EMPATHY, CLIENT DEPTH OF EXPERIENCING, AND GOAL ATTAINMENT SCALING: A WITHIN-SESSION EXAMINATION OF THE CLIENT-CENTERED THERAPY PROCESS

by

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We accept this thesis as conforming to the required standard

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ABSTRACT

This is an analogue study of process and outcome in client-centered therapy focusing chiefly on empathy. Therapist experienced, therapist communicated, and client received empathy were interrelated, and their impact on client depth of experiencing and problem resolution was examined.

Thirty subjects engaged in one session of Client-Centered treatment in which they dealt with "splits", internal conflicts characterized by personal incongruence. Before the sessions the subjects prepared a Goal Attainment Scale, which specified five personalized stages of behavioral and affective change regarding the split. During sessions audio recordings were made which were later rated for therapist communicated empathy and client depth of experiencing. Subjects also rated therapist empathy, and seven days later they assessed change on their Goal Attainment Scales.

Session scores for therapist experienced empathy, therapist communicated empathy, client received empathy, client depth of experiencing, and treatment outcome were then intercorrelated and analyzed in a manner analogous to path analysis. A similar process was applied to the combined results of similar research, and the path generated from this integrative summary and the results of the present study were compared to gain a clearer perspective on the causal flow among the process and outcome variables. As well, scores on the three empathy phases were compared for therapists across the two subjects they interacted with, and the interaction of therapist communicated empathy and client depth of experiencing was examined by a content analysis of each session.

The path results suggest that therapist empathic communications lead to client perceptions of therapist empathy, which directly facilitates treatment outcome. Client depth of experiencing was remote from the empathy
phases and outcome, failing to demonstrate that experiencing is an intervening variable between therapist empathy and outcome. These results are tentative since only one correlation, communicated by received empathy, was significant at .05. However the pattern is highly supported by the relations among empathy, experiencing, and outcome derived from the integrative summary.

The content analysis of therapist communicated empathy and client depth of experiencing suggested that client self-expression and exploration can be inhibited by therapists making an excessive number of reflections based on inaccurate or insufficient understanding of the client. This implied that there are some cases in which empathy and experiencing may be causally related, although this causal linkage is not consistent when examined across all client-therapist interaction.

Comparison of the correlations between the three empathy phases and process and outcome measures, in conjunction with the correlations among the phases, suggested that the phases were related but distinct constructs. Therapist experienced empathy appeared to be a relationship variable that was essentially unrelated to treatment process and outcome. Therapist communicated empathy and client received empathy were relatively stable across clients, suggesting that these variables reflect therapist trait empathy. Of the three phases, client received empathy was most strongly predictive of treatment outcome.

Overall, the study suggests that, within first sessions of client-centered treatment, therapist empathic communications are related to the client's perceptions of the therapist's empathy level in the relationship. These perceptions in turn positively influence treatment outcome. Changes in the level of client depth of experiencing may also be affected to a minor degree by communicated empathy, but experiencing does not appear to
powerfully influence the treatment process at this early stage.

The results suggest that client received empathy, being the empathy phase most predictive of treatment outcome, should be the phase most highly stressed in client-centered treatment. Frequent CRE ratings could furnish the therapist with a valuable index of the efficacy of the treatment process. A further implication for training of Rogerian therapists is that the overall concept of empathy encompasses therapist verbal and kinesic actions beyond the scope of scales measuring communicated empathy, the empathy phase most often stressed in the training process.

Finally, this study points to the potential value of an extensive meta-analysis of client-centered treatment research which would quantitatively integrate and summarize the extant findings regarding this school of psychotherapy.
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CHAPTER ONE

The Scope of the Study

Background of the Problem

Empathy is a construct of major importance in psychotherapy research. It is also a construct which is still obscured by controversies regarding its definition and value.

Empathy was first investigated in depth by Carl Rogers (1951, 1957). He wrote that three "core" therapeutic conditions: genuineness, empathy, and warmth, inhered in all successful therapy and were necessary and sufficient conditions for positive client change. Rogers believed this true not only for client-centered therapy but also for treatments based on all other theoretical orientations.

He described empathy as a focusing on the client's phenomenal world. This focusing on or immersion in the client's thoughts and feelings was in fact the source of the term "client centered".

Meador and Rogers wrote regarding empathy:

The therapist attempts to "get into the shoes" of his client, to get "under his skin". He not only listens to the client's words, but he immerses himself in his world. His comments reflect not only what the client is saying, but also reflect the hazy area at the edge of the client's awareness. Through the therapist's communicating his understanding of the client's felt meanings not yet conceptualized into awareness, the client broadens his understanding of himself and allows into awareness more of his organismic experiencing. The confirmatory experience of feeling understood seems...
to give substance and power to the client's expanding self-concept. It is as though the client affirms, "It's o.k. to be me, even this tentative new me which is emerging."
The therapist does not focus on the present experiencing of the client's world in order to make an interpretation or diagnosis. He believes that it is the experience of feeling understood itself which effects growthful change (Meador & Rogers, 1973, p. 138).

Others have supported Roger's hypothesis. Several researchers have focused on therapist communicated empathy as an important therapeutic condition (Carkhuff, 1973; Carkhuff & Berenson, 1967; Garfield & Bergin, 1971; Gurman, 1973; Truax, 1965; 1972), and have developed methods of rating therapist communicated empathy from video and audio tapes of therapy sessions, and of rating therapist empathic understanding or experiencing from therapist self-report inventories (Barrett-Lennard, 1963; 1974).

During the years since Rogers' original work several interesting and provocative issues have received attention in the client-centered literature.

1. Is empathy a therapist trait or ability which is stable at a specific level and which can be measured outside of treatment, or does therapist empathy vary sharply as a function of some qualities of the particular relationship and situation?

2. How is empathy best measured?

3. Is empathy a unitary construct?

4. How does therapist empathy relate to therapy process and outcome?
These issues still require empirical and conceptual clarification, and the present study seeks to provide both these types of clarification, primarily for issue number four. Specifically, the study first discusses the theoretical model of the client-centered treatment process. This model is also examined by means of a quantitative summary of previous research. Finally, data on empathy, client process, and outcome are generated by means of a laboratory analog of the first session of client-centered treatment. The pattern of the interrelations of these variables is then compared to the pattern suggested by client-centered theory and previous research.

Tangential questions relating to empathy such as issues one to three on the previous page are also discussed in light of the results of this study and previous findings. In these ways the study presents client-centered treatment examined within sessions and tests the efficacy of its findings by comparing them to theory and to related research.

The Research Problem

A client-centered view of process in psychotherapy is represented by the following flowchart:

A \[\rightarrow\] B \[\rightarrow\] C \[\rightarrow\] D \[\rightarrow\] E

- therapist experiences empathy for the client
- therapist communicates empathy to the client
- client receives communicated empathy
- client depth of self-experiencing is enhanced
- client experiences positive change

Figure 1. The Client-Centered Therapeutic Process

Barrett-Lennard (1974) refers to parts A, B, and C in this series as
the "empathy cycle". The cycle starts with the therapist actively attending to the client who is in some way expressing his unique experiencing (A). The therapist reflects the client's experiencing in such a way that overtly or covertly expressed aspects of it are enhanced (B). The client is attending to the therapist's response sufficiently for him to perceive the extent of the therapist's immediate personal understanding (C).

The client then continues expressing himself in a manner noticeably enriched by the therapist's empathic reflections (D). This study endeavors to examine the principal components to the empathy cycle and their relationship to client depth of experiencing and treatment outcome (E).
Definition of Terms

Therapist experienced empathy (A) has been defined by Rogers (1957) as sensing "the client's world as if it were your own, but without losing the "as if" quality...to sense the client's anger, fear, or confusion as if it were your own, yet without your anger, fear, or confusion getting bound up in it..." (p. 99). In this study, level of therapist experienced empathy is operationally defined as a score on the therapist form of the Barrett-Lennard Relationship Inventory (BLRI), (Barrett-Lennard, 1963).

Therapist communicated empathy (B) is the degree to which therapist statements reflect empathic understanding, and is measured by Carkhuff's (1969) five point scale for measuring empathy from tapes.

Client received empathy (C) is the degree to which the client feels understood by the therapist. It is operationally defined as a score on the BLRI (client form).

Client depth of experiencing (D) is defined as the degree to which client statements evidence a willingness and ability to explore personally relevant feelings and thoughts, and is operationally defined as a score on the Experiencing (EXP) Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969).

Treatment outcome (E) is assessed through the level of success in treatment as measured by Goal Attainment Scaling (GAS), a technique in which client and therapist conjointly set goals and devise a five level scale describing the degree of achievement of these as a result of therapy (Kiresuk & Sherman, 1974).
Statement of the Hypotheses

The hypotheses will be presented in formal fashion in the methodology section of the thesis. Following are their essential intents.

Pattern Hypotheses

The first set of hypotheses deals with the principal focus of the study; the pattern of interaction among the three empathy phases, depth of experiencing, and treatment outcome. The expected overall pattern formed by the correlations of the five main variables is illustrated in Figure 2.

Figure 2. Expected Pattern to be Derived from Intercorrelation of Five Main Variables.

The main hypotheses arising from this pattern are:

1. It is predicted that client received empathy (CRE) will be the strongest positive significant correlate of treatment outcome (TO).

2. It is predicted that therapist communicated empathy (TCE) will be the strongest positive, significant correlate of client received empathy (after treatment outcome).

3. It is predicted that therapist communicated empathy will be the strongest positive, significant correlate of depth of experiencing (EXP).

4. It is predicted that therapist experienced empathy (TEE) will be positively and significantly related to therapist communicated empathy, and that the TEE by TCE correlation will be significantly stronger than the

.../7
correlations between TEE and CRE, EXP, or TO.

Segment-by-Segment Hypothesis Concerning the Relationship of Therapist Communicated Empathy to Depth of Experiencing

Therapist communicated empathy and depth of experiencing are correlated in the main analysis by using TCE and EXP scores averaged within segments. In a further analysis, however, TCE and EXP ratings are correlated using individual scores from each four-minute segment of the 30 experimental sessions. This was done to increase accuracy by producing a correlation coefficient based on a large n including all possible data points.

A further analysis involved correlating all the EXP segment scores with TCE scores from preceding and following segments. The complete rationale for these additional analysis components is contained in the Design section of the Methodology chapter. The hypothesis which deals with these analyses is:

It is predicted, that the correlation of TCE and EXP ratings in the same segment will be significantly greater than TCE by EXP correlations derived from staggering segment TCE scores ahead or lack of time within sessions.

Stability Hypothesis Concerning the Three Empathy Phases for Therapists Across Subjects

Disagreement exists over whether therapist experienced, communicated, and client received empathy are primarily therapist traits or relationship variables. Since each therapist in the study interacted with two
subjects, the trait-state issue is addressed by computing \( t \) -scores for the two sets of three empathy measures generated by the two interviews conducted by the therapist. The following hypotheses deal with this phase of analysis:

6. It is predicted that the subject one-by-subject two comparison of therapist experienced empathy will yield a statistically significant difference.

7. It is predicted that the subject one-by-subject two comparison of therapist communicated empathy will yield a statistically significant difference.

8. It is predicted that the subject one-by-subject two comparison of client received empathy will yield a statistically significant difference.

Rationale for the Hypotheses

The hypotheses follow from client-centered theory which suggests that experienced empathy, communicated empathy, client received empathy, depth of experiencing, and treatment outcome are positively related. A therapist's internal experiencing of the client's thoughts, feelings, and behaviors should lead to accurate empathic reflections. These communications, if received by the client, tend to enhance the probability of successful treatment outcome. They also are thought to enhance client expressions of personal thoughts and feelings.

Research has shown that therapist communicated empathy and client received empathy can be positively related to outcome (Kurtz & Grummond, 1972), and that communicated empathy and depth of experiencing can be
positively interrelated. However, these relationships have not been consistently demonstrated. It is these relationships which are the focus of this study.

An often successful means of improving on previous research is to examine suggestions made by researchers in related studies. A search of this type through the literature relating therapist communicated empathy and client depth of experiencing to treatment outcome yielded fruitful results, four recommendations appearing consistently.

One concerned the measurement of therapist communicated empathy and depth of experiencing. Researchers suggested that these variables could vary considerably in level within the therapy hour. They therefore recommended that TCE and EXP would most accurately be measured by minute-by-minute ratings rather than by the usual procedure of extracting and rating only two or three sample segments of the variables in a treatment session (Beutler, 1973; Kurtz and Grummon, 1973; Kiesler, Klein and Mathieu, 1965; Mintz and Luborsky, 1971).

Another recommendation concerned the assessment of treatment outcome. Researchers pointed to the ever-present problem in psychotherapy research of finding sensitive, responsive instruments with which to discern client progress. They tended to downplay the value of global outcome measures such as the MMPI, preferring more client-specific measures which allow themselves to be tailored to the individual client's goals (Bergin and Suinn, 1975; Garfield and Bergin, 1971; Luborsky and Spence, 1971).

A third suggestion arose from the fact that most research on the client-centered treatment process has been conducted in the form of longitudinal studies of actual therapy. This practice has augmented the generalizability of the research but has also allowed for considerable error
variance inasmuch as exact treatment interventions, nature of presenting problem and treatment duration were often not fixed. Researchers therefore have recommended that these factors be held constant as much as possible (Clarke, 1977; Greenberg, 1976; Klein, et al., 1969).

A final recommendation has come mainly from the research of Rappaport and Chinsky (Chinsky and Rappaport, 1970; Rappaport and Chinsky, 1971). They advocated the use of as many therapists as possible in studies of communicated empathy to protect against rater bias. That is, having a number of therapists generate hundreds of rateable segments effectively eliminates the possibility that empathy raters will recognize therapists from voice or style, and thus develop a response set to particular therapists.

The importance and nature of client depth of experiencing as an intervening variable which leads to positive change in treatment are much debated issues. Klein et al. (1969) cited numerous findings that show a high level of experiencing as being associated with positive therapy outcome, but no significant trend of improvement in experiencing from beginning to end of successful therapy. The present single session, problem and treatment method-specific therapy analog study was designed to examine the communicated empathy/depth of experiencing relationship more powerfully by looking inside a treatment session in a moment-to-moment manner. It was expected that the analysis would show that therapist communicated empathy and client received empathy lead to higher levels of experiencing and outcome through examination of Pearson product-moment correlations among the variables in a manner analogous to path analysis.

The importance of therapist experienced empathy in the therapeutic chain of events has received no strong empirical support. It was nonetheless included in the study in hopes that the novel experimental situation
would expose a relationship between this and any of the other main variables.

In summary this study seeks to examine empirically the interrelations among three types of empathy, and to see which type better predicts client depth of experiencing and treatment outcome by an intensive examination of the first session of client-centered treatment. The study also seeks to augment the empirical analysis with a thorough integrative summary of previous research findings.

Assumptions

The medium for examining the research questions was a therapy analog. That is, subjects and therapists interacted in a client-centered therapy situation for only one session. It was therefore assumed that

1) the treatment analog was sufficiently similar to the first session of an actual therapy situation to enable the researcher to generalize results to such a setting,
2) that therapists with more than two years of experience were sufficiently qualified to conduct one session of client-centered treatment,
3) that the audio-taping and self-report measures did not significantly contaminate the treatment effects, and
4) that volunteer clients drawn from a community college population could be regarded as clients in general.

This last assumption was grounded in the belief that everyone, regardless of whether or not they have actively sought professional help, is continually engaging in the resolution of emergent life issues. These issues may vary in their debilitating effect but the basic dynamics of resolution remain the same.

Delimitation

Strictly speaking, since subjects were recruited from students in a...
community college, this study generalizes to community college students in the first session of client-centered counselling, but it possesses implications for psychotherapy in general inasmuch as the relations it demonstrates inhere in therapist/client interactions at all stages of treatment. That is, high levels of therapist empathy should enhance client self-exploration and self-expression, client processes which should theoretically be causally linked to modest cognitive, affective, and behavioral change with regard to the problem the client brought into treatment.

Justification for the study

Unlike similar studies in which communicated empathy and depth of experiencing ratings were taken at random from three or four points in treatment sessions, yielding only several data points for these two variables per session, the intensive analysis phase of this study includes ratings of every therapist-subject interaction in each session on communicated empathy and experiencing.

