</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Graph 2**

Frequencies of Client and Therapist Responses

- = Client
--- = Therapist

Emotional Impact to Therapist
Closeness
Reordering
Useful Insight
Shift of Distorted Perceptions

Frequencies
### TABLE 9
Client and Therapist Responses to Question, "What was the Nature of the Change Process?"

<table>
<thead>
<tr>
<th>Subject</th>
<th>Client's Response</th>
<th>Therapist's Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>client activity</td>
<td>counselling strategy</td>
</tr>
<tr>
<td>2</td>
<td>client activity</td>
<td>counselling strategy</td>
</tr>
<tr>
<td>3</td>
<td>intervention</td>
<td>client activity</td>
</tr>
<tr>
<td>4</td>
<td>-</td>
<td>intervention</td>
</tr>
<tr>
<td>5</td>
<td>technique</td>
<td>technique</td>
</tr>
<tr>
<td>6</td>
<td>intervention</td>
<td>intervention</td>
</tr>
<tr>
<td>7</td>
<td>intervention</td>
<td>-</td>
</tr>
<tr>
<td>8</td>
<td>intervention</td>
<td>intervention</td>
</tr>
<tr>
<td>9</td>
<td>technique</td>
<td>technique</td>
</tr>
<tr>
<td>10</td>
<td>intervention</td>
<td>intervention</td>
</tr>
<tr>
<td>11</td>
<td>intervention</td>
<td>intervention</td>
</tr>
<tr>
<td>12</td>
<td>intervention</td>
<td>strategy</td>
</tr>
</tbody>
</table>

### GRAPH 3
Frequencies of Client and Therapist Responses

---

\[7\]

\[6\]

\[5\]

\[4\]

\[3\]

\[2\]

\[1\]

---

\(\text{-----} = \text{client}\)

\(\text{---} \text{---} = \text{therapist}\)
attributed to client's activity and the therapist's interventions or strategies. Two clients attributed change to themselves and one client related change to the therapist's interventions. One therapist attributed change to the client's activity and ten therapists related change to their own interventions or strategies. Agreement was reached by eight clients and their therapists that the critical event was attributable to the therapist's statement or techniques.

Comparison of Positions in Sessions for Focal Events

Time into Session

Table 10 (p.89) listed the times that the critical and non-critical events occurred into the sessions. Graphs 4 and 5 (p.90) showed their positions across the session.

In the critical event, the time positions ranged from 15:03 to 53:31 with a mean of 34.43. In the noncritical event, the time positions ranged from 5:10 to 47:20 with a mean of 20:48. In the critical episode, one subject experienced a focal event in the first third of the session, eight in the second third and three in the last third. In the noncritical episode, six subjects experienced the noncritical event in the first third, four in the second third and two in the last third.

The statistical results supported the hypotheses on client experiencing, vocal quality and durations of silence. The quality of therapist's helpfulness before and after the focal event was also confirmed although not to the same level of significance.

A discussion of these results and conclusions were provided in the following chapter.
TABLE 10

Comparison of Timing Positions within the Session where critical and noncritical events occur
(in minutes)

<table>
<thead>
<tr>
<th>Subject</th>
<th>Critical Events</th>
<th>Noncritical Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15:03</td>
<td>40:49</td>
</tr>
<tr>
<td>2</td>
<td>29:00</td>
<td>22:57</td>
</tr>
<tr>
<td>3</td>
<td>22:50</td>
<td>7:33</td>
</tr>
<tr>
<td>4</td>
<td>50:25</td>
<td>7:01</td>
</tr>
<tr>
<td>5</td>
<td>35:24</td>
<td>13:22</td>
</tr>
<tr>
<td>6</td>
<td>40:06</td>
<td>6:16</td>
</tr>
<tr>
<td>7</td>
<td>24:10</td>
<td>5:10</td>
</tr>
<tr>
<td>8</td>
<td>38:43</td>
<td>26:59</td>
</tr>
<tr>
<td>9</td>
<td>53:31</td>
<td>15:55</td>
</tr>
<tr>
<td>10</td>
<td>33:47</td>
<td>23:20</td>
</tr>
<tr>
<td>11</td>
<td>39:43</td>
<td>31:31</td>
</tr>
<tr>
<td>12</td>
<td>32:39</td>
<td>47:20</td>
</tr>
<tr>
<td>Mean</td>
<td>34:43</td>
<td>20:48</td>
</tr>
</tbody>
</table>

**Critical Event**
- First Third = 1 subject
- Second Third = 8 subjects
- Last Third = 3 subjects

**Noncritical Event**
- First Third = 6 subjects
- Second Third = 4 subjects
- Last Third = 2 subjects
GRAPH 4

*Time Intervals into Session*

CRITICAL EVENT

Subjects 1 to 12

GRAPH 5

*Time Intervals into Session*

NONCRITICAL EVENT

Subjects 1 to 12
CHAPTER V

Discussion of Results and Conclusions

This chapter is involved with a discussion of the results of this study and conclusions on the meanings that emanated from this research, implications for theory and practice of psychotherapy and recommendations for future investigation.

