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Psychotherapeutic Operations and
Client Behavioural Commitments

by

Robin Gagnon

A Dissertation

Submitted in partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
in Clinical Psychology

University of Ottawa

August, 1994



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CURRICULUM STUDIENTUM

After having completed his CEGEP studies at The New School of Dawson College, Robin Gagnon graduated With Great Distinction with his B.A. (Honours in Psychology) from Concordia University in 1987. From 1987 to 1988, he worked at Concordia University as a Research Associate, executing a Health and Welfare funded research project on the long-term effects of child sexual abuse, as well as a Health and Welfare funded literature review on the same topic.

OVERVIEW

Patients' in-session commitments, decisions, or statements of intention to carry out novel behavioural acts between sessions are valued events for many therapeutic approaches. The value or importance of such events is enunciated in the body of psychotherapy theory as well as demonstrated by the results of research. First, the value of behavioural commitments is evident in many theories of psychotherapy, whether this be explicit or implicit. Secondly, research has demonstrated that in-session behavioural commitments are significantly associated with the carrying out of the selected behavioural acts post-session. Despite the importance of behavioural commitments in many systems of psychotherapy, scholars of psychotherapy have pointed out that serious lacunae exist in the specification of therapeutic operations which may be used in catalyzing the occurrence of behavioural commitments. Consequently, it is proposed that the study of therapeutic methods which catalyze such events would constitute a useful avenue of research.

A research category encompassing instances of behavioural commitments has as its defining characteristics that within the therapy session, a patient expresses a significant intention or commitment to carry out certain therapeutically or personally relevant novel behaviours outside of the therapy session and in the near future. These behaviours are qualitatively new for the patient.

An exhaustive review of psychotherapy process research reveals that few research projects have studied the links between

psychotherapeutic operations and behavioural commitments. Moreover, the few existing studies suffer from considerable limitations of scope and essentially have failed to identify links between psychotherapeutic operations and behavioural commitments.

In order to address this question with a research focus which is appropriate to the current state of knowledge on the matter, the rationale is provided for a qualitative methodology. The aim of the study is to identify psychotherapeutic operations which catalyze "naturally occurring" instances of behavioural commitments identified in psychotherapy session transcripts. Raw data for the study was obtained through an exhaustive search of published transcripts of sessions from a broad array (any and all varieties) of psychotherapies. The research strategy began with the use of a team of judges for identifying instances of behavioural commitments according to a rigorous definition. Following the identification of a behavioural commitment, each judge followed a systematic procedure of examining the statements occurring prior to the occurrence of the behavioural commitment and provided a description of the therapist's operations which were judged to catalyze the occurrence of the behavioural commitment. These descriptions of therapists' behavioural commitment-catalyzing operations were written without jargon or technical terms related to any theory of psychotherapy. All judges' descriptions were merged into composite descriptions. Composite descriptions were in turn analyzed to create descriptions of distinct therapeutic operations used in

catalyzing the behavioural commitments. Categories of psychotherapeutic operation resulting from analysis of the composite descriptions were subject to a criterion of agreement among the team of judges. As a final verification step, a 70% level of agreement was required of the team of judges in order to identify which of the categories of psychotherapeutic operation were used in catalyzing the occurrence of each behavioural commitment under study. Products of the study are relevant to the practitioner as practitioner-ready concrete descriptions of behavioural commitment-catalyzing therapeutic operations, and to the researcher as a collection of propositions for further theorizing and research.

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Chapter 1

INTRODUCTION AND REVIEW OF THE LITERATURE

Behavioural commitment is a clinical concept encompassing patients' in-session commitments, decisions, or statements of intention to carry out personally novel behavioural acts between sessions. Following a section describing and defining the concept of "behavioural commitment", this chapter will go on to discuss its relevance to many schools of psychotherapy. Both technical literature and research literature on psychotherapy will be reviewed separately in order to ascertain the importance of behavioural commitments in the practice of psychotherapy. The term "technical literature" includes publications on psychotherapy theory and publications describing psychotherapeutic techniques which have their source in clinical lore rather than in research. In sharp contrast to clinicians' obvious strong theoretical and practical interest in behavioural commitment, the literature review will demonstrate that neither technical literature nor empirical research provide any significant clinically useful knowledge on bringing about this event in psychotherapy. A review of studies on the occurrence of behavioural commitments or on their relation to psychotherapeutic operations will reveal that virtually no research has been conducted on the question of which therapeutic operations result in behavioural commitments. This chapter will conclude with a short discussion of this study's purpose: empirically studying psychotherapeutic operations which catalyze patient behavioural commitments.