As well, the study seeks to augment the power of its design by controlling treatment duration (one session per client), method of therapist intervention (strictly reflective), and the form of the presenting issue (a personal incongruence, or "split"), factors which other studies have often left uncontrolled.

In this study the minute-by-minute measurement mentioned above was engineered to provide a powerful test of the relationship between communicated empathy and experiencing, being more sensitive to small fluctuations in level of these two variables.

It was assumed that this control would remove some of the design-induced error variance that can obscure relations among variables.
Overall, the present study reviews the principles of client-centered theory and quantitatively summarizes relevant previous research which has generally examined client-centered process by spot-checking clients across the full duration of their treatment. The study then generates comparable data by examining the therapeutic process on a moment-to-moment basis within one session of client-centered treatment, and compares this data to theory and previous research.
CHAPTER TWO
Survey of the Literature

Rogers conceptualized therapy as consisting of "...experiencing the self in a wide range of ways in an emotionally meaningful relationship with the therapist" (Rogers, 1951, p. 172). Presence of the three core conditions in the therapist is the catalyst for change. Change will occur if the client perceives the core conditions in the therapist and has a sufficient amount of anxiety related to the problem that he is experiencing.

Rogers and others conducted research that suggested a positive relation between the core conditions and change in treatment (Rogers, 1967).

In the ensuing years other researchers offered support for Roger's propositions. Truax, Imber, Battle, Hoehn-Saric, Nash, and Stone (1966), found significant positive relationships between the core conditions and therapy outcome. Barrett-Lennard (1962) found that client received empathy as measured by the Barrett-Lennard Relationship Inventory was positively related to outcome as measured by the Manifest Anxiety Scale, the MMPI, and the Q-Adjustment Scale.

Other research, however, that has examined empathy in and outside of client-centered treatment has produced results which often have not confirmed Roger's initial formulations.

of the core conditions to therapy outcome with a sample of predominately non client-centered therapists. No significant relationship was secured between tape-rated measures of the core conditions and a variety of outcome measures. Furthermore it was found that while empathy and warmth were positively and significantly correlated, both correlated negatively with genuineness. The authors concluded:

The widely discussed Truax et al. (1965) findings are probably not replicable outside of a client-centered therapy situation. It could be argued that genuineness, empathy and warmth are just as important in other orientations, but they must be measured differently in those settings. This may be true, and it is worth developing new scales, but this is not what client-centered researchers have advocated. The burden of proof would appear to rest on them to demonstrate that their concepts and scales have the wide applicability which they have claimed. (Garfield & Bergin, 1971, p. 113).

Another noteworthy study attempting to empirically evaluate the therapeutic process described by Rogers was conducted by Kurtz and Grummon in 1972. Using six measures of therapist empathy employed in previous research, the authors correlated the empathy measures with each other, with a measure of therapeutic process (depth of self-exploration), and several outcome measures (Tennessee Self-Concept Scale, MMPI, therapist and client ratings of success). The empathy measures were not significantly related to each other, and the authors concluded that previous research had been measuring several different variables employing a common label. Of the six empathy
measures, only therapist communicated empathy was related to depth of self-exploration*, a variable similar to depth of experiencing. All the correlations between communicated empathy and therapy outcome measures were positive, but only one (with the Tennessee Self-Concept Scale) was significant (p < .01). Client received empathy was the most powerful predictor of therapy outcome in the study, accounting for 30% of the variance of the combined outcome score.

The most important finding of the Kurtz and Grummon study for present purposes was that client received empathy more or less independently of therapist experienced and communicated empathy, was the strongest predictor of outcome, suggesting that what really matters in treatment is whether or not the client perceives the therapist as understanding his problem and as being honest with the client, and that this perceived or received empathy may vary almost independently of communicated or experienced empathy in the therapist.

A review of the research related to the core conditions and their relation to outcome was carried out by Bergin and Suinn (1975). They concluded:

It could be that a number of negative findings on genuineness, empathy, and warmth are due to the fact that the therapists being studied were not employing a strictly client-centered technique and thus the Truax-type scales were not applicable even though the original claim was that these variables cut across schools. Perhaps these conditions are vital to positive change, or are at least correlated with it, but are not being measured appropriately. For example, in a number of studies showing a positive relationship between tape rated empathy and outcome there

* A five-point scale measuring experiencing levels from "remote from experiencing...unaware" to "lives in process of experiencing" (Walker, Rablen, & Rogers, 1960, p. 80).
were quite significant correlations between client received empathy and outcome, usually as measured by the Barrett-Lennard Relationship Inventory (p. 515).

Five issues of major importance in understanding the role of empathy in the therapeutic process have been:

1. Is empathy a therapist trait or is it a variable quality of therapeutic relationships?

2. Is empathy a unitary construct?

3. How are experienced, communicated, and client received empathy operationally defined?

4. How do the three phases of empathy relate to depth of experiencing and therapy outcome?

5. How does depth of experiencing relate to therapy outcome?

The question of whether empathy is a stable therapist trait (ability) or a function of particular relationship variables was first dealt with by Rogers (1957) who defined the therapeutic condition of empathy as a two-phase process:

The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client (p. 95), and the communication to the client of the therapist's empathic
understanding is to a minimal degree achieved (p. 96).

The empathy described by Rogers was conceptualized by some as a consistent ability of the therapist to understand the client and then to communicate this understanding fully and clearly. They used this trait model of empathy to construct measures of therapist empathy outside the therapy setting (Kagan, 1967) and within it (Carkhuff, 1967; Truax, 1967).

However, a study by Beutler (1972) showed that communicated empathy was not always constant between or within sessions, but often varied considerably. He concluded that:

accurate empathy may not be a stable quality of the therapist as is usually assumed, but instead may reflect a dyadic or relationship variable (p. 167).

Gurman (1973) examined the stability of the therapeutic conditions of three high and three low functioning therapists with one ongoing client per therapist. He too found that empathy ratings of therapists varied, not only from session to session, but also from minute to minute in a given session.

It is thus also possible that therapist empathy may not be a trait, but rather a state of being which can vary considerably from minute to minute in therapy. The issue is still unresolved inasmuch as the literature abounds in contradictory findings.

Regarding the construct definition of empathy, the data of several studies indicate that the facilitative condition in question is probably a group of related but distinct constructs. Kurtz and Grummon (1972) looked at measures of empathy representing three facets of the construct; therapist trait empathy, which was measured by the Affective Sensitivity Scale (Kagan et al., 1967); therapist communicated empathy as measured by tape ratings; and client received empathy as measured by the BLRI. They concluded "The data do not reveal a unitary construct of empathy, but several different
variables which are thought to be similar but in fact are not" (p. 113).

McWhirter (1973) also found that therapist experienced empathy, therapist communicated empathy, and client received empathy were three distinct variables.

Barrett-Lennard (1974) most accurately summed up this situation by positing three phases of empathy:

Phase One — empathic understanding or experienced empathy, which is a therapist's ability to fully comprehend what the client is saying and feeling;

Phase Two — communicated empathy, which is the quality of the feedback the therapist gives to the client; and

Phase Three — client received empathy, which is the degree to which the client feels understood and respected by the therapist.

Regarding the lack of correlation sometimes found between measures of the three phases, Barrett-Lennard wrote:

One might expect that a modest correlation would exist among valid measures of the principal experiential and communicational processes involved in the different phases (over a broad sample of relationships). However, theoretically, there is no reason to expect, for example, a close association between a genuine empathic set and level of expressed empathy; or a strong relationship between inner resonance and personal understanding (phase one) and the degree to which the receiving person is actually conscious that the
other is with him in personal understanding (phase three) (p. 6).

Thus empathy appears to be most accurately conceptualized as three constructs: therapist experienced empathy, therapist communicated empathy, and client received empathy, which may or may not be statistically related.

The most appropriate means of operationally defining empathy depends on the type or phase under examination. The literature indicates that phase one empathy is most commonly measured by the therapist form of the Barrett-Lennard Relationship Inventory, phase two empathy by tape rating scales such as those of Carkhuff (1969) and Truax (1961), and phase three empathy by the client form of the BLRI.

The question of whether or not (and how) therapist communicated empathy relates to therapy outcome has drawn a fairly consistent response in the literature. Kurtz and Grummon (1972), Garfield and Bergin (1971), and Bergin and Suinn (1975) found that communicated empathy tended to correlate positively but usually non-significantly with a variety of outcome measures. Therapist experienced empathy has not been shown to be a powerful predictor of outcome, and client received empathy has consistently been highly correlated with the results of psychotherapy (Barrett-Lennard, 1962; Kurtz and Grummon, 1974).

A possible problem with the above-cited studies and other similar research has been that all employed global outcome measures which can be insensitive to positive client change. It is interesting with respect to this to note that the authors of these studies all recognized that this problem might have existed and suggested that it might have been remedied by utilization of a more client-specific outcome measure.

To summarize, the construct empathy is either a situational quality of psychotherapy or a therapist trait that can best be conceptualized as a group
of three variables: therapist experienced empathy, therapist communicated empathy, and client received empathy. Of these, communicated empathy and client received empathy have been most consistently positively related to therapeutic outcome, and of the two, client received empathy has been the more powerful predictor of change.

Communicated empathy is best measured by frequent ratings of video or audio tapes of therapy sessions, and client received empathy is most effectively measured by the Barrett-Lennard Relationship Inventory.

Therapist communicated and client received empathy have been related to several global therapy outcome measures, but more case-specific measures have been recommended by researchers (Barrett-Lennard, 1962; Bergin and Suinn, 1975; Garfield and Bergin, 1971; Greenberg, 1976; Gurman, 1973; Kelley, 1976; Kiresuk and Sherman, 1968).

Bergin and Suinn (1975) summed up the status of empathy as it relates to process and outcome in counselling and psychotherapy when they wrote:

It is clearer now that (the core conditions of genuinesness, empathy, and warmth) are not as prepotent as once believed, but their presence and influence are ubiquitous, even showing up strongly in behavior therapies (p. 521).

In other words, empathy is less and less seen as a necessary or sufficient condition for facilitating client movement. Change can occur in the presence of low empathy levels. However, the efficacy of most forms of psychotherapy is often enhanced by an empathic client-therapist relationship.

The role and importance of client depth of experiencing in therapy are final issues to be dealt with. The most authoritative treatise on experiencing is the two volume manual for measuring the construct written
by Klein, Mathieu, Gendin, and Kiesler, (1969). They defined depth of experiencing as:

The quality of an individual's experiencing of himself, the extent to which his ongoing, bodily felt flow of experiencing is the basic datum of his awareness and communications about himself, and the extent to which this inner datum is integral to action and though (p. 1).

These authors conceptualized experiencing as a seven point continuum. At a low level of this hierarchy, client communication is markedly impersonal and superficial. Moving up the scale, communications become more and more personal and feeling-oriented. Higher still, feelings are freely examined and emergent levels of experiencing serve as the basic referents for problem solving. They continue:

(The EXP Scale is) sensitive to shifts in patient involvement, even within a single interview session, making it useful for microscopic process studies, for example, to assess the productivity of different topics, to appraise different patterns of interaction between patients and therapists, or to establish a profile of patient performance during the therapy hour (p. 1).

Klein et al. reviewed over a dozen studies in their manual ranging from 1960 to 1969 which sought to relate experiencing to various process and outcome variables. They concluded:

In toto, these early studies show that both depth of experiencing and the global process ratings of brief therapy segments are consistently and highly reliable, and yield a meaningful differentiation between more and less successful cases and between neurotics and schizophrenics.
The most powerful and consistent finding is that successful therapy patients start, continue, and end therapy at a higher level than do less successful patients. Apparently the behavior that the scales measure is higher in successful cases from the start. Some of these studies show change in experiencing or process, that is, upward movement over therapy associated with success and downward movement associated with failure, but these findings are generally less striking than those for overall level, and are less consistently replicated. We can safely conclude that the process and experiencing scales measure patient behavior affecting change, but how this behavior may vary or change over therapy is more open to question (p. 16).

Thus, while it is clear that overall adjustment and likelihood of success in therapy vary directly with level of experiencing, it is still unclear whether EXP changes from beginning to end of treatment and whether certain therapist behaviors strongly influence its occurrence.

Experiencing can thus be interpreted as tapping the degree of depth of the patient's involvement in therapy, including his willingness and ability to provide the therapist with material with which to empathize, and his openness to the therapist's approach. It is, however, still unclear if client depth of experiencing is or is not significantly affected by therapist empathy.

The Integrative Summary of Previous Research

This summary is a cumulative review of major, original studies presented in a quantitative form. The goal of the summary is to provide a model of...
client-centered treatment with which to compare the date derived from the study. A theoretical model of course already exists (see Figure 1). However, the empirical examination of client-centered therapy over two decades has not consistently demonstrated relationships among all elements of this model.

The studies included in the summary matrix were chosen chiefly because they are major, landmark investigations of client-centered therapy, investigations that spawned a multitude of similar examinations of Rogerian treatments. Other considerations that led to their inclusion were that they were correlational in nature and that with the exception of Goal Attainment Scaling, they employed similar or identical measures to those in the present study. The summary is not intended to constitute an all-inclusive review of the research which has interrelated some or all of the five main variables in the present study. However, the researcher has endeavored to include research with findings representative of the results of similar studies. In other words, if all the research relating, for example, TCE and EXP were presented in the appropriate cell, the summary correlation coefficient would not be expected to differ appreciably from .60, the value presented in the matrix.

The results of this procedure are presented in Table 1 (following). Where several correlation coefficients were available mean coefficients were calculated. When results were not correlational, coefficients were derived from the n and the alpha level (Glass and Stanley, 1970). This exercise was undertaken with the understanding that the results from the various studies cited were not directly comparable in any strict, quantitative manner, but nonetheless could serve as heuristics. In other words, an indication of causal linkages or paths among variables could be derived from the combined data. This is what is presented in Figure 3.
<table>
<thead>
<tr>
<th>TCE</th>
<th>CRE</th>
<th>EXP</th>
<th>TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kurtz &amp; Grummon, 1974. BLRI therapist form &amp; Carkhuff empathy scale were correlated.  ( r = -0.24 ) (NS; ( n = 31 ).</td>
<td>Kurtz &amp; Grummon, 1974. BLRI therapist form correlated with depth of self-exploration.  ( r = -0.06 ) (NS; ( n = 31 ).</td>
<td>Kurtz &amp; Grummon, 1974. BLRI therapist form correlated with composite outcome measures score.  ( r = 0.01 ) (NS; ( n = 31 ).</td>
<td></td>
</tr>
<tr>
<td>Barrett-Lennard, 1963. Compared client &amp; therapist forms of BLRI. (( n = 29 ).)</td>
<td>Rogers et al., 1967. BLRI correlated with depth of self-exploration:  ( r = -0.23 ) (modal) &amp; ( r = -0.72 ) (peak); ( n = 29 ).</td>
<td>Garfield &amp; Bergin, 1971. TCE correlated with MMPI. ( (n = 31, r = 0.28 ) (NS).</td>
<td></td>
</tr>
<tr>
<td>Kurtz &amp; Grummon, 1974. BLRI client &amp; therapist forms correlated.  ( r = 0.20 ) (( n = 31 ), NS).</td>
<td>Kurtz &amp; Grummon, 1974. Carkhuff empathy ratings correlated with depth of self-exploration.  ( r = 0.47 ) (( p &lt; 0.01 ), ( n = 31 ).)</td>
<td>Kurtz &amp; Grummon, 1974. Carkhuff scale correlated to TSCS  ( r = 0.42 ) (( p &lt; 0.01 ), ( n = 31 ) &amp; composite outcome score.  ( r = 0.30 ) (NS).</td>
<td></td>
</tr>
<tr>
<td>Rogers et al., 1967. BLRI correlated with depth of self-exploration:  ( r = -0.23 ) (modal) &amp; ( r = -0.72 ) (peak); ( n = 29 ).</td>
<td>Rogers, et al. 1967. TCE significantly related to several outcome measures. ( n = 16 ).</td>
<td>Rogers, et al. 1967. TCE significantly related to several outcome measures. ( p &lt; 0.05 ), ( n = 40 ).</td>
<td></td>
</tr>
<tr>
<td>van der Veen, 1965. TCE significantlv related to EXP (( n = 3 ), ( p = 0.01 ).)</td>
<td>Truax et al., 1966. TCE significantly related to several outcome measures. ( p &lt; 0.05 ), ( n = 40 ).</td>
<td>Truax et al., 1966. TCE significantly related to several outcome measures. ( p &lt; 0.05 ), ( n = 40 ).</td>
<td></td>
</tr>
<tr>
<td>Kurtz &amp; Grummon, 1974. Correlation between BLRI client form &amp; Carkhuff Empathy scale = 0.31 ( (n = 31, p &lt; 0.10) ).</td>
<td>( r = 0.14 ).</td>
<td>( r = 0.01 ).</td>
<td></td>
</tr>
<tr>
<td>Rogers et al., 1967. TCE correlated with modal EXP:  ( r = 0.54 ) (( p &lt; 0.05 )) and peak EXP; ( r = 0.73 ) (( p &lt; 0.01 )). ( n = 28 ).</td>
<td>Kurtz &amp; Grummon, 1974. Carkhuff scale correlated to TSCS  ( r = 0.42 ) (( p &lt; 0.01 ), ( n = 31 ) &amp; composite outcome score.  ( r = 0.30 ) (NS).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>van der Veen, 1965. TCE significantly related to EXP ( (n = 3, p &lt; 0.001) ).</td>
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<td></td>
</tr>
<tr>
<td>Rogers et al., 1967. EXP correlated with BLRI client form: ( r = 0.19 ) (( p &lt; 0.05 )) for modal EXP &amp; ( r = 0.38 ) for peak EXP ( (n = 28) ).</td>
<td>Kurtz &amp; Grummon, 1974. BLRI client form correlated with composite outcome measures score.  ( r = 0.55 ) (( p &lt; 0.01 ), ( n = 31 ).)</td>
<td>( r = 0.29 ).</td>
<td></td>
</tr>
<tr>
<td>( r = 0.30 ).</td>
<td>( r = 0.27 ).</td>
<td>( r = 0.40 ).</td>
<td></td>
</tr>
</tbody>
</table>