Discussion and Conclusions

The significant findings on the four stated hypotheses supported the contention that the client is a valuable resource in the selection of significant events. This client's involvement in procedures clearly indicated an ability to make fine distinctions between various segments of the therapy session in terms of their productive and nonproductive quality by a fairly swift appraisal of the passing dialogue.

It was also apparent from an analysis of the data that the client's depth of experiencing was a vital factor in creating an environment in which a critical event might occur, particularly at the focal moment which differed significantly in experiencing from a noncritical moment.

Experiencing

In the three-minute critical episode, three subjects peaked at a 5 level on the 7-point Experiencing Scale which indicated a
focus on feelings and personal experiences, eight subjects peaked at a 4 level involving descriptions of feelings and personal experiences and one subject reached the 3 level associated with reactive and emotionally involved behaviour. In the noncritical episodes, eleven subjects peaked at the 3 level and one at the 4 level. Scores at the focal events were sharply different in terms of client experiencing. The critical event contained three 5 scores, five 4 scores and four 3 scores as opposed to five 3 scores and seven 2 scores (which concentrate on external events and intellectual self-description) in the noncritical event. Two clients who peaked at the 5 level attributed change to a new awareness that success in therapy was their responsibility and one client was able to connect with deeper level feelings. The vocal quality of the subjects under the critical and noncritical focal conditions tended to match the level of experiencing.

Vocal Quality

In the critical event, three examples of focused voice quality emerged, five emotional, three external and one limited. One client remained focused under the noncritical condition, but nine displayed external quality and two limited. There was no evidence of the emotional dimension under this condition. The three focused subjects scored 4 and 5 on the Experiencing Scale and the two limited subjects scored at a 2 and 3 on the Experiencing Scale.
The Gestalt two-chair dialogue technique produced a high level of experiencing for two subjects in this study, but two other subjects rejected this therapeutic strategy. It is concluded that a state of client readiness for this particular exercise is present. These varying inclinations amongst clients supports the concept of "process diagnosis" that determines an appropriate choice of treatments on the basis of the client's emotional state.

An outstanding example of vocal variation within a critical episode occurred with a client in a Gestalt two-chair exchange involving dialogue between the self and her grandmother. The subject shifted dramatically from the voice of an anxious child to a strong, authoritative tone that demonstrated the power of re-experiencing a past event in a current context. A further variation occurred in the noncritical event when the client projected the personality of her adult self. Her experiencing score under the critical and noncritical conditions ran from 4 to 2 with a voice quality shift from focused to external.

The impact of deep experiencing and focused vocal quality become particularly significant when their occurrence during a critical episode is compared with the cognitive reflection and problem description level of the noncritical episodes. This heavy dialogue is also significant when compared with the longer speaking pauses contained in the critical episodes.
Durations of Silence

The third hypothesis that longer durations of silence accompany a higher depth of experiencing and are more prevalent in critical events than noncritical events was based on the rationale that the client cannot engage in extensive dialogue and focus inward at the same time. Therefore, although it is preferable to have the client speaking rather than the therapist, this practice may become circular and nonproductive as occurred in the noncritical episodes of this study. The findings resulting from the Speech Interaction System indicated significant differences in the levels of silence in the critical and noncritical episodes. A comparison of this method with the simple accumulation of silence focused on the balance created by the formula between individual speaking styles. It was noted that variations amongst subjects were substantial, i.e. the silence of some subjects in the noncritical condition was higher than other subjects in the critical condition. The significance of differences rested in each speaker's tendency to change under these conditions. The three subjects who scored at the 5 level on the Experiencing Scale had 61% more silence under the critical condition, subject scoring at a 4 had 57% more silence and the one client who scored at a 3 under both conditions had a 49% higher level of silence in the critical episode. An extreme imbalance occurred with one subject that related to excessive dialogue of the therapist using Rational Emotive therapy. However, the Speech Interaction formula balanced out this discrepancy when it related the occasions of silence to the
speaking units for each participant.