**Definitions:**
- TEE: Therapist Experienced Empathy
- TCE: Therapist Communicated Empathy
- CRE: Client Received Empathy
- EXP: Depth of Experiencing
- TO: Treatment Outcome

**Notes:**
- Rogers et al. 1967. EXP significantly related to MMPI & Wittenbom scales (\( p < 0.10 \), \( n = 28 \).
- Tomlinson & Hart, 1962. Rogers Process Scale significantly related to success in therapy \( (n = 10, p = 0.01) \).
Figure 3. Data from Table 1 Applied to the Main Variables.
The dotted line represents one path or possible causal flow suggested by a comparison of the relative magnitudes of the correlations in Table 1, with consideration given to the theoretical and logical factors involved. The line was determined by working backward from treatment outcome, picking the strongest correlate, working back from that to its strongest correlate, and so on. The path implies that treatment outcome is most likely to be successful when therapist communicated empathy is high and when it is perceived and received by the client. Depth of experiencing drops out of the process since the EXP/TO correlation is smaller than the CRE/TO correlation.

Since the correlation between therapist communicated empathy and client received empathy is close to the one between client received empathy and client depth of experiencing, another possibility suggests itself; that client received empathy leads to treatment outcome and experiencing, which are thus conceptualized as two outcome variables which are related (r = .40) but distinct nonetheless.

If one works backward from EXP as well as TO, the pattern suggested in Figure 4 emerges.
Figure 4. The Data from Table 1 Applied to Correlational Analysis with Main Variables.
Therapist communicated empathy is the strongest correlate of experiencing, client received empathy the strongest correlate of treatment outcome. CRE and TCE are moderately related. This model implies that therapist communicated empathy most directly induces experiencing. It may also facilitate client received empathy which in turn would lead to treatment outcome. This would be the expected model to appear from the data generated from this study.

In summary, the literature has delinated five variables (therapist experienced empathy, therapist communicated empathy, client received empathy, client depth of experiencing, and treatment outcome) as the salient elements in the client-centered therapy process. It is the aim of this study to see which of these variables best predict therapy process and outcome and to determine if a causal link is indicated between any of the empathy measures, between empathy and depth of experiencing, or among the empathy measures, depth of experiencing, and treatment outcome within a session of client-centered treatment.

The three phases of empathy, therapist experienced, therapist communicated, and client received empathy are also examined for each therapist across subjects by means of $t$-tests to address the state/trait issue, and interrelations among the three phases are analyzed for information regarding the construct definition of empathy.

Issues Relating to Client-Centered Therapy

The chief goal of this study is to present an overall statement of the client-centered treatment process by examining the interrelations among measures of empathy, experiencing, and outcome. The study also examines several issues conceptually related to this goal. They are: Is empathy a therapist trait or a relationship variable? Is empathy a unitary entity
or a group of related but distinct constructs? What is the preferred operational definition of empathy? Is depth of experiencing a client trait or a relationship variable? What measure of empathy best predicts depth of experiencing? How do communicated empathy and experiencing interrelate? and What empathy measure best predicts outcome? The chief goal and the related issues are presented in Table 2 along with the variables they encompass and the relevant data analysis components in the study.
### TABLE 2
**Issues Relating to Client-Centered Therapy**

<table>
<thead>
<tr>
<th>Questions</th>
<th>Variables Involved*</th>
<th>Data Analysis Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) What is the overall state-</td>
<td>all variables</td>
<td>all components, esp.</td>
</tr>
<tr>
<td>ment of the client-centered</td>
<td></td>
<td>path chart</td>
</tr>
<tr>
<td>therapy process in</td>
<td></td>
<td>(Figures 7 &amp; 8)</td>
</tr>
<tr>
<td>the study?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Empathy: state or trait?</td>
<td>TEE</td>
<td>therapist sessions</td>
</tr>
<tr>
<td></td>
<td>TCE</td>
<td>1 x 2;</td>
</tr>
<tr>
<td></td>
<td>CRE</td>
<td>(Table 8)</td>
</tr>
<tr>
<td>3) Is empathy a unitary</td>
<td>TEE x TCE x CRE</td>
<td>main analysis matrix</td>
</tr>
<tr>
<td>construct?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>†</td>
<td></td>
</tr>
</tbody>
</table>

.../32
4) Empathy: what is the main analysis preferred operational TEE definition in terms of TCE x EXP x TO predicting client process & treatment outcome?

5) EXP: state or trait? EXP graphs of EXP in sessions (Appendix B)

6) How is client process all main therapist sessions (EXP) best predicted? variables 1 x 2 (Table 8)

7) How do communicated empathy and experiencing TEE main analysis TCE x EXP matrix interrelate? CRE (Table 5) TCE x EXP staggered (Table 6) analysis
8) How is outcome best predicted? all main variables x TO main analysis matrix (Table 5)

* TEE: therapist experienced empathy
* CRE: client received empathy
* TO: treatment outcome.

TCE: therapist communicated empathy
EXP: depth of experiencing
CHAPTER THREE
Methodology

The primary focus of this study is what happens inside a therapy session; how therapist affects client on an immediate basis and how this relates to the resolution of client issues. The methodology presented below describes a therapy analog situation which attempted to allow a naturalistic observation of client-centered therapeutic communication while simultaneously structuring the interactive process so as to eliminate through its design interference from other variables not important to the study (Heller, 1971; Yee and Gage, 1970).

Five main variables (therapist experienced empathy, therapist communicated empathy, client received empathy, depth of experiencing, and treatment outcome) and four secondary variables (number of hours doing client-centered treatment, total number of hours spent doing treatment, therapist valuation of client-centered treatment, and subject ability to focus) were examined in the main analysis, which consisted of a correlational analysis with inference and statistical procedures analogous to path-analysis (Neale and Leibert, 1973; Yee and Gage, 1970). As well, therapist communicated empathy and depth of experiencing were examined on a minute-by-minute basis, and TCE/EXP patterns within sessions were observed in the intensive analysis. The results of the main and intensive analyses were combined and compared to a summary matrix (Table 1) in which data from selected similar studies were summarized. The pattern suggested by the summary matrix has been presented in Figure 4. It is the pattern expected to be derived from the data generated by this study, and is reproduced in Figure 5 with the correlations labelled with letters A to I.
Figure 5: The Ten Correlational Paths Among The Main Variables.
The relationship illustrated in Figure 5 are expressed in the following general equation:

\[ D > B > C > E = F > I > A > G > H > J \]

This equation is the basis for the formal hypotheses presented below.

Formal Hypotheses

It is predicted that the following relationships between the magnitude of the correlation coefficients will be found and that differences in each case will be significant at the .05 level.

1. \( r_{\text{TO.CRE}} \) will be significantly greater than \( r_{\text{TCE.CRE}} \)
2. \( r_{\text{TO.CRE}} \) will be significantly greater than \( r_{\text{TO.TCE}} \)
3. \( r_{\text{TO.CRE}} \) will be significantly greater than \( r_{\text{EXP.TO}} \)
4. \( r_{\text{TO.CRE}} \) will be significantly greater than \( r_{\text{EXP.CRE}} \)
5. \( r_{\text{TO.CRE}} \) will be significantly greater than \( r_{\text{TEE.CRE}} \)
6. \( r_{\text{TO.CRE}} \) will be significantly greater than \( r_{\text{TEE.TO}} \)
7. \( r_{\text{TO.CRE}} \) will be significantly greater than \( r_{\text{TEE.EXP}} \)
8. \( r_{\text{TO.CRE}} \) will be significantly greater than \( r_{\text{TEE.TCE}} \)
9. \( r_{\text{EXP.TCE}} \) will be significantly greater than \( r_{\text{CRE.TCE}} \)
10. \( r_{\text{EXP.TCE}} \) will be significantly greater than \( r_{\text{TO.TCE}} \)
11. \( r_{\text{EXP.TCE}} \) will be significantly greater than \( r_{\text{TO.EXP}} \)
12. \( r_{\text{EXP.TCE}} \) will be significantly greater than \( r_{\text{CRE.EXP}} \)
13. \( r_{\text{EXP.TCE}} \) will be significantly greater than \( r_{\text{TCE.TEE}} \)
14. \( r_{\text{EXP.TCE}} \) will be significantly greater than \( r_{\text{TO.TEE}} \)
15. \( r_{\text{EXP.TCE}} \) will be significantly greater than \( r_{\text{EXP.TEE}} \)
16. \( r_{\text{EXP.TCE}} \) will be significantly greater than \( r_{\text{CRE.TEE}} \)
Since this study focuses on the relation of three phases of empathy to client depth of experiencing and outcome, several of the hypotheis are of special importance. Hypotheses 12 and 15, if significant, will imply that therapist communicated empathy is the empathy phase most highly predictive of client process. The relationship of the empathy phases to outcome is addressed by hypotheses 2 and 6. Significance of these will suggest that client received empathy is the strongest empathy correlate of the results of treatment.
Hypothesis Testing

The process involved performing $z$ - tests to determine the level of significance of the 34 pair-wise comparisons between the nine correlational coefficients in Table 5. Two classes of comparisons existed. Class One comparisons involved pairing correlation coefficients which had a common variable; for example, the correlation between therapist experienced empathy and treatment outcome and the correlation between therapist communicated empathy and treatment outcome ($r_{TCE,TO}^{}$) ($r_{TEE,TO}^{}$). For these comparisons, Glass and Stanley's $z$ - test for dependent correlations was employed (Glass and Stanley, 1970, p. 313).

Class two comparisons tested the difference between two correlations with no common variable (for example, the correlation between therapist experienced empathy and client received empathy ($r_{TEE,CRE}^{}$), and the correlation between depth of experiencing and treatment outcome ($r_{EXP,TO}^{}$). Class two comparisons were computed by means of the Pearson - Filon test for dependent correlations (Arlin, 1976). Computer programs were written to perform the two classes of comparisons described above (see Appendix C).
Therapists

Of the seventeen therapists involved in the study, eleven were graduate students in Counselling Psychology, three in Clinical Psychology, and one in School Psychology. Seven of these were engaged in Doctoral and six in Master's level studies. The remaining two experimental therapists were practicing psychologists. Other information is summarized in Table 3 below.

TABLE 3
Description of Therapists

<table>
<thead>
<tr>
<th>Age</th>
<th>Mean</th>
<th>Mode</th>
<th>S.D.</th>
<th>Range</th>
<th>Hours of experience conducting client-centered therapy.</th>
<th>Total Hours of experience conducting therapy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>28.94</td>
<td>32</td>
<td>6.35</td>
<td>23-50</td>
<td>489.80</td>
<td>884.07</td>
</tr>
<tr>
<td>Mode</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1000</td>
<td>1000</td>
</tr>
<tr>
<td>S.D.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1139.62</td>
<td>1002.04</td>
</tr>
<tr>
<td>Range</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10-2000</td>
<td>10-3000</td>
</tr>
</tbody>
</table>

The table shows that most of the therapists had ample background in conducting therapy and that most were familiar with the client-centered method of counselling.

Subjects.

The subjects acting as clients in the treatment analog sessions were adult education students at the British Columbia Institute of Technology. They volunteered for what was described as a study of communication processes. They represented as a group a wide age range, and were fairly equally
balanced by sex, as can be seen by the information in Table 4 below.

TABLE 4
Description of Subjects

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Age</td>
<td>29.25</td>
</tr>
<tr>
<td>Mode Age</td>
<td>32</td>
</tr>
<tr>
<td>S.D. Age</td>
<td>6.36</td>
</tr>
<tr>
<td>Range Age</td>
<td>23-50</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>17</td>
</tr>
<tr>
<td>F</td>
<td>13</td>
</tr>
</tbody>
</table>

The experimental sessions averaged 40.16 minutes with a mode of 40 minutes and a range of from 25 to 55 minutes.

Instruments

Each of the five main variables was measured by one instrument, and client and therapist perceptions of the value of the treatment, and client focusing ability were assessed as well. These inventories, questionnaires, and rating scales are described below and are contained in their entirety in Appendix A.

Therapist communicated empathy (CRE) was measured by rating therapist statements from audio tapes of the experimental sessions, which were broken into four-minute segments and randomized for rating. Two empathy raters were employed, and inter-rater reliabilities were obtained before and during the rating. The reliability coefficients ($r_{xy}$) were .90 and .85 respectively. These compare favorably to the coefficients reported in
studies by Gurman (1973) and Garfield and Bergin (1971), which were .95 and .91 respectively for similar rating situations. The raters were both familiar with the construct involved, and both had experience as therapists in conducting client-centered treatment. Informed judges were chosen over naive ones, as was the case in the Wisconsin Study (Rogers, 1967) to increase the validity of the ratings (Blaas and Heck, 1975).

The therapist communicated empathy scores for each segment were collapsed into 30 mean TCE scores, one for each session, for comparison with the other sessional measures (therapist experienced and client received empathy) in the main analysis, and were employed separately (n = 257 four-minute segments) in the intensive analysis of the communicated empathy/experiencing relationship.

The scale employed for rating therapist communicated empathy was Carkhuff's (1967) Empathic Understanding in Interpersonal Process Scale, which derived from the Truax Accurate Empathy Scale (Truax, 1961) which in turn was based on the earlier theoretical presentations of Rogers (1957).

Carkhuff's scale is composed of five levels of which the following three are examples:

**Level One:** the therapist's responses either do not attend to or detract significantly from the expressions of the client;

**Level Three:** the therapist's responses are interchangeable with the client's in that they express essentially the same affect and meaning;
Level Five: the responses of the therapist add significantly to the feelings and meanings of the client in such a way as to express accurately feelings and meanings which the client himself is unable to express clearly, or in the event of ongoing deep self-expression by the client, the therapist is fully with the client in his deepest moments.

Therapist experienced empathy (TEE) is the degree to which the therapist sees himself as being cognizant of his client's cognitions and feelings. It was measured by the Barrett-Lennard Relationship Inventory (therapist form). This instrument was filled out by the therapists immediately after each session. It has a range of -48 to +48 and it yields one score which rates average empathy for the entire session. Some examples of BLRI items are:

I want to understand how _______ sees things
I understand _______ 's words but do not know how he/she feels
I nearly always know exactly what _______ means.

Respondents rated the accuracy of these and similar statements on a six-point scale which ranged from -3 (No, I strongly feel that it is not true) to +3 (Yes, I strongly feel that it is true).

Client received empathy (CRE) is the degree to which the receiving person sees the therapist as being in touch with his issues. It was measured by the client form of the BLRI, which the client filled out immediately after the experimental session. As with the therapist form of the BLRI, this form elicits one score for average received empathy in the entire session. Examples of items are:
wants to understand how I see things
usually senses or realizes what I am feeling
realizes what I mean even when I have difficulty in saying it.

Barrett-Lennard (1969) reported that the split-half reliability of the two forms of the relationship inventory ranged from .75 to .94, and a test-retest correlation over a two to six week period of .92. Since there exist no parallel inventories to which the BLRI can be correlated to assess validity, Barrett-Lennard (1962) had five judges rate the strength of the inventory items, and these ratings contributed to the final development of the instrument.

**Depth of experiencing** (EXP) is the degree to which the client's statements evidence the depth of his involvement in the therapy task. It was measured by the EXP Scale (Klein et al., 1969), which has a range of one to seven and was rated from treatment session tapes by three trained raters. The EXP Scale possesses construct validity inasmuch as the concept of client willingness to introspect and own feelings and behaviors is a core one in client-centered therapy theory. Below are examples of several of the seven levels from the short form of the scale:

<table>
<thead>
<tr>
<th>Level One</th>
<th>content</th>
<th>treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>external events; refusal to participate</td>
<td>impersonal, detached</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level Four</th>
<th>content</th>
<th>treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>description of feelings and personal experiences</td>
<td>self-descriptive; associative</td>
</tr>
</tbody>
</table>
The interrater reliability of the EXP Scale has been found by Kiesler (1967) to be as high as .79 for four judges. In this study, reliability coefficients of .85 (modal EXP) and .75 (peak EXP) were obtained.

As with therapist communicated empathy, sessions were broken into four-minute segments for EXP ratings, which were carried out by ascribing two EXP levels (peak and mode) to each segment.

Goal Attainment Scaling -- this is a process of designing before treatment a scale for each client-therapist goal and specifying for each goal a transformation of overall goal attainment into a standardized t-score (Kiresuk and Sherman, 1968). It allows for idiosyncratic goals instead of evaluating achievement according to general criteria of improvement (Kelley, 1976). The use of GAS in this study involved a facilitator and the subjects writing a description of projected stages of improvement (for example, see appendix A).

With reference to behaviorally observable outcome, the GAS has been shown to be an effective and efficient measure in various treatment modalities with a variety of problems. Mauger (1974) analyzed the GAS against the MMPI for validity. He found its concurrent validity to be .84 when correlated with MMPI scores. Reliability was found to be .71 for different follow-up raters in initial goal setting, .70 after two months, and .47 after six months (Garwick, 1974). Sherman, Baxter and Audette (1976) found a moderately high test-retest reliability of .57.
Secondary Data Sources

Questionnaires (see appendix A) eliciting demographic and other information were completed by all participants immediately after the research interviews.

The Participant Questionnaire, administered to all subjects one week after the interviews, contained several items designed to screen out subjects who had experienced a disruptive event during that time period. On the basis of the responses to these questions, no respondents were rejected.

The questionnaire also asked: "Sometimes people change goals as a result of talking with a skilled listener. Did this happen to you?". If subjects checked "yes" they were instructed to fill out a Goal Attainment Scale regarding their new goal and check off their progress. Seven subjects of the thirty did in fact experience such goal shifts, and the scores derived from their alternate GAS forms were entered as treatment outcome scores for these subjects in the main data analysis. Participants were also asked if they would seek help from a client-centered psychologist or psychiatrist.

Information regarding training, theoretical orientation, and amount of general and client-centered therapy experience was collected in the Therapist Questionnaire, administered to all therapists on the day of the research interview. They were asked to give their valuation of client-centered treatment on a five-point scale.

From the therapist questionnaire were derived three variables, amount of time in hours spent conducting client-centered treatment and conducting therapy in general, and the therapist's valuation of the treatment method employed in the study.
The Post-Focusing Questionnaire (Gendlin, 1973) was also administered to all subjects one week prior to the interviews. This unstandardized instrument purports to measure client ability to function adequately in an affectively oriented, experiential form of psychotherapy. Only 17 subjects completed the questionnaire, the remaining 13 subjects claiming it was too abstract or unclear to fill out. Results from this instrument were integrated with the five main variables and the three above-mentioned therapist variables in the main analysis.

Procedure

The research procedure was built around 30 quasi-treatment sessions (one per subject) in which subjects and therapists interacted in a client-centered manner. Therapists were recruited from graduate programs in counselling, clinical, and school psychology. Subjects were solicited from the student body of British Columbia Institute of Technology. Their only screening criterion other than willingness to participate in research on the "listening process" was normality, defined here as Rogers (1967) defined it: "any individuals who are functioning outside a hospital setting, with no external evidence of psychological malfunctioning and no expressed desire for help" (p. 27).

All experimental sessions were carried out on the same morning. They were preceded by a group administration of the Goal Attainment Scaling process, during which subjects were first asked to define a "split", or area of intra-personal conflict (Greenberg, 1976). The format for this split was, "I am torn between_____ and______" (e.g. I am torn between spending my free time with my family or studying). The split format was employed for two reasons. First it was considered advantageous to keep problem nature homogeneous to eliminate as much as possible error variance
due to subjects presenting issues for discussion that differed greatly in nature. While the "split" format allowed for considerable latitude in seriousness of issue, it still kept subjects focused on internally defined problems.

This internal or self-focused problem type was highly compatible with the Rogerian concept of incongruence, defined as a conflict between real and ideal self. This compatibility with the client-centered therapy process was the second reason for using the "split" format.

Once all subjects had defined a split, they were asked to devise behavioral and affective indices of change for better or worse regarding their issue. For example, the above-mentioned split could have been monitored by charting amount of time spent studying or with the subject's family (behavioral measure) and feelings of anxiety (affective measure). Subjects would subsequently check off their progress on the five-point GAS one week after the experimental sessions. This Goal Attainment Scaling procedure took one hour. The instructions were read from a prepared procedural format which was also given to all subjects so they could read along with the researcher and have a reference to past parts of the instructions (see appendix A).

When all subjects had completed the GAS procedure, they were randomly assigned to therapists. The interviews which ensued were conducted in small classrooms (one subject and therapist per room). The therapists were instructed to stay as much as possible in a client-centered mode throughout the sessions. Audio recordings were made of all sessions for purposes of rating therapist communicated empathy and depth of experiencing. It was originally hoped that each therapist would see two subjects, the
interviews running in tandem. Due to several therapists being absent, however, 17 therapists were employed yielding 13 cases of two subjects per therapist and four cases in which a therapist interacted with only one subject. The 30 sessions which resulted were considered to be examples of a first session in client-centered treatment.

Exactly one week after the sessions subjects re-examined their personal Goal Attainment Scales and checked off the appropriate level descriptive of their positive or negative progress regarding their split. The movement was assessed on both affective and behavioral criteria yielding scores with a possible range of from -4 to +4 for each criterion. The entire research process is diagramed below:

\[
\text{(one week pre-treatment) } \rightarrow \text{(morning of experiment) } \rightarrow \text{(one week post-treatment) }
\]

\[
\text{A } \rightarrow \text{B } \rightarrow \text{C } \rightarrow \text{D }
\]

administration of Focusing Q'aire \hspace{1cm} introduction to research and how to fill out GAS \hspace{1cm} client-centered experimental sessions \hspace{1cm} GAS follow-up & participant Q'aire

Figure 6. The Research Process.

Design

The design was correlational, due to the nature of the process being explored. Relationships among variables were examined by means of Pearson correlations in three distinct elements, 1) a general correlation matrix of the five primary and four secondary variables, 2) a specific analysis of the relationship between therapist communicated empathy and client depth of experiencing, and 3) sessions one by two comparison of the scores for the
three empathy measures.

In the first element, differences among correlations were tested for statistical significance by z-tests for dependent correlations. In the second element, the covariation of TCE and EXP was explored in two ways. First, every pair of TCE and EXP scores (257 segments in all, ergo 257 pairs) was entered into a correlation program, the purpose being to produce a coefficient based on as much data as possible. This procedure was somewhat biased inasmuch as some sessions contained more segments than others, but this was not considered a serious problem since over 50% of the sessions contained between eight and ten rateable segments.

Next an intriguing possibility was investigated. It was considered possible that communicated empathy's effect on experiencing could be of a latent nature (i.e. could have a delayed effect on experiencing). Perhaps the facilitative powers of TCE on EXP would not become evident until several minutes after the therapist had spoken. To test for this possible delayed effect, the EXP scores for the 257 TCE/EXP segments were staggered so that for each of the thirty sessions, the EXP scores were auto-correlated with the therapist communicated empathy score in the next time segment of the session, and then with the TCE score in the segment below that.

This staggering was then reversed. The EXP scores were moved up twice within each session's segments. This was done to explore another interesting possibility: perhaps client depth of experiencing was the causal element in the TCE/EXP relationship. It was assumed that a high magnitude of correlation at either level of staggering would suggest this.

Next the TCE and EXP scores in each of the thirty cases were graphed and examined for any consistent trends. Several were identified. The audio tapes of the sessions were then re-examined to gain subjective impressions regarding the nature of the trends (see Appendix B).
In addition, _t_ - tests were performed on the TCE and EXP scores from the 13 therapist who saw two subjects, comparing subject one to subject two to assess consistency on therapist experienced, communicated, and client received empathy scores across interviews. These scores were also correlated across the two subjects seen by each therapist. The _t_ - tests and the correlations were both employed in order to get closer to a clear understanding of therapist empathy as perceived by therapist, client, and independent rater, across clients.

The _t_ - tests indicate whether or not the therapist's performance is significantly different across subjects. Of course, if the tests do not yield significant results, it cannot be claimed that the two groups are the same. This is because the lack of significance could have been a result of differences among therapists which would mask all but very large differences for therapists across subjects.

The correlations were included to see whether variables that are found to be nonsignificantly different across subjects in fact are highly related in a correlational sense. If, for example, TCE is found to be nonsignificantly different across subjects by means of the _t_ - test, and if the TCE sessions one-by-two correlation is significant, these two pieces of information taken together would suggest a continuity of TCE level across subjects implying a therapist trait definition of TCE.
Scores for the five main and four secondary variables were intercorrelated, and the coefficients obtained are arrayed in Table 5. The only correlation among the three empathy phases that was significantly different from zero was the CRE by TCE correlation ($p < .05$). None of the empathy phases correlated significantly with outcome, but client received empathy was, as predicted, (hypotheses 2 and 6), the strongest outcome correlate among the phases. Also, as predicted (hypotheses 12 and 15), therapist communicated empathy was the strongest correlate of experiencing.

The therapist communicated empathy by client depth of experiencing correlation ($-.13$) was obtained by averaging empathy and experiencing scores within each experimental session, and then correlating these averages with the other measures, all of which also yielded one score per session. When all 257 therapist communicated empathy by experiencing scores were correlated, the coefficient was $.04$, also non-significant. The difference between this and the averaged sessional correlation was $.09$, a non-significant value.
Intercorrelations among the Empathy Phases,

Depth of Experiencing, Outcome, and Four Secondary Variables

n = 30

<table>
<thead>
<tr>
<th></th>
<th>TEE</th>
<th>TCE</th>
<th>CRE</th>
<th>EXP</th>
<th>TO</th>
<th>HRCC</th>
<th>HRTOT</th>
<th>VALCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>8.</td>
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<td>8</td>
</tr>
</tbody>
</table>

1. Therapist experienced empathy (TEE).
2. Therapist communicated empathy (TCE).
3. Client received empathy (CRE).
4. Depth of experiencing (EXP).
5. Treatment outcome (TO).
6. Hours of experience Client-centered (HRCC).
7. Hours of experience: total (HRTOT).
8. Therapist valuation of client-centered treatment (VALCC).

* p .05  + taken from intensive analysis of TCE/EXP relationships (n = 257)
** p .001  ++ taken from averaged TCE and EXP session scores.
Staggered Correlations of Therapist Communicated Empathy and Client Depth of Experiencing

When all the 257 segments were included in the TCE by EXP correlation, EXP scores were staggered two segments ahead and two back for each TCE segment score (e.g., the TCE score for segment three of a treatment session was paired with the EXP score for segment one, two, three, four, and five) yielding five separate TCE by EXP correlation coefficients. These are presented in Table 6.

### TABLE 6

<table>
<thead>
<tr>
<th>Experiencing scores</th>
<th>Correlation Coefficients</th>
<th>Number of Segments</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staggered back two</td>
<td>-.0142</td>
<td>197</td>
<td>.421</td>
</tr>
<tr>
<td>Staggered back one</td>
<td>.0098</td>
<td>227</td>
<td>.442</td>
</tr>
<tr>
<td>Direct</td>
<td>.0406</td>
<td>257</td>
<td>.217</td>
</tr>
<tr>
<td>Staggered ahead one</td>
<td>-.0027</td>
<td>227</td>
<td>.484</td>
</tr>
<tr>
<td>Staggered ahead two</td>
<td>.0247</td>
<td>197</td>
<td>.365</td>
</tr>
</tbody>
</table>

The direct phase of the staggering process, in which TCE and EXP scores from the same four-minute segment of an experimental session were interrelated, achieved a higher correlation than any of the staggered phases. However, none of the correlations, including the direct phase, achieved statistical significance at the .05 level. Therefore the data
indicate no latency of the effect of empathy on experiencing. As well, no suggestion is given that experiencing has a latent effect on communicated empathy.

Examination (Session One by Session Two) of the Three Empathy Phases and Depth of Experiencing

Twelve of the therapists interacted with two subjects, thus generating two scores on the empathy and other measures. These two scores were correlated, and the results are presented in Table 7. The only significant correlation was of TCE sessions one by two (p < .025). It is interesting that although the TCE scores generated by trained raters showed a significant relationship for therapists across subjects, therapist's own evaluations of their empathy and client perceptions of therapist empathy were not significantly correlated across subjects.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient</th>
<th>Z-Value</th>
<th>Alpha Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEE</td>
<td>.412</td>
<td>1.420</td>
<td>.150</td>
</tr>
<tr>
<td>TCE</td>
<td>.609</td>
<td>2.239</td>
<td>.025*</td>
</tr>
<tr>
<td>CRE</td>
<td>.359</td>
<td>1.190</td>
<td>.240</td>
</tr>
<tr>
<td>EXP</td>
<td>.177</td>
<td>.606</td>
<td>.790</td>
</tr>
</tbody>
</table>

* p < .05
The difference between the three empathy phases for therapists across their two subjects were further explored by subjecting scores to t-tests for dependent samples. The results of these tests are presented in Table 8. Only therapist experienced empathy (TEE) differed significantly from session one to session two. The information in Tables 7 and 8 is employed in the following chapter chiefly to examine construct definitions of the empathy phases.

**TABLE 8**

T-Tests for Therapist Experienced Empathy, Therapist Communicated Empathy, Client Received Empathy, and Client Depth of Experiencing.