Hill et al. (1983) claimed a 40% dialogue participation by the therapist was an indicator of productive activity. In this study, the therapist provided a 41.7% contribution in the noncritical episodes and 34.1% contribution under the critical conditions. It is therefore suggested that a reduced tendency for discussion might produce a higher likelihood of internal focusing and this may be controlled by the therapist.

**Helpfulness Scale**

A significant difference occurred in the client's perceptions of the therapist's level of helpfulness before and after a critical event and a decided peak occurred immediately before the focal event. This finding occurred in spite of two 5 ratings on the Helpfulness Scale before the event and two 9 and one 8 ratings after the event. The peak event suggested a process of effective intervention that connects with the client's experiencing and facilitates movement to some new realization. The decline of helpfulness from the client's perspective suggested more of a disengagement from the therapist's influence than a reduction in therapist proficiency.

On the whole, the clients' regard for their therapists were clearly apparent during this study. Apart from self-report, client ratings of therapists were positive. Only four hindering scores were recorded across seventy-two rated interventions. Although their association was of a short-term nature, nine subjects volunteered their feelings of appreciation for their therapists. Two of the subjects expressed some animosity that
appeared to have an age bias, and one subject was indifferent.
Of the nine positive clients, five regarded their therapists as
irreplaceable. Most of the dialogue on the therapeutic alliance
occurred during the Interpersonal Process Recall on a voluntary
basis.

Process Recall

The process recall interaction created interesting reactions
from clients who viewed it as a learning experience in itself. The
therapy sessions that were reviewed had taken place from one week
to several months before. The time lapse since the event may have
been instrumental in producing a variety of responses. Similar to
Elliott's (1983) client, three subjects (one male and two female)
were moved to tears on recall within two weeks after the session.
Three clients, female, expressed jubilation because of a recognition
of how far they had progressed since the event some months before.
The one client who expressed no change as a result of the critical
event attributed considerable improvement in attitude and personal
regard as a result of the process recall. Two therapists identified
a fresh motivation in their clients as a result of the process re­
call and this appeared to occur with dyads that were experiencing
an impasse situation in counselling. All clients believed they had
gained from the experience, even when discomfort occurred.

The ratings on the Process Recall instrument suggested perio­
dic peaks throughout the session. Scores mainly occurred at the 5
"moderately significant" level, and clients were obviously intimidated
by the instruction "use sparingly" at the 6 and 7 ends of the scale.
When they scored at the 6 and 7, it appeared to be a serious decision that overrode the restriction. An unforeseen difficulty in this study was the identification of noncritical events that were determined by a 3 or 4 rating on the Process Recall Scale. The deeper the client went into the session, the more difficult it was to attach limited significance to any of the dialogue. The client tended to link the importance of all dialogue to the relevance of the larger picture of problem issues. Perhaps if a session had been selected on the basis of its limited significance this problem would not have arisen. There also appeared to be very little content that the client did not have an opinion on, and the 4 level "I don't know" was rarely used for scoring.

The tendency to attach meaning to all dialogue after the first ten minutes supported Hill et al.'s (1983) findings in a 3-way split of the interview session. The highest level of experiencing appeared to occur in the second third of the session. In this study, the majority of critical events occurred after the first third, and a higher incidence of noncritical events happened in the first third.

No apparent relationship existed in the content of a critical versus a noncritical event, indicating one event did not influence another. However, only two noncritical events followed a critical event which is assumed would have the strongest effect.

Client/Therapist Perceptions of Change Process

The comparison of client and therapist perceptions of the change events indicated that the client identified change across a wider range
of criteria, i.e. the client identified 22 dimensions and therapists identified 16. It also appeared that the client more frequently perceived change as insight while the therapist tended to identify client change as a cognitive reframing. The possibility existed that the participants overlapped on these definitions. Both client and therapist placed significant emotional impact high on their priority lists, possibly because of the observable nature of high client affect in a therapy session. However, this factor had different implications across clients. An inability to experience emotionally was a key element in three clients' core problems, while three other clients appeared to have a natural propensity for high affect.

The therapists did not consider "emotional closeness with the therapist" and "distorted perceptions of the therapist" when called upon to consider the nature of client change. It appeared that these characteristics were perceived more to be basic factors in the counselling interaction than indicators of change, i.e. "emotional closeness" was related to client/therapist rapport and "distorted perceptions" were perceived to be examples of transference. It was found that the criteria developed by Rand (1978) covered all responses of clients and therapists, and there was no need to build extra categories into this framework.