<table>
<thead>
<tr>
<th>Variable</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEE</td>
<td>2.208*</td>
</tr>
<tr>
<td>TCE</td>
<td>.258</td>
</tr>
<tr>
<td>CRE</td>
<td>.047</td>
</tr>
</tbody>
</table>

* p < .05

**Results of Hypothesis Tests**

The 32 hypotheses of relationships among the three empathy phases, client depth of experiencing, and treatment outcome are restated below. Only hypotheses 4, 17, and 23 were significant at an alpha level of .05.
Formal Hypotheses

1. $r_{TO.CRE}$ will be significantly greater than $r_{TCE.CRE}$
2. $r_{TO.CRE}$ will be significantly greater than $r_{TO.TCE}$
3. $r_{TO.CRE}$ will be significantly greater than $r_{EXP.TO}$
4. $r_{TO.CRE}$ will be significantly greater than $r_{EXP.CRE}$
5. $r_{TO.CRE}$ will be significantly greater than $r_{TEE.CRE}$
6. $r_{TO.CRE}$ will be significantly greater than $r_{TEE.TO}$
7. $r_{TO.CRE}$ will be significantly greater than $r_{TEE.EXP}$
8. $r_{TO.CRE}$ will be significantly greater than $r_{TEE.TCE}$
9. $r_{EXP.TCE}$ will be significantly greater than $r_{CRE.TCE}$
10. $r_{EXP.TCE}$ will be significantly greater than $r_{TO.TCE}$
11. $r_{EXP.TCE}$ will be significantly greater than $r_{TO.EXP}$
12. $r_{EXP.TCE}$ will be significantly greater than $r_{CRE.EXP}$
13. $r_{EXP.TCE}$ will be significantly greater than $r_{TCE.TEE}$
14. $r_{EXP.TCE}$ will be significantly greater than $r_{TO.TEE}$
15. $r_{EXP.TCE}$ will be significantly greater than $r_{EXP.TEE}$
16. $r_{EXP.TCE}$ will be significantly greater than $r_{CRE.TEE}$

* $r_{CRE.TCE}$ will be significantly greater than $r_{TO.TCE}$
18. $r_{CRE.TCE}$ will be significantly greater than $r_{TO.EXP}$
19. $r_{CRE.TCE}$ will be significantly greater than $r_{CRE.EXP}$
20. $r_{CRE.TCE}$ will be significantly greater than $r_{TCE.TEE}$
21. $r_{CRE.TCE}$ will be significantly greater than $r_{TO.TEE}$
22. $r_{CRE.TCE}$ will be significantly greater than $r_{EXP.TEE}$

* $r_{CRE.TCE}$ will be significantly greater than $r_{CRE.TEE}$
24. $r_{TO.TCE}$ will be significantly greater than $r_{CRE.EXP}$
25. $r_{TO.TCE}$ will be significantly greater than $r_{TCE.TEE}$
26. $r_{TO.TCE}$ will be significantly greater than $r_{TO.TEE}$
27. $r_{TO.TCE}$ will be significantly greater than $r_{EXP.TEE}$
28. $r_{TO.TCE}$ will be significantly greater than $r_{CRE.TEE}$
29. $r_{CRE.EXP}$ will be significantly greater than $r_{TCE.TEE}$
30. $r_{CRE.EXP}$ will be significantly greater than $r_{TO.TEE}$
31. $r_{CRE.EXP}$ will be significantly greater than $r_{EXP.TEE}$
32. $r_{CRE.EXP}$ will be significantly greater than $r_{CRE.TEE}$

(* Indicates hypotheses that are significant at .05 (one-tailed test of significance)).
Since only three of the 32 pattern hypotheses have been confirmed, the pattern describing the causal interrelations among the variables (Figure 5) is not supported at the .05 level of significance. This lack of significance and its implications are discussed in the following chapter.

The pattern suggested by the relative magnitudes of the correlation coefficients, however, does merit discussion insofar as it coincides closely with a pattern found in the integrative summary of previous research.

Pattern Suggested by the Data

As was done earlier with correlation coefficients derived from previous research, the results of this study were examined for causal links or paths. Figure 7 represents the expected linear relationship among the variables. The dotted line represents the path derived by finding the strongest correlate of TO (in this case, CRE), locating the strongest predictor of CRE, and so on. It suggests that therapist understanding of client issues (TEE) leads to therapist empathic communications (TCE). TCE facilitates client received empathy which in turn is positively related to treatment outcome.

Again it is emphasized that only one of these correlational links, TCE by CRE, achieved statistical significance. Therefore this discussion of patterns suggested by the data is presented with the understanding that the patterns are only interpretable insofar as they relate to client-centered theory and extant research.
Figure 7. Path Arrangement of Data from the Main Analysis.
Depth of experiencing was positively related only to therapist communicated empathy (0.0406) and this correlation was non-significant (p = .259). Therefore the data do not confirm the expected importance of EXP in the client-centered therapy process as suggested by theory and previous research. This is presented in Figure 8.
Figure 8. Final Path Arrangement Derived from Study Data.
With the exception of the TCE - EXP interrelation, Figure 8 presents the same patterns illustrated in Figure 5. The pattern in Figure 5 was produced using correlation coefficients which represented summaries of past research. Therefore the results of the present study regarding the interrelation of empathy, experiencing, and outcome, although non-significant, present a pattern highly similar to the pattern derived from the summarized findings in the extant literature of client-centered therapy.

Qualitative Results: Descriptive Analysis of the Therapist Communicated Empathy by Client Depth of Experiencing Relationship

This section describes a qualitative analysis of the data derived from a visual examination of the 30 graphs generated by the experimental procedure (see Appendix B). Unlike other components of the data analysis which were focused on specific issues in the therapy process, this examination was purely exploratory. The object was to seek any pronounced patterns in the graphs and then to return to the original data tapes of the individual sessions to listen to the subject and therapist statements in order to generate possible explanations for the observed patterns.

Several patterns were discovered. They are fully described in the following paragraphs and are presented here with the other more quantitative data. All the information gained from the various data components will be referred to when discussing the results in following sections of the paper.

Divergence

A pattern occurring frequently was divergence of the levels of communicated empathy and experiencing as sessions progressed. This type of
deviation was operationally defined as a measurable shift of TCE and EXP (one point for the former, one-half point for the latter) away from each other. The shifting variables remained at their new levels for two or more four-minute segments. The divergence pattern was observed in the graphs of sessions 1.2, 8.13, 16.28, and 17.30*, and it appeared like the pattern illustrated below:

(\text{graph 1.1})

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{graph11.png}
\caption{Divergence Pattern}
\end{figure}

The tapes were examined with particular attention to the segment (indicated by parallel vertical lines) in which the divergence occurred. An example of the dialogue involved in and around the point of divergence is presented below in edited form:**

* The graphs are located in Appendix B; the first number indicates therapist, the second indicates subject.

** The elipses represent deletion of segments of the dialogue.
Session 1.2

S: ...this man wasn't doing his job...I complained to the manager...he fired him. Maybe I didn't give him enough time to prove himself...

TH: Kind of a feeling... what more can I do... could I have done...

S: He should have done better...not my fault, at least I don't think it's all my fault, is it...but still I'm unsettled...

TH: Maybe it's my fault, not his...I feel very guilty...

S: Everybody else though he did a bad job: it wasn't just me... I mean nobody likes being a heavy...being the one whose responsible for someone getting fired, but somebody has to...people should help one another...

TH: There's a feeling of...I don't want to be a real son-of-a-gun and have the guy out on the street with no job to get because of this...there's still a feeling of "what more can I do?"

S: Well, yes...people should be responsible for others...people should watch out for themselves.

This excerpt exemplifies the apparent cause of the divergence pattern with therapist communicated empathy ascending and client experiencing descending in the other three cases as well. The cause seems to be a therapist response that is perhaps too accurate, too incisive, too affectively
oriented for the client to handle immediately. This is experienced as a threat to which the subject reacts by retreating from personal material into vague generalities in hope of shaking off the attacker. This "too much too soon" phenomenon was the most clearly defined trend noticed in the tapes.

It has also been discussed by Carkhuff (1970) who wrote that the pattern is often characteristic of therapists who possess perhaps a minimum of empathic understanding for their client that they seek to compensate for by making reflections based on erroneous or insubstantial understanding of their client's issues.

In one case, 17.30, it appeared that the opposite of the "too much too soon" type of divergence occurred. In that case, empathy decreased while experiencing increased. Eventually experiencing dropped as empathy rose. The explanation in this case appeared to be "too little too soon"; initially high experiencing was brought down by low therapist communicated empathy. This pattern also was noted and discussed by Carkhuff, and is discernable in the following brief segments from the interview:

S: I'm tired of this line of study...unhappy...I want a change but...I'm afraid of my father's pressure...

TH: You're afraid.

S: I'm homesick...miss my family...want to return and work there now, but I can't without a degree...I'm very upset...

TH: You're very upset. You want to be able to help your family at home...

S: ...Well, I'm not sure...I'm confused...what do you want to know...
people want a happy family at home...

TH: Now how does that make you feel...I don't understand...

In this example the subject eventually succumbed to the low facilitative level therapist statements, ultimately lapsing into a confused interaction in which the session ceased being client-centered and became "therapist-centered", with the subject trying to help the therapist understand the content of their communications.

Another commonality noticed in a number of sessions (3.4, 3.5, 5.8, 5.9, 11.19, 12.21, 12.22, 12.24) was an initial high level of experiencing which almost immediately decreased. To a large extent this pattern may have been artifactual, resulting from subjects being instructed before the session to conceptualize their topic in terms of an incongruence or "split" described earlier. Subjects tended to verbalize these splits almost immediately in each interview.

To test for this artifact, all 30 first segments were removed from the data, and communicated empathy and experiencing were again correlated, resulting in a coefficient of .0601. The correlation coefficient originally generated with first segments in was .0405, and the difference between these two coefficients, .0202 was not significant when subjected to a $z$-test for dependent correlations.

Therefore, although over 34% (11 out of 30) of the sessions evidenced a one point or greater drop in the modal level of EXP, at the beginning of the session it was not empirically demonstrated that the EXP scores in the first segments of sessions induced an appreciable amount of error variance into the correlation of TCE and EXP.
A final phenomenon that has received attention in the client-centered therapy literature (Carkhuff, 1967; Rogers, 1951) appeared in graphs 8.13 and 8.14. Here experiencing remained low in the presence of barely adequate levels of therapist communicated empathy. In these sessions the therapist offered no structure, no guidance as to the appropriateness of the material presented by the subject, choosing instead simply to parrot subject statements in much the same words as used by a subject, a situation exemplified by the following statements taken from session 8.13:

S: I'm worried about the oil crisis...electrifying Canada's railroads is imperative...

TH: You seem disturbed about the fact that no one seems to be reacting to this crisis...

S: Electric railroads are highly efficient...they produce well over ten thousand horsepower...

TH: You sound impressed by that much horsepower...

Perhaps it was appropriate to stay with the subject's topic, but one cannot help but suggest that a more skillful and facilitative therapist could have focused the subject on more personally relevant material. The meaning of these subjective impressions and of the quantitative data will now be discussed in the light of the study expectancies and research questions.
In summary, the descriptive analysis has presented several patterns which suggest that certain therapist empathic behaviors may influence client depth of experiencing. This finding may seem contradictory to the low TCE/EXP correlations presented in the main analysis. In fact, there is no contradiction. The low correlations together with the patterns may be taken to imply that while communicated empathy in initial treatment sessions is not strongly related to EXP when received across subjects, there do exist instances in which TCE does in fact strongly influence experiencing. Perhaps TCE/EXP correlations taken from later sessions of client-centered therapy, when a deeper client-therapist relationship has been formed, would be more supportive for such a relationship. The possible bearing of the results of the study die to the first-session nature of the experimental sessions limits generalizability of the results to first sessions of client-centered treatment.
The purpose of this study is to present an overall statement of the client-centered treatment process by examining the interaction of empathy, experiencing, and outcome. Several issues related to the treatment process have also been presented. These issues will now be discussed in light of findings of this study. The information presented regarding the related issues will then be employed to describe the view of client-centered therapy that the results of the study suggest.

The nature of the construct empathy is first discussed since it encompasses the interaction of the three empathy phases and their relation to experiencing and outcome.

**Is empathy a unitary construct?**

Various measures of empathy may all be assessing the identical construct from different perspectives. They may alternately be measuring related but distinct constructs. This question was approached by examining the correlations among the three empathy measures (see Table 5). Results suggest that therapist experienced empathy is a distinct construct and that therapist communicated and client received empathy are separate but related constructs (see Figure 10 below). However, the degree of relatedness here is small (approximately 15% of the variance in these constructs is overlapping), and more extensive examination of the CRE/TCE relationship is needed to more concretely define the nature of their interrelation.
Figure 10: Relations among Empathy Phases from Data of the Present Study.

Their relationship is indexed by their significant positive correlation (0.38, p < .05). It could be assumed that if they were measuring the same process or construct, the correlations between them and process and outcome measure would be equivalent. Since this was far from the case (see Figure 3) it follows that communicated and client received empathy are two associated but different steps in the therapy process. These conclusions must be tempered by the low values of the correlation coefficients involved. The results presented here are, however, encouragingly similar to the findings of similar studies presented in Table 3 earlier. There again two patterns tell the story. The first is illustrated below:
Again therapist experienced empathy is isolated, with communicated and received empathy showing an affinity. The second pattern concerns the association of the three empathy measures with the process and outcome measures. It is illustrated in Figures twelve and thirteen below:

Figure 11: Relations among Empathy Phases from Summary Data of Previous Research.

Figure 12: The Relationship of the Three Phases of Empathy to Client Depth of Experiencing From Summary Data of Previous Research.
In these figures, it is again apparent that therapist experienced empathy remains distinct and that communicated and received empathy, though related, are nonetheless separate inasmuch as their associations with process and outcome are distinctly different. When the above two figures are reproduced with coefficients from this study, the important parallels are that communicated empathy is the strongest positive correlate of experiencing and client received empathy is the strongest positive correlate of treatment outcome.
However, several disparities between the integrated review and study data are also evident. One is the negative correlation (-.29) between client received empathy and experiencing appearing in the study analysis...
which contrasts strikingly with the coefficient of .27, a summary figure representing related research. The likely reason for the negative correlation is that the Barrett-Lennard Relationship Inventory tends to phrase items in such a way that they are more applicable to long-standing relationships than to brief encounters such as the experimental sessions that occurred in this study. The relationship between client received empathy and depth of experiencing in other studies is small at best (see Table 3), and this added error variance was perhaps responsible for obscuring an accurate quantification of the relationship.

Another anomaly is the .29 correlation between communicated empathy and treatment outcome in the integrated review table that shrank to the vanishing point (-.003) in the study data. Here the problem likely lies with the outcome measure in this study which was of a behavioral, action-oriented type. The basic problem here is that outcome, like empathy, is a confused construct, and the quantitative relationship between it and any process measure is dependent on their qualitative association. In other words, depth of experiencing, being related as it is to introspection, focus on affect, and in general to cognitive and affective rather than behavioral change, tends to correlate more highly with introspective, non-action-oriented outcome measures, such as the Tennessee Self-Concept Scale (Ashcraft & Fitts, 1964). This is not to say that one kind of outcome is necessarily superior to another. It merely highlights a problem encountered when one attempts to compare outcome results.

The communicated empathy/depth of experiencing correlation in the present study (r = .04) was noticeably smaller than the TCE/EXP correlation (r = .60) from the combined data of other studies (Table 3). Therapist
communicated empathy was, however, the strongest positive correlate of depth of experiencing in this study as well as in the studies summarized in Table 3. Again, a probable explanation for the difference in size of the coefficients was the first-session nature of the experimental treatment sessions. That is, perhaps as the therapeutic relationship matures, the TCE by EXP relationship is enhanced. If, in later sessions, the TCE and EXP levels increased, perhaps this heightened level of client and therapist involvement would result in a stronger positive correlation between communicated empathy and experiencing.

To summarize the issue which began this discussion, there appear to be two types of empathy, therapist communicated and client received. The former is the better predictor of psychotherapy process, the latter of treatment outcome.

**Therapist empathy: state or trait?**

The issue here is whether therapist empathy is primarily an ability applied with consistency by a therapist to all his clients, or an unstable relationship variable. The analysis components that address this question are the t-tests of the therapist experienced, communicated, and client received empathy scores between subjects one and two for each therapist (see Table 8). The results indicate that only therapist experienced empathy was significantly different for therapists between their subjects, and this indicates a state or relationship variable definition for this empathy phase. The reasoning is that if any of the empathy phases is dependent largely on interpersonal dynamics, it will tend to rate differently for each client seen by a given therapist. Conversely, a trait definition could be indicated by stable scores on empathy phase measures for particular therapists across clients.
The significant TCE session one by session two correlation \((p < .05)\) supports the motion that therapist communicated empathy may be consistent across clients. The client received empathy sessions one by two correlation was not significant, but the \(t\) - test showed no difference between the session scores for this variable. Client received and therapist communicated empathy are thus portrayed as more likely indicative of therapist traits than relationship variables.

However, any consistency of empathy measures for therapists across clients may be the result of therapists tending to communicate with clients in a very uniform "let's get to know each other" manner in first sessions of treatment. In that case, communicated empathy scores for therapists in first sessions across clients would understandably be homogeneous and only in later therapy hours would any substantial deviation in therapist empathic communication surface as the therapist adjusts to the unique individual he is treating.

Gurman (1973), in a study which examined three high and three low functioning therapists engaged in client-centered treatment with one client found that while variance of communicated empathy between and within sessions was considerable, the high and low therapists could still be distinguished by their communicated empathy performance profiles. The significant communicated empathy correlation for therapists across clients in the present study supports Gurman's findings, since it, too, suggests a degree of consistency for therapists on their general level of TCE.