The comparison of client and therapist perceptions on the nature of the change process yielded a high level of agreement. Twenty-one of 24 responses attributed change exclusively to some element of counselling; 12 of which related to the therapist's interventions. Contrary to past
research, there was little evidence that the client or therapist perceived the therapy interaction as a collaborative effort. On the whole, clients attributed progress to the therapist's skills and the therapists felt the same. In the two instances where the clients attributed change to themselves, there was no apparent recognition of the therapist's contribution to the event. The clients were encouraged to explore a variety of factors, without direct reference to the therapist, but expansions tended to be related to self-perceptions. Interestingly, these two clients were the subjects who expressed hostility towards their therapists, although one of these issues was resolved on process recall.

The two hostile clients and a third subject were being administered indirect counselling strategies which their therapists felt created the critical event. The clients however indicated no awareness that particular techniques were being used. Agreement between clients and therapists on the nature of the change process occurred as a result of the Gestalt two-chair interaction which is easily recognizable by clients. Other clients responded to reflection of their feelings which does not place the same demands on the client. This finding supported the Rice & Greenberg (in press) concept of "process diagnosis" as "markers" to the client's readiness to work on problems in particular ways.

The therapist who perceived no change in his client as a result of the critical event actually was terminating treatment in the session under study. The therapist accurately predicted this client's
emotional reaction to process recall, but perhaps his assessment of change would be better described as "anticipated no change" as a result of the event. The client perceived the episode as highly meaningful and instrumental in creating change by the therapist's intervention. The impact of the intervention was unexpected, possibly contributing to the therapist's reservations about its effectiveness.

Implications for Theory and Practice

The results of this study suggested that a focus of attention on the critical events occurring during the therapy session offers valuable information on the nature of the client change process. It was also apparent that the client has an intuitive sense of the important features and the nonproductive elements of the interaction. The varying perceptions of events of the therapist and client suggested that assumptions regarding discrepancies would serve the participants better than assumed agreement, particularly if these differences were shared. The tendencies were for the therapist to identify change events in terms of the client's cognitive restructuring, while the client referred to insight as a kind of revelation that was accompanied by strong emotions. This feature has some relevance to the Frank (1982) study in which clients favoured an insight-oriented therapy, while therapists tended to believe the client wanted more reality-oriented treatment.

The degree to which the client's depth of experiencing was associated with a critical event and a noncritical event in this study
has important implications for the practice of psychotherapy, particularly when it is considered that the 24 3-minute episodes encompassed a range of treatment orientations under both the critical and noncritical conditions. The level of client experiencing was an independent feature of the process and this result supports the contention that experiencing can be facilitated by any practitioner regardless of his orientation. The client appears to determine its suitability at any point in time.

The Experiencing Scale appears to be an effective tool in measuring the client's level of experiencing and might be used as an indicator of the client's progress as various stages of this graduated scale are reached and surpassed. The Vocal Quality Classification System serves to confirm the findings of the Experiencing Scale.

The use of the Speech Interaction System confirmed the prevalence of increased periods of silence in the conditions where experiencing intensified. It is suggested by these results that the importance of productive dialogue should be balanced with silence as a necessary condition of inward focusing. The rate of dialogue and quantity of speaking pauses are also measures of the success of a counselling session if deeper level client experiencing is the objective.

The timing of critical events as an area of study offered a better understanding of the sequential rhythms across the therapy hour from which predictions might be made regarding client behaviour
and the most advantageous timing and pacing of therapeutic interventions. Knowing some of the component processes in terms of emotional characteristics and prevailing levels of readiness may enable the therapist to select appropriate strategies at a time when their effectiveness is assured.

The client and therapist responses to what changed in the critical event indicated a combination of Rand's (1978) criteria were operating simultaneously. The implication of this finding was that some events create a single change factor and others may impact on a number of problem concerns, e.g. a change event may not contain insight alone but may compound to include insight, cognitive restructuring and a new closeness with the therapist. If such quality differences exist in the change process, then the question arises as to what variations are present across a group of events classified as critical and what internal factors in a population of subjects contribute to these variations.

Recommendations for Future Research

The first recommendation for research would be a replication of this study. Orlinsky & Howard (1978) advised that very little replication of process investigations has been made, and findings have restricted meaning without such verification from independent researchers.

A replication would gain from an increase in population size, a better balance of male and female subjects, with the consideration of separate groups under the critical and noncritical conditions.
More thought needs to be put into a method of identifying non-critical events for comparison and might be achieved by the selection of noncritical sessions from which focal events could be taken. Taking noncritical events from different sessions than those used for the critical events provides the opportunity of matching the timing within the session where focal moments occur.

A replication study might also include an analysis of content and the classification of dialogue. The use of Hill's (1978) Counsellor Verbal Response Category system would give an indication of the type of intervention that precipitates a strong impact from the client. A sequential analysis of the therapist/client exchanges may also determine whether the client reaction is immediate or prompted by an earlier intervention. For example, in this study, one client interrupted her own dialogue to comment on a therapist's suggestion that occurred three statements earlier.

The compilation of critical and noncritical episodes also offers substantial material for the study of the stylistic complexity of language of the counsellor and client (Meara et al., 1979). It would be interesting to determine whether a tracking and convergence of language styles occurs in both critical and noncritical episodes and whether a disparity exists or widens in a noncritical situation.

It would also be interesting to study how experiencing of the client could be incorporated with different treatment orientations, without disturbing the basic techniques of a particular therapy. This would be particularly challenging with the cognitive therapies
that are less involved with internal focusing than experiential models. In this study, experiencing appeared to occur dramatically by use of the Gestalt two-chair technique, but this exercise created considerable difficulty for some clients who appeared to lack the creative, innovative skills to deal with a conflict split in this way. Other resistance appeared to be connected to a difficulty in comprehending the mechanics of the technique. On the other hand, one subject appeared to have a natural skill that utilized visualization and imagery. Perhaps certain qualities that distinguish these two types of clients by a classification system resembling the resolver/nonresolver model might be developed as it relates to natural competence and transitory states of mind.

The Vocal Quality Classification System has been extensively used to measure the client's speech patterns as focused, emotional, external and limited. It is also suggested that it has application to the vocal quality of the therapist who may use voice to create an environment that encourages emulation of more focused and emotional tendencies. Wexler & Butler (1976) found that the deliberate adoption of a higher level of expressiveness established this pattern for nonexpressive clients, and it is felt that such a mood may be set that invites deeper experiencing.

Nonverbal communications might also provide valuable information on the different properties of critical and noncritical episodes. Greenberg (1983) expressed the current need for a nonverbal measurement, and the comparison of nonverbal cues under these two conditions
might offer an excellent testing ground for such a scale.

Possibly one of the most unexpected results from this study was the impact of the Interpersonal Process Recall experience on subjects. This instrument was merely intended to select focal event from client evaluations but provided considerably more information. This measure was recommended for ratings immediately following sessions (Elliott, 1978). However, because of the availability of significant sessions extending back over several months, this requirement was not fulfilled. The result indicated that a delayed time frame produced benefits in two important ways. Firstly, the clients gained new perspectives of themselves and a new appreciation for their therapists' involvement. One client reported greater change from the process recall than from the critical event, and another resolved a feeling of hostility towards her therapist. Secondly, the clients became aware of the progress they had made since the critical event had occurred. This verification of movement by recall appeared to have more impact and substantiating quality than therapist reassurance might provide. It would therefore appear useful to conduct research on the implementation of the Process Recall Scale to increase client awareness and to encourage continued effort. It appeared to be particularly fruitful for those occasions where treatment had reached an impasse and some form of revitalization was called for.

The Interpersonal Process Recall Scale might also be combined with the analysis of critical and noncritical events in the training of counsellors who would not only gain from their own performance appraisals over time, but from those of their supervisors and clients.
It would be possible to plot variations in perceptions within and across sessions and progress of counselling skills over a training period. Certainly, in this study, the feedback directed to the participating therapists was of considerable interest to them in confirming their appraisals with the client's view and uncovering discrepancies of which they were unaware.

Another possible focus for future research would be a grading system for critical events determined possibly by the level of impact and the long-term effects of apparent improvement, what differences exist in movement to higher levels on the Experiencing Scale and can the client's state of readiness to change be anticipated. Do particular counselling styles lend themselves to each graduation point on the scale and are these indicators that more responsibility and more demanding tasks should be assigned to the client? In this study, there was a high level of protectiveness displayed by therapists towards their clients when sessions were highly experiential and sensitive to the invitation to participate in research. It was therefore concluded that more powerful sessions would have to be postponed for study until the client had passed some critical point in treatment. The three clients who cried on recall were examples of a review a week after the session.