The relationship of client perceptions of therapist understanding (client received empathy) for therapists across clients could also have been obscured by variables not accounted for in the present study. Again the possibility exists that the client may be describing some sort of "ideal therapist" in the first session, and that only later would received
empathy scores accurately reflect the nature and quality of the relationship. Kurtz and Grummon (1972), however, found significant consistency in CRE for client ratings of the third and final interviews of client-centered therapy.

To recapitulate, the data suggest that therapist communicated and client received empathy are relatively stable across clients indicating a trait empathy definition for phase two and phase three empathy.

**Empathy: What is the Most Useful Operational Definition?**

Several "answers" emerge from Table 3 (the integrative summary) and from Table 5 (the study data). They are based on one premise: that a useful operational definition is one that enables a variable to be measured in such a way that it can be utilized to predict related variables. Therefore therapist behavioral variables such as experienced, communicated, and client received empathy are only of value inasmuch as they are able to predict process and/or outcome.

In the light of this premise, therapist communicated empathy emerges as the strongest positive predictor of depth of experiencing. Thus the Carkhuff Accurate Empathy Scale is considered the more accurate predictor of experiencing.

In the same way, client received empathy is the strongest correlate of treatment outcome, inferring that the client's perceptions of empathy are the strongest prognosticators of measured outcome.

It is recognized that the size of the empathy-by-process-by-outcome, correlations is small and thus any conclusions based upon it are inconclusive. The data arrayed from previous studies in Table 3 do, however, lend support and credibility to the study findings in that there too one
finds communicated empathy the most powerful predictor of depth of experiencing, and client received empathy the strongest predictor of treatment outcome.

Client Depth of Experiencing: State or Trait?

This question would be best answered by a longitudinal study examining trends of experiencing in subjects across a number of sessions. Consistent levels or trends among subjects would indicate a trait definition, while varying levels and patterns would point more toward a state or relationship variable. The data presented here can address this issue by examining the variation of depth of experiencing in the sessions and the correlations between the empathy measures and experiencing. If experiencing were a relationship variable one would expect to see a moderate to strong positive correlation between it and therapist behavior as measured by the three empathy tests. As evidenced by the low, non-significant TCE by EXP correlation of .04. This was not the case, as well, examination of the shifts in experiencing within experimental sessions showed that 80% of these were of only one point, the smallest possible increment of change on the experiencing scale, and 17% were shifts of two points.

On the basis of these tenuous results, notably the TCE by EXP correlation, it appears that the level of experiencing stood relatively steady and immutable in the face of shifts in therapist empathy within experimental sessions. This study therefore fails to indicate a definition of experiencing as relationship variable that is significantly under the control of the therapist by means of his empathic reflections. This conclusion is supportive of the results of other researchers who examined experiencing trends across sessions (Kiesler, Mathieu, & Klein, 1967;
Klein, Gendlin, & Kiesler, 1969; Tomlinson & Hart, 1962). The only significant change in experiencing these researchers discovered was a variation of the level of overall experiencing corresponding to degree of pathology; the more severe the pathology, the lower the overall EXP level. It therefore seems that other studies of the client-centered process as well as this one indicate a predominately trait definition of depth of experiencing.

However, several studies relating Gestalt treatment techniques to client depth of experiencing have demonstrated the EXP can be significantly influenced by therapist interventions (Clarke, 1977; Greenberg, 1976). These findings point to a state or relationship variable definition of EXP, thus posing an apparent controversy in the literature, a controversy further complicated by findings in client-centered studies which show positive and significant relationships between communicated empathy and experiencing (Rogers et al., 1967; van der Veen, 1965).

In view of the contradictory findings described above, the answer to the state/trait issue regarding depth of experiencing must be held in abeyance until future research can establish some consistent findings. The most promising vein of research at present is examining changes in experiencing within sessions as a result of varied therapeutic intervention techniques (Clarke, 1977; Greenberg, 1976). The ultimate answer to the nature of client depth of experiencing probably lies in studies such as these.

How is Client Process Best Predicted?

The literature has supported therapist communicated empathy, usually as measured by the Carkhuff or Truax scales, as the empathy phase that is most
highly correlated with client depth of experiencing (Kurtz & Grummon, 1974; Rogers et al., 1967; van der Veen, 1965). TCE was the strongest positive correlate of EXP in this study, but the magnitude of the correlation (.04) is not great enough to lead to any solid conclusions. Again, it may well have been the first-session nature of the experimental interviews that surpressed the TCE by EXP relationship.

A noteworthy point here is that although correlation does not necessarily denote causation, the two variables correlating significantly can be an indicator that they are somehow causally related. The fact that several studies cited above have demonstrated significant correlations between therapist communicated empathy and client depth of experiencing could therefore suggest an element of causation existing between them. This is mentioned here inasmuch as if experiencing were in fact a client trait, therapist interventions such as empathic reflection would have little relation to it. Therefore, the fact that some studies have shown a positive and significant TCE/EXP correlation is in a logical sense indicative of a definition of experiencing as a relationship variable influenced by communicated empathy or some other concomitant therapist behavior. These studies possibly are more accurately portraying the true nature of the TCE/EXP relationship since they measured the variables farther on in treatment, when a deeper relationship had developed.

**How do Empathy and Experiencing Interrelate?**

The data from this study do not indicate that any of the three empathy measures is strongly, positively related to experiencing. The extensive analysis, however, does show a small positive correlation between communicated empathy and experiencing (.04). The intensive analysis results...
are also notable in that they fail to support the possibility that depth of experiencing causes empathy. This would have been suggested by a significant TCE/EXP correlation when TCE scores were correlated with EXP scores from segments earlier in the sessions. This did not occur, implying that clients generally had little effect on the communicated empathy of their therapists in the experimental sessions.

How is Treatment Outcome Best Predicted?

This is not an outcome study, but an answer is suggested by the data, an answer which meshes with the findings of studies presented in the integrative summary; that client received empathy, or the client's perception of the therapist's empathic ability, is the variable most highly predictive of the results of therapeutic intervention.

This finding reaffirms the findings of previous research (Barrett-Lennard, 1962; Bergin and Suinn, 1975; Kurtz and Grummon, 1974). As well, the significant TCE/CRE correlation in this study suggests that client perceptions of therapist empathy as measured by the Barrett-Lennard Relationship Inventory are to a large extent based on a therapist's empathic verbalizations as operationally defined by the Truax empathy scale. The fact that the TCE and EXP do not correlate perfectly is probably due largely to the fact that when a client perceives a therapist as being empathic, he is probably receiving cues of this empathy that are non-verbal. For example, therapist eye contact, posture, and related kinesic cues are probably involved.
What is the Overall Statement of Client-Centered Therapy Process Supported by the Study?

Empathy was not shown to be a significant predictor of outcome in this study. However, similar research has often shown that empathy accounts for a significant proportion of the variance of the results of client-centered therapy.

The three phases of empathy, therapist experienced, therapist communicated, and client-received empathy, are shown to relate to one another (the TCE/CRE correlation was significant at .05), but they correlated differentially with depth of experiencing and treatment outcome. These findings imply that the empathy phases are related but distinct constructs.

Examination of the three empathy scores for each therapist across subjects supports a trait definition of communicated empathy with a significant across-client correlation. Client received empathy across-client scores were not significantly correlated, and across-client t-tests showed no significant subjects one-by-two differences. The data therefore do not conclusively show that CRE is a relationship variable. This is most likely due to the first session nature of the experimental interviews. That is, it is possible that non-significantly different CRE scores for therapists across their two subjects were the result of client expectancies or stereotypic views of their therapists. Perhaps only in later therapy sessions would client statements reflect a true image of the therapeutic relationship, after the client would have had the opportunity to get to know the therapist more fully. This first-session situation was the strongest limitation of the study.

Client received empathy is the strongest predictor of outcome, a consistent finding across studies, suggesting that client perceptions of a
therapist's understanding are more valuable prognosticators of success than judgements of the therapists themselves or of outside raters.

Client depth of experiencing is not positively and significantly related to empathy or outcome measures. As predicted, therapist communicated empathy is the empathy phase that related most highly to EXP, but the correlation value is non-significant. This implies that EXP is a client variable not powerfully influenced by therapist interventions. A content analysis of the TCE/EXP relationship in each of the 30 experimental sessions, however, indicates that there may be specific instances in which TCE and EXP are causally related. Overall, the data coincide with a majority of related research presenting depth of experiencing as predominately a client trait variable.

In toto this study suggests that, within first sessions of Client-Centered treatment, therapist empathic communications are related to the client perceptions of the therapist's empathic ability. These perceptions in turn positively influence treatment outcome. Changes in client depth of self-experiencing may also be affected to a minor degree by therapist communicated empathy, but EXP does not appear to powerfully affect the treatment process at this early stage.

The Role of Congruence

Thus far this study has focused on empathy as the prepotent core condition in the client-centered therapy process. However, Rogers and Truax (1967) and Barrett-Lennard (1962) also stressed the importance of client perceptions of therapist congruence in treatment.
Client-received congruence (CRC) refers to the degree to which one person is functionally integrated in the context of the relationship with another, such that there is absence of conflict or inconsistency between his total experience, his awareness, and his overt communication...the highly congruent individual is completely honest, direct, and sincere in what he conveys, but he does not feel any compulsion to communicate his perceptions, or any need to withhold them for emotionally self-protective reasons... Direct evidence of lack of congruence includes, for example, inconsistency between what the individual says, and what he implies by expression, gestures, or tone of voice. Indications of discomfort, tension, or anxiety are considered to be less direct but equally important evidence of lack of congruence. (Barrett-Lennard, 1962, p. 4).

The central role of CRC in therapy process is seen by Barrett-Lennard (1962) as establishing an upper limit to the degree to which empathic understanding of another is possible... (and) the degree to which an individual can actually respond unconditionally to another is considered a function of his security and integration in relation to the other... lack of congruence implies threat and defensiveness and this would tend to reduce overall regard (p. 5).
Since congruence can be defined as exerting a limiting or enhancing effect on therapist empathy, it was included in this study to enhance the completeness of the description of Client-Centered treatment.

Client received congruence as well as client received empathy is measured by the BLRI. Examples of BLRI items assessing CRC are:

_____ is comfortable and at ease in our relationship.

I feel that _____ puts on a role or front for me.

Since all 30 subjects completed the BLRI, data was available for CRC, and these data were analyzed to examine relationship of CRC to therapist communicated empathy (TCE), client received empathy (CRE) and treatment outcome (TO). CRC ratings of therapists by their two subjects were also examined by means of a t - test for dependent samples. As well, a t - test was performed on the CRC and CRE scores for each therapist. This analysis of congruence was added post hoc to the study to provide additional information to more thoroughly describe the client-centered therapy process. The results of these analyses are summarized below:

TABLE 9
Correlations among CRC, TCE, CRE, and TO

<table>
<thead>
<tr>
<th></th>
<th>TCE</th>
<th>CRE</th>
<th>TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRC</td>
<td>-.03</td>
<td>.72*</td>
<td>.09</td>
</tr>
</tbody>
</table>

* p < .0001
### TABLE 10

<table>
<thead>
<tr>
<th>Variables</th>
<th>t-value (dependent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRC x CRE</td>
<td>-0.12</td>
</tr>
<tr>
<td>CRC (subject one)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>0.54</td>
</tr>
<tr>
<td>(subject two)</td>
<td></td>
</tr>
</tbody>
</table>

The correlation between client received congruence and client received empathy is high (r<.72) and significant (p<.0001). This index of relationship between the two variables could be interpreted either to mean that CRC and CRE are tapping the same variable or highly related but distinct variables in the therapeutic process. This interpretation can be addressed by diagramming the interrelationships among CRC, CRE, TCE, and TO.
Figure 16: The Interrelationships among Therapist Communicated Empathy, Client Received Congruence, Client Received Empathy, and Treatment Outcome.

Figure 16 shows that the TCE by CRC and the TO by CRC correlation coefficients are significantly different (p < .05); and that the TO by CRC and TO by CRE coefficients also differ, although non-significantly (p < .10). This pattern suggests that client perceptions of empathy and congruence are highly similar, but that clients are nonetheless perceiving two separate therapist qualities. The result of the t-test of CRE by CRC is supportive of the above conclusions inasmuch as the scores for subjects on the two variables were not significantly different.

These findings support the position of Barrett-Lennard (1962) that therapist congruence is related to client perceptions of therapist empathy. However, the data are correlational and therefore cannot prove this definitively. Research is indicated that would vary the level congruence in a controlled, systematic fashion, and observe changes on empathy and outcome.
Limitations

A primary limitation of this study was the small n, a necessary condition in view of the amount of rater hours involved in assessing TCE and EXP. It was predicted that a ratio of thirty subjects for five main variables would furnish sufficient power to achieve strong correlational results. This prediction proved to be optimistic. It appears that enough error variance was present in the design to weaken the results.

Another limitation was the "first session" nature of the experimental sessions. It seems that even when subjects have a prepared topic to discuss, it may well take more time to establish a therapeutic relationship of the type intended by Rogers. Perhaps only in later sessions do client and therapist shed their stereotypic behaviors and begin to interact meaningfully.

The treatment outcome measure, Goal Attainment Scaling, also presents itself as being susceptible to reactivity inasmuch as simply the act of mapping out the affective and behavioral steps toward getting better can be of itself an effective treatment (Kelley, 1976; Kiresuk and Sherman, 1968).

Another problematic instrument is Carkhuff's scale for measuring communicated empathy. Truax (1972) has shown that communicated empathy ratings with and without client statements present are not significantly different. Rappaport and Chinsky (1972) have raised the issue that if Truax's findings are representative of the use of empathy rating scales in general, it would be possible for therapists to achieve high communicated empathy ratings by simply reciting from memory statements possessing characteristics of high ratings on an accurate empathy scale without even considering the content of client communications. In the light of this research, it is certainly
possible that communicated empathy scales are measuring a therapist quality best described as a skill in uttering words and phrases that sound empathic but are not necessarily accurate reflections of their client's thoughts and feelings.

Another issue regarding limitations is: did the experimental sessions provide an accurate analog of the actual client-centered therapy process? Klein et al., (1969) considered productive therapy to be happening when levels four through seven on the experiencing scale are achieved in treatment. In the present study, segments with peak ratings at these EXP levels comprised 23% of the total number of segments, and seventeen out of the thirty clients achieved levels of experiencing at or over level five. One could make the case that in the other thirteen sessions productive therapy was not really occurring. This may have been true, but even if it were, it would not necessarily follow that the relationships among the empathy and experiencing variables were any different. That is, even in situations where the EXP level was low, the interrelation of empathy, experiencing, and outcome is likely to be essentially identical to the interrelation occurring when EXP levels are high. At any rate, this is an empirical question which is not answered in the literature.

Overall, the experimental sessions are considered to be acceptable analogs of initial sessions of client-centered treatment since 60% of the subjects achieved EXP scores at or over level four, 60% of the therapists achieved TCE scores over level three (the minimum facilitative level), all therapists acted in a reflective manner, and all subjects discussed issues of personal incongruence.

A final comment regarding the relatively small magnitude of the correlations among the variables involved in this study is that the three empathy phases alone certainly do not account for the majority of the
variance in client depth of experiencing or treatment outcome.

A large variety of other variables such as severity of problem, client willingness to change, and amenability to treatment method account for the rest of the variance. In fact, Moos and MacIntosh (1970), conducted a study of the therapy process and found that empathy accounted for only 30% of the variance of treatment outcome. Therefore it is not unreasonable to expect small correlations when only three of these many predictors of therapy process and outcome are assessed.
CHAPTER SIX
Conclusion

This study has depicted empathy as being most accurately defined operationally as two related but distinct constructs, therapist communicated and client-received empathy, each possessing unique qualities and predictive powers. This finding is not unique, but rather represents a reaffirmation of similar findings in recent literature. The importance of this study lies mainly in its within-session focus on the five salient variables in the therapy process, a departure from similar studies dealing with the same topic which have tended to be macroscopic or longitudinal in nature, taking less frequent measures of the five variables.

This study arose out of a perceived need to parallel these broad, naturalistic studies of the client-centered therapeutic process in in vivo situations with analog research which kept constant treatment method, duration, and problem type, and which employed a more individually tailored, action-oriented measure of change.