In conclusion, it appears evident that the study of critical and noncritical events is a means by which process can be effectively studied, compared and substantiated by the presence and the absence of the characteristics that create positive client change.


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Client's rating of selected segments in terms of his level of feelings and perception of significant moments that were meaningful

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<tr>
<th>SEGMENT</th>
<th>1 no meaning</th>
<th>2 very little meaning</th>
<th>3 some meaning</th>
<th>4 I don't know</th>
<th>5 moderately significant</th>
<th>6 greatly significant</th>
<th>7 extremely significant</th>
</tr>
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<tbody>
<tr>
<td>1</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>15</td>
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</tbody>
</table>
APPENDIX B

TRANSCRIPTION OF EPISODES (Sacks, Schegloff and Jefferson, 1978)

"H" and "h" are out-breaths;

"h" stands for inbreath;

"=" stands for "latching" on one speaking turn onto another without pause;

"" represents the stretching out of a sound;

"O" indicates something said oversoftly;

underlining denotes raised loudness or pitch;

"t" is a tongue click

Uncertain hearings are enclosed by parentheses

Time in seconds in parentheses is or can be approximate.

Cl: would be client's first statement

Tl: would be therapist's first statement

C2: client's second statement

T2: therapist's second statement.

Large dot represents focal therapist intervention, preceding client's critical moment.

(Elliott, 1983)
RESPONSE HELPFULNESS RATING SCALE - CLIENT VERSION (7/79)

How helpful or hindering to you was that response by your therapist?

SIGNIFICANTLY HINDERING

<table>
<thead>
<tr>
<th>1*</th>
<th>2*</th>
<th>3*</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8*</th>
<th>9*</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>G</td>
<td>M</td>
<td>S</td>
<td>NEUTRAL OR</td>
<td>S</td>
<td>M</td>
<td>G</td>
<td>E</td>
</tr>
<tr>
<td>X</td>
<td>R</td>
<td>O</td>
<td>L</td>
<td>DOES NOT</td>
<td>L</td>
<td>O</td>
<td>R</td>
<td>X</td>
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<tr>
<td>T</td>
<td>E</td>
<td>D</td>
<td>I</td>
<td>APPLY</td>
<td>I</td>
<td>D</td>
<td>E</td>
<td>T</td>
</tr>
<tr>
<td>R</td>
<td>A</td>
<td>E</td>
<td>G</td>
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<td>A</td>
<td>R</td>
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<td>R</td>
<td>T</td>
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<td>T</td>
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<td>Y</td>
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<td></td>
<td>E</td>
<td>Y</td>
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<tr>
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<td>L</td>
<td>Y</td>
<td></td>
<td></td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HINDERING

HELPFUL

Instructions:

- Try to remember how helpful/hindering the response felt to you at the time; immediately after your therapist said it. If how it seemed then is different from how it seems now, please tell the Recall Consultant both ratings.

- Significantly Hindering = Responses which made things worse for you or really interfered with your getting help.

- Significantly Helpful = Responses which brought about desirable change(s) for you or which have really made it possible for you to change (use these ratings sparingly).

- * = If you rate a response in this range, please give a brief (1-sentence) description of how it was helpful or hindering.
APPENDIX D

Short form of the Experiencing Scale used.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Content</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>External events; refusal to participate.</td>
<td>Impersonal, Detached.</td>
</tr>
<tr>
<td>2</td>
<td>External events; behavioural or intellectual self-description.</td>
<td>Interested, personal, self-participating</td>
</tr>
<tr>
<td>3</td>
<td>Personal reactions to external events; limited self-descriptions, behavioural descriptions</td>
<td>Reactive, emotionally involved.</td>
</tr>
<tr>
<td>4</td>
<td>Descriptions of feelings and personal experiences.</td>
<td>Self-descriptive, associative.</td>
</tr>
<tr>
<td>5</td>
<td>Problems or propositions about feelings and personal experiences.</td>
<td>Exploratory, laborative, hypothetical.</td>
</tr>
<tr>
<td>6</td>
<td>Synthesis of readily accessible feelings and experiences to resolve personally significant issues.</td>
<td>Feelings vividly expressed, integrative, conclusive, or affirming.</td>
</tr>
<tr>
<td>7</td>
<td>Full, easy presentation of experiencing; all elements confidently integrated.</td>
<td>Expansive, illuminating, confident, buoyant.</td>
</tr>
</tbody>
</table>

MODE AND PEAK RATINGS

1. If a segment is more or less equally divided between two stages of the scale, make the higher stage the peak and the lower the mode.