The contradictory findings in this and similar studies attest to the confused nature of the client-centered process (and the variables involved in it) under study. Each piece of research is able only to distill a part of the truth about the therapeutic process, but an integration of the research does add up to some inescapable conclusions.

Regarding the issue of whether empathy is a state or a trait, this study along with a majority of others in the current literature favors the conceptualization of empathy as having two phases, therapist communicated and client received empathy, and this study defines both of these as being relatively stable for therapists across clients.

Therapist experienced empathy, the weakest of the empathy phases in
a predictive sense, has been at best a measure of dubious value from its inception (Barrett-Lennard, 1962), and this study further undermines its usefulness. Therapists seemed to have some idea of how much their verbalizations sounded empathic ($r_{tce/tee} = .22$ (NS)), but no conception at all as to how their words were received by clients ($r_{cre/tee} = -.12$ (NS)). In fact, in some cases it was apparent that those with the highest ratings from clients gave themselves equally low ratings, while in several other cases the converse appeared.

Similar findings were reported by Rogers in the Wisconsin Study (1967). He wrote:

> It is a sobering finding that our therapists, competent and conscientious as they were, had over-optimistic and in some cases seriously invalid perceptions of the relations in which they were involved (Rogers et al., 1967, p. 92).

The inaccuracy of these perceptions is likely due in large part to therapists basing their ratings on either a comparison of their actual and ideal performance or on an "effort" scale reflecting how hard they tried to be empathic. These and other similar biasing factors are essentially unavoidable in any self-rating scale of performance.

The importance of depth of experiencing as a variable describing the internal process the client engages in as a mediator between therapist intervention and treatment outcome has not been reaffirmed in this study. This result, however, may have been artifactual inasmuch as perhaps the therapeutic relationship must be allowed to mature and deepen over a greater number of therapy sessions for the empathy-experiencing interrelation to achieve its maximum potency.
A final comment on the causal linkage between experiencing and therapist communicated empathy is that, after listening to many hours of therapy, it is subjectively apparent that the causal forces can flow both ways; from therapist to client in some cases and vice versa in others. This is affirmed by van der Veen's finding in a similar study that "both client and therapist significantly influenced each other's behavior" (van der Veen, 1965, p. 6).

In other words, insightful therapist reflections in some cases brought about increased self-exploration by subjects, while at other times it was the therapist whose level of empathic communication seemed to be elevated by a client whose statements were rich with self-description and affect.
Implications

Theory

The clinical importance of empathy has not been reaffirmed at a significance level of .05. However, of the three empathy phases (therapist experienced, therapist communicated, and client received empathy), client received empathy was the strongest positive correlate of treatment outcome. Thus the findings support Roger's initial hypothesis (1951) that the client's perception of the therapist's empathic understanding is one of the crucial conditions for change in psychotherapy. This runs counter to Truax and Carkhuff (1967) who stated that the client often misperceives therapist empathy, leaving tape-judged or therapist communicated empathy as the preferred empathy measure.

It could thus be concluded that whatever it is that communicates empathic understanding to the client, it is not simply high-rated verbal behavior as measured by the Carkhuff Accurate Empathy Scale. If it were, the TCE/CRE correlation would probably have been much higher. It can only be assumed that the empathic communication as measured by the rating scale is but one component of total empathic communication, other components perhaps being variables such as eye contact, voice quality, and kinesic responses.

Therapist communicated empathy seems to be viewed less and less often as the focal point for measuring empathy in therapy. As Rogers wrote:

The method (of rating empathy from audio tapes of therapy sessions) was open to the pitfalls of a rather wooden imitation, a sort of formula behind which a frightened, or conflicted, or uninvolved therapist could hide. The reflection formula of "you feel..." might look good on a tape transcript, but in action it could vary from a deep response to an artificial front (Rogers et al., 1967, p. 10).
Practice

This highlighting of client received empathy and downplaying of communicated empathy in empathy assessment has definite implications for therapist training, since many graduate programs, particularly those in counseling psychology, are heavily committed to nurturing empathic ability in trainees, often requiring moderate to high proficiency in communicated empathy as a criterion for completion of the program or as an indication of counselling expertise.

The empathy measure of choice in assessing trainee performance has been the tape rating scale popularized by Carkhuff and Truax, but it appears improbable that this is the most meaningful way of measuring therapeutic skill. It is suggested that the augmentation of these scales with the Barrett-Lennard Relationship Inventory as the empathy measure would yield performance, profiles based less on acquired ability to parrot a certain style of communication and more on a genuine skill of understanding the client and communicating this understanding in a lucid manner. Emphasis on client perceptions rather than on stereotyped therapist verbal performance could free the trainee from the restraints of the stylized reflective mode of responding, allowing him to explore less orthodox means of expressing his inner understanding of the client.

Levels of CRE have been shown to change throughout the course of client-centered counselling (Kurtz and Grummon, 1974). Therefore, frequent assessments of client received empathy in ongoing treatment could provide the therapist with a powerful barometer of his effectiveness as a facilitator of change. On the basis of the information he would obtain, the therapist could take positive steps toward enhancing the counselling relationship, such as altering his treatment methods or communication style. The communicated and client received
empathy ratings could also be openly discussed with the client, both as a means to help the therapist function more effectively and as an aid to the client in getting in touch with his expectations and desires regarding the therapist and the treatment process.

Research

This study has presented the within-session format as a valuable means of examining the client-centered process.

Future studies could benefit from application of this focused analysis of therapy sessions by examining sessions from the middle and end of treatment as well as the beginning to see if relationships among variables are constant at these various points. Such investigations would perhaps show that the strongest predictors of client movement vary as treatment progresses. Maybe, for example, therapist communicated empathy and depth of experiencing are more highly correlated at the middle-point of treatment than at the beginning or end.

Another interesting avenue of study would be to measure therapists on empathy measures across many clients, a process that would probably clarify the state/trait definitions of the phases of the construct.

The exact nature of therapist communicated empathy should also be explored, perhaps by open-ended inquiry into what cues clients interpreted as indicators of empathic communications.

A final and most emphatic recommendation is that more attempts should be made to quantitatively summarize the vast amount of data regarding the client-centered treatment process. Table 3 in this text is a simple example of such a quantitative summary. It was inspired by a thorough, elaborate methodology devised by Glass (1976) called meta-analysis. Using these
techniques, Glass was able to perform statistical operations to compare the curative powers of various psychotherapeutic treatments by summarizing hundreds of relevant studies.

It is apparent that meta-analysis of the salient variables in client-centered treatment could serve the valuable function of pulling together the vast quantity of exact data and distilling from it a solidly based model of the therapeutic process. The application of meta-analysis to one theoretical formulation of psychotherapy process such as the client-centered model would probably result in a powerful, authoritative picture of the process since the studies from which results would be drawn would have employed very similar measures to quantify essentially the same variables.

Summary

Empathy as it relates to therapy process and outcome has been the focus of one of therapeutic psychology's most fruitful and exciting veins of research. For a long time, the findings have been accumulating but have not been cumulative. This study and similar recent research has, however, been integrating past results, and has caused them to begin maturing into consistent and useful information for the psychotherapist.
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APPENDIX A

COMPILATION OF MEASURES

AND

SCALES
SCALE 1:

EMPATHIC UNDERSTANDING IN INTERPERSONAL PROCESSES

A SCALE FOR MEASUREMENT

Level 1: The verbal and behavioural expressions of the helper either do not attend to or detract significantly from the verbal and behavioural expressions of the helpee (2) in that they communicate significantly less of the helpee's feelings and experiences than the helpee has communicated himself.

Example: The helper communicated no awareness of even the most obvious, expressed surface feelings of the helpee. The helper may be bored or disinterested or simply operating from a preconceived form of reference which totally excludes that of the helpee(s).

In summary, the helper does everything but express that he is listening, understanding, or being sensitive to even the most obvious feelings of the helpee, and does so in such a way as to detract significantly from the communications of the helpee.

Level 2: While the helper responds to the expressed feelings of the helpee(s), he does so in such a way that he subtracts noticeable affect from the communications of the helpee.

Example: The helper may communicate some awareness of obvious surface feelings of the helpee, but his communications drain off a level of the affect and distort the level of meaning. The helper may communicate his own ideas of what may be going on, but these are not congruent with the expressions of the helpee.

In summary, the helper tends to respond to something other than that which the helpee is expressing or indicating.

Level 3: The expressions of the helper in response to the expressions of the helpee (2) are essentially interchangeable with those of the helpee in that they express the same affect and meaning.

Example: The helper responds with accurate understanding of the surface feelings of the helper but may not respond to or may misinterpret the deeper feelings.

In summary, the helper is responding so as to neither subtract nor add to the expressions of the helpee. He does not respond accurately to how that person really feels beneath the surface feelings, but he indicates a willingness and openness to do so. Level III constitutes the minimal level of facilitative interpersonal functioning.
Level 4: The responses of the helper add noticeably to the expressions of the helpee(s) in such a way as to express feelings at a level deeper than that with which the helpee was able to express himself.

Example: The helper communicates his understanding of the expressions of the helpee at a level deeper than they were expressed and thus enables the helpee to experience and/or express feelings he was unable to express previously.

In summary, the helper's responses add deeper feeling and meaning to the expressions of the helpee.

Level 5: The helper's responses add significantly to the feeling and meaning of the expressions of the helpee(s) in such a way as to accurately express feelings some levels below that which the helpee himself was able to express, or, in the event of on-going, deep self-exploration on the helpee's part, to be fully with him in his deepest moments.

Example: The helper responds with accuracy to all of the helpee's deeper as well as surface feelings. He is "tuned in" on the helpee's wave length. The helper and the helpee might proceed together to explore previously unexplored areas of human existence.

In summary, the helper is responding with a full awareness of who the other person is and with a comprehensive and accurate empathic understanding of that individual's deepest feelings.

---

### Short Form of EXP Scale

<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; behavioral or intellectual self-description.</td>
<td>Interested, personal, self-participation.</td>
</tr>
<tr>
<td>3</td>
<td>Personal reactions to external events; limited self-descriptions; behavioral descriptions of feelings.</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, elaborative, 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 affirmative.</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>
Below are listed a variety of ways that one person may feel or behave in relation to another person.

Please consider each numbered statement with reference to your present relationship with _______________, mentally adding his or her name in the space provided. For example, if the other person's name was John, you would read statement #1, as 'John respects me as a person'.

Mark each statement in the answer column on the right, according to how strongly you feel that it is true, or not true, in this relationship. Please be sure to mark every one. Write in +3, +2, +1, or -1, -2, -3, to stand for the following answers:

+3: Yes, I strongly feel that it is true.
+2: Yes, I feel it is true.
+1: Yes, I feel that it is probably true, or more true than untrue.
-1: No, I feel that it is probably untrue, or more untrue than true.
-2: No, I feel it is not true.
-3: No, I strongly feel that it is not true.

**ANSWER**

1. ______ respects me as a person
2. ______ wants to understand how I see things
3. ______'s interest in me depends on the things I say or do
4. ______ is comfortable and at ease in our relationship
5. ______ feels a true liking for me
6. ______ may understand my words but he/she does not see the way I feel
7. Whether I am feeling happy or unhappy with myself makes no real difference to the way ______ feels about me
8. I feel that ______ puts on a role or front with me
9. ______ is impatient with me
10. ______ nearly always knows exactly what I mean
11. Depending on my behaviour, ______ has a better opinion of me sometimes than he/she has at other times

* Combines Forms OS-M-64 and OS-F-64
12. I feel that ___ is real and genuine with me.

13. I feel appreciated by ___.

14. ___ looks at what I do from his/her own point of view.

15. ___'s feeling toward me doesn't depend on how I feel toward him/her.

16. It makes ___ uneasy when I ask or talk about certain things.

17. ___ is indifferent to me.

18. ___ usually senses or realises what I am feeling.

19. ___ wants me to be a particular kind of person.

20. I feel that what ___ says usually expresses exactly what he/she is feeling and thinking at that moment.

21. ___ finds me rather dull and uninteresting.

22. ___'s own attitudes toward some of the things I do or say prevent him/her from understanding me.

23. I can (or could) be openly critical or appreciative of ___ without really making him/her feel any differently about me.

24. ___ wants me to think that he/she likes me or understands me more than he/she really does.

25. ___ cares for me.

26. Sometimes ___ thinks that I feel a certain way, because that's the way he/she feels.

27. ___ likes certain things about me, and there are other things he/she does not like.

28. ___ does not avoid anything that is important for our relationship.

29. I feel that ___ disapproves of me.

30. ___ realises what I mean even when I have difficulty in saying it.

31. ___'s attitude toward me stays the same: he/she is not pleased with me sometimes and critical or disappointed at other times.

32. Sometimes ___ is not at all comfortable but we go on, outwardly ignoring it.

33. ___ just tolerates me.

34. ___ usually understands the whole of what I mean.
If I show that I am angry with ____ he/she becomes hurt or angry with me, too.

____ expresses his/her true impressions and feelings with me.

____ is friendly and warm with me.

____ just takes no notice of some things that I think or feel.

How much ____ likes or dislikes me is not altered by anything that I tell him/her about myself.

At times I sense that ____ is not aware of what he/she is really feeling with me.

I feel that ____ really values me.

____ appreciates exactly how the things I experience feel to me.

____ approves of some things I do, and plainly disapproves of others.

____ is willing to express whatever is actually in his/her mind with me, including personal feelings about either of us.

____ doesn't like me for myself.

At times ____ thinks that I feel a lot more strongly about a particular thing than I really do.

Whether I happen to be in good spirits or feeling upset does not make ____ feel any more or less appreciative of me.

____ is openly himself/herself in our relationship.

I seem to irritate and bother ____.

____ does not realise how sensitive I am about some of the things we discuss.

Whether the ideas and feelings I express are "good" or "bad" seems to make no difference to ____'s feeling toward me.

There are times when I feel that ____'s outward response to me is quite different from the way he/she feels underneath.

____ feels contempt for me.

____ understands me.

Sometimes I am more worthwhile in ____'s eyes than I am at other times.
56. ____ doesn't hide anything from himself/herself that he/she feels with me.

57. ____ is truly interested in me.

58. ____'s response to me is usually so fixed and automatic that I don't really get through to him/her.

59. I don't think that anything I say or do really changes the way ____ feels toward me.

60. What ____ says to me often gives a wrong impression of his/her total thought or feeling at the time.

61. ____ feels deep affection for me.

62. When I am hurt or upset ____ can recognise my feelings exactly, without becoming upset too.

63. What other people think of me does (or would, if he/she knew) affect the way ____ feels toward me.

64. I believe that ____ has feelings he/she does not tell me about that are causing difficulty in our relationship.

Please also provide the following information about yourself and the other person.

<table>
<thead>
<tr>
<th>Yourself</th>
<th>Other Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>____ years</td>
</tr>
<tr>
<td></td>
<td>____ years (known or estimated)</td>
</tr>
<tr>
<td>Sex:</td>
<td>____ (M or F)</td>
</tr>
<tr>
<td></td>
<td>____ (M or F)</td>
</tr>
<tr>
<td>Occupation:</td>
<td>___________</td>
</tr>
<tr>
<td></td>
<td>___________</td>
</tr>
<tr>
<td>Position in this relationship:</td>
<td>Son</td>
</tr>
<tr>
<td></td>
<td>___________</td>
</tr>
<tr>
<td></td>
<td>___________</td>
</tr>
<tr>
<td>Examples:</td>
<td>Client/or patient</td>
</tr>
<tr>
<td></td>
<td>Counsellor (therapist)</td>
</tr>
<tr>
<td></td>
<td>Friend</td>
</tr>
<tr>
<td></td>
<td>(Best) Friend</td>
</tr>
<tr>
<td>Actual:</td>
<td>(Please fill in)</td>
</tr>
<tr>
<td></td>
<td>___________</td>
</tr>
<tr>
<td></td>
<td>___________</td>
</tr>
</tbody>
</table>
RELATIONSHIP INVENTORY--FORM MO--64

Below are listed a variety of ways that one person may feel or behave in relation to another person.

Please consider each statement with reference to your present relationship with __________, mentally adding his or her name in the space provided. If, for example, the other person's name was John, you would read statement #1 as 'I respect John as a person'.