2. If more than half of the segment is at the higher stage, then the mode and the peak should be the same.

3. If the statements at the higher stage occur so frequently and so regularly throughout the segment that they seem to encompass and upgrade any lower portion, the mode and peak can also be the same.

4. If the segment covers a range of the scale (e.g. starting at 1, moving to 2 and ending at 3), make the highest stage the peak and the predominant lower stage the mode. It may be useful to note the range of the scale covered. It is not unusual for the modal rating to be two stages lower than the peak. The intervening stages may or may not be present.
## APPENDIX E

### Reliabilities of Ratings of Individual Therapy Segments

<table>
<thead>
<tr>
<th>Study</th>
<th>Segment type and length</th>
<th>N raters</th>
<th>rkk</th>
<th>Mode</th>
<th>Peak</th>
</tr>
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<tbody>
<tr>
<td>Rubenstein, 1971</td>
<td>Audio, n = 247, 1/2 to 2 min</td>
<td>5</td>
<td>.91</td>
<td>.93</td>
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</tr>
<tr>
<td>Rogers et al., 1967</td>
<td>Audio, n = 592, 4 min</td>
<td>4</td>
<td>.76</td>
<td>.79</td>
<td></td>
</tr>
<tr>
<td>Kiesler et al., 1964</td>
<td>Audio, n = 21, 4 min</td>
<td>4</td>
<td>.91</td>
<td>.92</td>
<td>.89</td>
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<td>Kiesler, 1971</td>
<td>Audio, n = 780, 4 min</td>
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<td>NR</td>
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<tr>
<td>Gruver, 1971</td>
<td>Audio, n = 90, 4 min</td>
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<tr>
<td>Schaeffer &amp; Ables, 1977</td>
<td>Audio, n = 80, 4 min</td>
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<tr>
<td>Yalom et al., 1977</td>
<td>Transcript, n = 807, 5 min</td>
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<td>.65</td>
<td>.61</td>
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<tr>
<td>Fontana et al., 1980</td>
<td>Transcript, n = 120, 5 min</td>
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<td>.91</td>
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<tr>
<td>Jachim, 1978</td>
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<td>.91</td>
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<tr>
<td>Schoeninger, 1965</td>
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<tr>
<td>Fishman, Note 8</td>
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<td>.90</td>
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<tr>
<td>Kiesler et al., 1965</td>
<td>Audio, n = 120, 8 min</td>
<td>4</td>
<td>.85</td>
<td>.87</td>
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<tr>
<td>Ryan, 1966</td>
<td>Audio, n = 96, 8 min</td>
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<td>.77</td>
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<tr>
<td>Jennen et al., Note 5</td>
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<tr>
<td>Leitaer, Note 9</td>
<td>Transcript, n = 36, length unknown</td>
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</tbody>
</table>
APPENDIX F

CLIENT VOCAL QUALITY CLASSIFICATION SYSTEM

The characteristics of the four different patterns are as follows:

A. Focused

1. **Energy.** The energy is fairly high. Pitch is moderate to low, with appropriate loudness.

2. **Primary stresses.** Primary stresses are achieved more by an increase in loudness than by a rise in pitch. Loudness/pitch is greater than 1. The stress may also be achieved by lengthening the stressed syllable (a drawl).

3. **Regularity of stresses.** The stress pattern is irregular for English, and stresses sometimes occur in unexpected places. For instance, adjoining syllables sometimes receive almost equal stress.

4. **Pace.** The pace is irregular, it is usually slowed, but there may be patches that are speeded up.

5. **Timbre.** The voice is full and resting firmly on the platform.

6. **Contours.** These may be unexpected in direction, but the effect is ragged rather than mellifluous.

A. External

1. **Energy.** The energy is fairly high. The pitch is moderate to high, but the volume is adequate.

2. **Primary stresses.** These are achieved with pitch rise as well as some increase in loudness. Loudness/pitch is equal to or less than 1.

3. **Regularity of stresses.** The stress pattern is markedly regular for English. The melodic line may sound sing-song at lower energy levels and resounding at higher levels.

4. **Pace.** The pace is fairly even, though it may be slightly speeded as it approaches a stress point.

5. **Timbre.** The voice is fairly full and resting on the platform.