Mark each statement in the left margin, according to how strongly you feel that it is true, or not true, in this relationship. Please mark every one. Write in +3, +2, +1, or -1, -2, -3, to stand for the following answers:

+3: Yes, I strongly feel that it is true.
+2: Yes, I feel it is true
+1: Yes, I feel that it is probably true, or more true than untrue.
-1: No, I feel that it is probably untrue, or more untrue than true.
-2: No, I feel it is not true.
-3: No, I strongly feel that it is not true.

1. I respect _______ as a person.
2. I want to understand how _______ sees things.
3. The interest I feel in _______ depends on the things he/she says or does.
4. I feel at ease with _______.
5. I really like _______.
6. I understand _______'s words but do not know how he/she actually feels.
7. Whether _______ is feeling pleased or unhappy with himself/herself does __ change my feeling toward him/her.
8. I am inclined to put on a role or front with _______.
9. I do feel impatient with _______.
10. I nearly always know exactly what _______ means.
11. Depending on _______ 's actions, I have a better opinion of him/her sometimes than I do at other times.
12. I feel that I am genuinely myself with ________.

13. I appreciate ________, as a person.


15. The way I feel about ________ doesn't depend on his/her feelings toward me.

16. It bothers me when ________ tries to ask or talk about certain things.

17. I feel indifferent to ________.

18. I do usually sense or realise how ________ is feeling.

19. I would like ________ to be a particular kind of person.

20. When I speak to ________ I nearly always can say freely just what I'm thinking or feeling at that moment.

21. I find ________ rather dull and uninteresting.

22. What ________ says or does arouses feelings in me that prevent me from understanding him/her.

23. Whether ________ criticises me or shows appreciation of me does not (or would not) change my inner feeling toward him/her.

24. I would really prefer ________ to think that I like or understand him/her even when I don't.

25. I care for ________.

26. Sometimes I think that ________ feels a certain way, because that's the way I feel myself.

27. I like ________ in some ways, while there are other things about him/her that I do not like.

28. I don't feel that I have been ignoring or putting off anything that is important for our relationship.

29. I do feel disapproval of ________.

30. I can tell what ________ means, even when he/she has difficulty in saying it.

31. My feeling toward ________ stays about the same; I am not in sympathy with him/her one time and out of patience another.

32. Sometimes I am not at all comfortable with ________ but we go on, outwardly ignoring it.
33. I put up with ________.
34. I usually catch and understand the whole of ________'s meaning.
35. If ________ gets impatient or mad at me I become angry or upset too.
36. I am able to be sincere and direct in whatever I express with ________.
37. I feel friendly and warm toward ________.
38. I ignore some of ________'s feelings.
39. My liking or disliking of ________ is not altered by anything that he/she says about himself/herself.
40. At times I just don't know, or don't realise until later, what my feelings are with ________.
41. I value our relationship.
42. I appreciate just how ________'s experiences feel to him/her.
43. I feel quite pleased with ________ sometimes, and then he/she disappoints me at other times.
44. I feel comfortable to express whatever is in my mind with ________, including any feelings about myself or about him/her.
45. I really don't like ________ as a person.
46. At times I think that ________ feels strongly about something and then it turns out that he/she doesn't.
47. Whether ________ is in good spirits, or bothered and upset, doesn't make me to feel any more or any less appreciation of him/her.
48. I can be quite openly myself in our relationship.
49. Somehow ________ really irritates me (gets 'under my skin').
50. At the time, I don't realise how touchy or sensitive ________ is about some of the things we discuss.
51. Whether ________'s expressing 'good' thoughts and feelings, or 'bad' ones, does not affect the way I feel toward him/her.
52. There are times when my outward response to ________ is quite different from the way I feel underneath.
53. In fact, I feel contempt toward ________. 
4.

54. I understand ________.

55. Sometimes ________ seems to me a more worthwhile person than he/she does at other times.

56. I don't sense any feelings in relation to ________ that are hard for me to face and admit to myself.

57. I truly am interested in ________.

58. I often respond to ________ rather automatically, without taking in what he/she is experiencing.

59. I don't think that anything ________ says or does really alters the way I feel toward him/her.

60. What I say to ________ often would give a wrong impression of my full thought or feeling at the time.

61. I feel deep affection for ________.

62. When ________ is hurt or upset I can recognise just how he/she feels, without getting upset myself.

63. What other people think and feel about ________ does help to make me feel as I do toward him/her.

64. I feel there are things we don't talk about that are causing difficulty in our relationship.

Please also provide the following information about yourself and the other person.

You                                    The Other

Age:    ________ years                  ________ years (known or estimated)

Sex:    ________ (M or F)               ________ (M or F)

Occupation: __________________________  __________________________

Position in this relationship.        Mother                  Son

Examples:                             Counsellor               Client

Personal Friend

Teacher

Pupil (or Student)

Actual: (Please fill in) ____________  ____________
GUIDE TO GOALS

People have many different splits they might wish to deal with. The purpose of this interview is to define clearly and specifically what you think treatment could do to help you with your split in the near future.

This page shows how one person completed his guide to goals. Yours will be filled in generally like this one during this interview.

SPLIT: I AM TORN BETWEEN SPENDING MY FREE TIME (ABOUT 18 HOURS PER WEEK) WORKING AT SCHOOL OR WITH MY FAMILY.

<table>
<thead>
<tr>
<th>MUCH WORSE THAN EXPECTED RESULTS:</th>
<th>LESS THAN AN HOUR OF FREE TIME SPENT PRODUCTIVELY WITH WORK AND/OR FAMILY, WITH A GREAT AMOUNT OF FEELINGS OF CONFLICT SPENT ABOUT CHOICE.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOMewhat LESS THAN EXPECTED RESULTS:</td>
<td>ABOUT THREE HOURS OF FREE TIME SPENT PRODUCTIVELY WITH WORK AND/OR FAMILY, WITH MODERATE TO GREAT FEELINGS OF CONFLICT ABOUT CHOICE.</td>
</tr>
<tr>
<td>EXPECTED OR MOST LIKELY RESULTS:</td>
<td>SIX HOURS/WEEK FREE TIME SPENT PRODUCTIVELY WITH WORK AND/OR FAMILY WITH MODERATE FEELINGS OF CONFLICT ABOUT CHOICE.</td>
</tr>
<tr>
<td>SOMewhat BETTER THAN EXPECTED RESULTS:</td>
<td>TEN OR MORE HOURS OF FREE TIME SPENT PRODUCTIVELY WITH WORK AND/OR FAMILY, WITH LITTLE FEELINGS OF CONFLICT ABOUT CHOICE.</td>
</tr>
<tr>
<td>MUCH BETTER THAN EXPECTED RESULTS:</td>
<td>FOURTEEN OR MORE HOURS OF WORK SPENT PRODUCTIVELY WITH WORK AND/OR FAMILY, WITH LITTLE OR NO FEELINGS OF CONFLICT ABOUT CHOICE.</td>
</tr>
</tbody>
</table>

(asterisk indicates the level at which this person thinks he is now)
Now think of a **practical, specific** way of measuring how well you are doing with your split. For example, if you were concerned about an issue dealing with time spent on conflicting tasks, **number of hours** would be a simple way to see how you were doing. If your split involved seeing friends, **number of contacts with friends** would be a concrete way to gauge change.

A good criterion for determining the adequacy of your measure is "is this measure clear enough so that someone else could be able to tell if I am getting better at handling my split".

You can also use an indication of your feeling state to clarify your progress in dealing with your split. For example, you might talk about mild to severe feelings of anxiety, joy, conflict, fear, or love, to mention a few feeling states. In the example on page one, the person spoke of "feelings of conflict", and then he projected change of feelings for better or worse.

Now use the concrete measure of change and the measure of feelings to predict how well you would be doing after **one week** once you have interacted with your counsellor. Of course, you cannot know for sure how well you will be doing, but try your best to predict. Be realistic about:

- how hard it is for you to handle your problems,
- your own abilities and your determination to handle your problems,

and

- how much success you have had before in dealing with your problems.

(Do: **Expected or Most Likely Results**)
So far you have written down what you think is the most likely result for progress on your split in a week's time. However, it is possible to do much better than expected. Therefore, using the same affective and behavioral measures you used to predict your "expected results", write in what the specific results would be if you did much better than expected. Show specifically how you would be doing something different. Use numbers if you can.

If you expected, for example to be with friends one night a week, doing much better might mean being with friends three nights a week. Be realistic. Do not set goals for yourself that you are sure you could not reach.

(Do: Much Better Than Expected Results)

Next, use your same measures to fill in the two remaining levels of your scale. The last two levels are Somewhat Less Than Expected Results and Somewhat Better Than Expected Results. They are close to your expected level of results, but are a little less or a little better than the expected level.

(Do: Somewhat Less Than Expected Results
And
Somewhat Better Than Expected Results)
Finally, please make an asterisk (*) at the level that shows how well you are doing now, today. This mark will help show how you started with your problems and whether or not you improve in the future.

Thank you
NAME: ___________________________  EDUCATION LEVEL: ___________________________

DATE: ___________________________  AGE: ___________________________

DESCRIPTION OF SPLIT YOU WILL BE WORKING ON: ____________________________________________________________

___________________________________________________________________________________________

MUCH WORSE THAN

EXPECTED RESULTS: _____________________________________________________________

___________________________________________________________________________________________

SOMewhat LESS THAN

EXPECTED RESULTS: _____________________________________________________________

___________________________________________________________________________________________

EXPECTED OR MOST

LIKELY RESULTS: _____________________________________________________________

___________________________________________________________________________________________

SOMewhat BETTER THAN

EXPECTED RESULTS: _____________________________________________________________

___________________________________________________________________________________________

MUCH BETTER THAN

EXPECTED RESULTS: _____________________________________________________________

___________________________________________________________________________________________

(place asterisk (*) next to level where you are now)
Thank you very much for volunteering your time to our research on the listening process. Please complete this form on the same day you check off your Goal Attainment Follow-up Guide and return the two together to Mr. Naegeli or Mr. Harper.

NAME: ____________________________

SEX: M __ F ___

1. Has any serious event, such as sickness in the family or job problems, occurred during the past week? YES____ NO____

2. If you checked "yes" to #1, did the incident affect your attaining the goal you set a week ago in the listening exercise? YES____ NO____

3. Sometimes people change goals as a result of talking with a skilled listener. Did this happen to you? YES____ NO____

4. If you checked "yes to #3, circle the appropriate Goal Attainment level for your new goal:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>much worse than expected results</td>
<td>somewhat expected or less than most likely expected results</td>
<td>somewhat better than expected results</td>
<td>much better than expected results</td>
<td></td>
</tr>
</tbody>
</table>

5. Was the listening process helpful in attaining your goal? YES____ NO____

6. Would you go to a psychologist or psychiatrist who worked mainly in a listening-oriented manner? YES____ NO____

Comments:__________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

__________________________
TO ALL THERAPISTS:

Please fill in the following demographic information.

1. Name: ____________________________

2. Age: ____________________________

3. Training in empathy skills (describe): ____________________________

4. Approximate number of hours of client-centered-type treatment you have done: ____________________________

5. Approximate number of hours of therapy in any orientation: ____________________________

6. Theoretical orientation: ____________________________

7. How valid do you see client-centered treatment as a means of inducing change?

1 2 3 4 5

totally ineffective very effective
Questionnaire: In this questionnaire we are seeking your help in evaluating the instructions which were just read to you. Please do not omit any questions. Do not report what you were thinking about.

1. In no more than four (4) sentences (one short paragraph) please describe what was happening to you in the last 10 minutes.

2. How did the feeling change after you got the words or picture?

3. What was the best thing about doing this?

4. What was the worst thing about doing this?

5. What surprised you most about all this?

6. How was thinking this way different from the way you usually do it?

7. Many people get lost near the start and then the rest doesn't make sense. Did that happen to you?  
   Yes ______  No ________

8. Some people use words and feelings. Others use pictures and feelings. Which did you find most important?  
   Words ______ Pictures ________ Neither ______

9. Your age ________
   Sex: Male ______ Female ________

FW
AUCE 1
APPENDIX B

SESSION GRAPHS

OF

THERAPIST COMMUNICATED EMPATHY AND

DEPTH OF EXPERIENCING
THERAPIST 2
SUBJECT 3
TCE LEVEL
EXP LEVEL

MODE EXP
PEAK EXP
TCE

FOUR-MINUTE SEGMENTS

THERAPIST 3
SUBJECT 4
TCE LEVEL
EXP LEVEL

MODE EXP
PEAK EXP
TCE

FOUR-MINUTE SEGMENTS
The graphs depict the TCE/EXP level of two therapists over 13 four-minute segments.

**Therapist 5**
- Subject 9
- Initial TCE level: 5.0
- Initial EXP level: 6

**Therapist 6**
- Subject 10
- Initial TCE level: 4.5
- Initial EXP level: 5

The graphs show fluctuations in TCE and EXP levels across the segments, with peaks and troughs indicated by specific markers. The segments are numbered from 1 to 13, and the TCE/EXP levels are plotted on a scale from 0 to 5.0.
APPENDIX C

COMPUTER PROGRAMS FOR

COMPARISON OF CORRELATION

COEFFICIENTS
Class One comparison of the type \( r_{xy} = r_{xz} \).

```
REAL*4 N,Z4,Z3,Z2,Z1
WRITE(6,10)
10 FORMAT('"THIS PROGRAM TESTS THE FOLLOWING HYPOTHESIS:
1 'H0: P(X,Y)=P(X,Z)'
2 'H0: P(X,Y) .NE. P(X,Z)'
3 'INPUT DATA FORMAT IS **.***."
WRITE(6,15)
15 FORMAT('"PLEASE INPUT YOUR R(X,Y)"
READ(5,20) R12
WRITE(6,25)
25 FORMAT('"PLEASE INPUT YOUR R(Y,Z)"
READ(5,20) R23
WRITE(6,30)
30 FORMAT('"PLEASE INPUT YOUR R(X,Z)"
READ(5,20) R13
WRITE(6,40)
40 FORMAT('"PLEASE INPUT YOUR N"
READ(5,27) N
27 FORMAT(F3.0)
Z2=2*R23*R23*R23
Z3=(1-R13*R13)*(1-R13*R13)
Z4=(1-R12*R12)*(1-R12*R12)
Z5=SQRT(Z4+Z3-Z2-Z1)
Z6=SQRT(N*(R12-R13))
Z=Z6/Z5
WRITE(6,50)Z,Z1,Z2,Z3,Z4,Z5,Z6,N
50 FORMAT('"Z=",(F9.4))
55 WRITE(6,60)
60 FORMAT('"DO YOU WANT TO CONTINUE?, 1=YES, 2=NO"
READ(5,70) IANS
70 FORMAT(I1)
IF(IANS .EQ. 1) GO TO 12
IF(IANS .EQ. 2) GO TO 100
GO TO 55
100 STOP
END OF FILE
```

Class Two comparison of the type: $r_wz = r_{xy}$.

```fortran
REAL*4 N,Z2,Z1,AK
WRITE(6,10)
10 FORMAT( ' THIS PROGRAM TESTS THE FOLLOWING HYPOTHESI$'
1      'H0: P(W,Z)=P(X,Y)'/
1      'H1: P(W,Z) .NE. P(X,Y)'/.
1      'INPUT DATA FORMAT IS **,****' )
7    12 WRITE(6,15)
8    15 FORMAT( ' PLEASE INPUT YOUR R(W,X)' )
9    20 FORMAT(F7.4)
10    25 WRITE(6,25)
11    25 FORMAT( ' PLEASE INPUT YOUR R(W,Y)' )
12    30 WRITE(6,30)
13    30 FORMAT( ' PLEASE INPUT YOUR R(W,Z)' )
14    35 WRITE(6,35)
15    35 FORMAT( ' PLEASE INPUT YOUR R(X,Y)' )
16    40 WRITE(6,40)
17    40 FORMAT( ' PLEASE INPUT YOUR R(X,Z)' )
18    45 WRITE(6,45)
19    45 FORMAT( ' PLEASE INPUT YOUR R(Y,Z)' )
20    50 WRITE(6,50)
21    50 FORMAT( ' PLEASE INPUT YOUR N' )
22    55 WRITE(6,55)
23    55 FORMAT( ' YOU WANT TO CONTINUE? 1=YES, 2=NO' )
24    60 IF(IANS.EQ.1) GO TO 12
25    70 IF(IANS.EQ.2) GO TO 100
26    80 GO TO 65
27    90 STOP
END
```