6. **Contours.** These may go up, down or remain level at times when this would not be quite the expected pattern, although meaning is not usually distorted. The effect is oratorical rather than ragged.

C. Limited

1. **Energy.** The energy is low. The volume is not adequate for the pitch.
C. Limited (cont'd.)

2. Primary stresses. The primary stresses are not very strong, and are achieved by normal balance of pitch to loudness.

3. Regularity of stresses. The stress pattern has about the normal irregularity of English.

4. Pace. The pace is somewhat slowed but tends to be quite regular.

5. Timbre. This is one of the clearest distinguishing characteristics. The voice is thinned from below, and the effect is that of a voice that is "not resting on its platform."


D. Emotional

Overflow. This subcategory is difficult to describe using the six features, because a variety of different emotions are put in the same class. The primary characteristic is a disruption of ordinary speech patterns. The voice may break, tremble, rise to a shriek, etc. However, the mere presence of emotion does not put it in this class, without disruption of speech patterns. For instance, laughter is often found in conjunction with Externalizing, and would not push the response into Emotional unless it really disrupts speech. This is not a very satisfactory class as it now stands, but is not too difficult to recognize.

Expressive

1. Energy. Very high. Pitch is generally higher and loudness greater than any of the other categories.

2. Primary stresses. These are generally achieved by substantial increases in both pitch and loudness - although one may have a larger relative increase than the other. Also, there is often a clipped sense to stressed syllables, and a slight pause after each one. Expressive vs. external - aside from regularity of stresses distinguishing expressive from external (see below) there is a greater pitch and loudness rise with expressive voice than with external. If X is generally at modal pitch and one step above, E varies between modal and two or three steps above (or even higher). Expressive vs. focused - similarly, focused generally stays on modal pitch and occasionally goes down, or there may be a pitch rise without loudness increasing to any marked degree.

3. Regularity of stresses. The most distinguishing feature of this category is stressed, adjoining syllables, with higher pitch and
APPENDIX F (cont'd.)

greater loudness than found in focused; e.g. the stressed adjoining syllables in the sentence below are "I hate."

I hate you

There may be a pitch rise on the second of the stressed syllables, but there is a clear sense of adjoining stressed syllables as shown in the sentence below.

I don't care about you.

4. **Pace.** Regular over stressed syllables, but not regular in general. Often a stacatto quality to stressed syllables (relates to the slight pauses after stressed syllables).

5. **Timbre.** Generally a very full voice.
APPENDIX G

Rand's (1978) Classifications of Factors that qualify a Critical Event from the Opinions of 46 Practising Psychotherapists

A = Client having felt some significant emotional impact.

B = Client having achieved some sense of emotional closeness with the therapist.

C = Client having had some major cognitive reorganization.

D = Client having achieved some important insight that is useful.

E = Client having shifted some distorted perceptions of therapist more towards reality.
"Three speech variables are derived from the interview data:

1. **Mean speech duration**

   The total times in seconds the interviewee (or interviewer) speaks divided by his total number of speech units;

2. **Mean speech latency**

   The total latency time (the period of silence separating two different speech units) divided by the number of units of interviewee (or interviewer) latency;

3. **Percentage interruption**

   The total number of times the interviewee (or interviewer) speaks divided into the number of these same speech units which were interruptions of his partner. Hence, the system has as its basic units the duration of each interview participant's speech, his reaction time before each unit of speech, and the number of these units which are interruptions of his conversational partner."

(Kiesler, 1973)

Matarazzo, Holman and Wiens (1967) point out that

"...a word count from a typescript of an interview is all that an investigator needs to derive (our) variables...since the correlation between average duration of utterance for each speaker as recorded by stopwatch or other chronographic device and the average number of words spoken per utterance by this same person in that interview is of the order of 0.92. Thus, any investigator can now tape record a therapy interview, transcribe it, count the number of words spoken in each utterance by each speaker, compute the mean number of words per utterance for both speakers, and thereby have data for his own cases comparable to(ours)."

(Kiesler, 1973)

**Training required of judges**

"...The results were striking evidence that one obtains reliable and equivalent interview speech scores from an inexperienced observer. The intrarater reliabilities for nine speech scores for the inexperienced..."
Training required of judges (cont'd.)

observer ranged from 0.71 to 1.00, with eight of the nine variables having coefficients above 0.94. The means and standard deviations of each measure for the two observers were almost identical and the scores for the two observers ranged in intercorrelation from 0.94 to 1.00.

(Kiesler, 1973)