Behavioural Commitment: Definition and Description

In this manuscript, the term "commitment" is defined as a decision (made by the patient during the therapy session) expressed with a substantial degree of intention to follow through. Commitment also includes both agreements between individuals and irrevocable personal decisions which control behaviour (Marzano & Marzano, 1988). Based on a review of social psychology research literature, Jones and Gerard (1967) concluded that "Once a person has committed himself to a course of action, he tends to remain on that course and engages in cognitive work that will sustain his decision" (p. 418). Behavioural commitments occurring in psychotherapy may have as their foci either therapist-selected behaviours or self-(patient)-selected behaviours. In this manuscript "behavioural acts" refers to any publicly observable actions, including verbalizations; this excludes intrapsychic events. A commitment may be an agreement or a decision controlling behaviour within the context of prescriptive psychotherapeutic approaches such as behaviour therapy (e.g., Goldfried, 1982), cognitive therapy (Beck and Emery, 1979) and ordeal therapy (Haley, 1984). Examples of behavioural commitments which might be requested by therapists ascribing to three therapeutic approaches respectively are: agreeing to take an elevator between two floors, agreeing to keep a written list of activities engaged in, and getting up to take a two-mile walk at three o'clock in the morning whenever insomnia occurs.

In contrast, the patient's commitment may be to a self-selected behaviour, the commitment being to the patient's self rather than to the therapist. In this instance the commitment could be referred to as a "decision". An example of such a behavioural commitment would be a patient spontaneously deciding to quit smoking and to begin exercising every day. Such a form of commitment is valued in psychotherapeutic approaches such as Rational Stage Directed Therapy (Boutin, 1978). Finally, commitment could include a patient's agreement with both the therapist and with the self to carry out a self-selected behaviour, such as in Mahrer's Experiential Therapy (Mahrer, 1989). An example of this would be: upon being requested to carry out a new extra-therapy behaviour, the patient decides to visit her cousin and give her a hug, and at the same time expresses a strong commitment to carry out this new behaviour. As will be discussed in the following section, patient "commitment", according to some scholars of psychotherapy, may also constitute events encompassing drastically different time frames and modalities of response.

The Value of Behavioural Commitments in Psychotherapy

The following two sections review technical and research literature on psychotherapy, respectively. The purpose of these reviews is to demonstrate the value of behavioural commitments in psychotherapy. The first of the two sections to follow reviews the importance of behavioural commitment in many systems of psychotherapy and in the observations of practitioners. The second of the two sections reviews research literature

demonstrating the relation of behavioural commitment to the occurrence of other therapeutically desirable events and outcomes.

A. Technical Literature:

Patients' Behaviour Change Commitments Are a Valued Event In Many Psychotherapeutic Systems

Many schools of psychotherapy value patients' commitments to undertake new behaviours between sessions. Though such an intra-session event is explicitly stated as valued in a few psychotherapies (e.g., Bakker, 1975; Bass, 1984; Boutin, 1978; DiClemente & Prochaska, 1982; Haley, 1984; Kanfer & Grimm, 1980; Mahrer, 1989; McElroen & Faltico, 1977; Montgomery & Montgomery, 1975; Prochaska & DiClemente, 1982; Tosi & Henderson, 1983; Whipple, 1985) it is obvious that it is also valued implicitly by many more psychotherapies (e.g., Andrews, 1977; Bakker, 1975; Bandura & Adams, 1977; Brady, 1972; Chambless & Goldstein, 1979; Glasser & Zunin, 1979; Ishiyama, 1986; Mendel, 1972; Omer, 1985; Wells, 1982; Levy and Shelton, 1990).

Montgomery and Montgomery (1975) speak of the importance of using behavioural contracts as a demonstration of commitments to behavioural change on the part of patients. Behavioural contracting without the inclusion of provisions for reinforcement or punishment ("noncontingent contracting") is a "commitment of...intentions" (Flanders & McNamara, 1985, p. 225).

Reality Therapy values behavioural commitments, the rationale being that "While (the patient) is making a commitment with the therapist, she is really making a commitment to herself,

to take control of her life" (Whipple, 1985, p. 26). Also from the perspective of reality therapy, McElroen and Faltico (1977) claim that behavioural commitments are crucial to any therapeutic change, stating that "a commitment to consider behavior options will be a key factor in any person's success with a therapy" (p. 80).

A few psychotherapy theorists have addressed behavioural commitments as a crucial stage or event in therapy which causally precedes patients' behaviour changes. In their process model of therapy, Kanfer and Grimm (1980) distinguish "Developing a Commitment for Change" (p. 426) as a stage of therapy preceding attempts at using behavioural techniques. Similarly, in their transtheoretical analysis of psychotherapy, DiClemente and Prochaska (1982) concluded that "Verbal processes were more important when the decision to change was being made. Behavioural processes were more important in the Active Change stage" (p. 141). Such a meaning of "commitment" has been referred to as "Commitment to Collaboration" (CTC) in psychotherapy literature (Harcum, 1989). Although no clear distinction between these concepts could be found in the literature, it is clear from the theoretical descriptions given that CTC is a general standing or ongoing commitment to the psychotherapeutic process, work, or effort, thus encompassing a time frame which includes all of the course of therapy. In contrast, the concern of this study encompasses a briefer time frame in therapy in that the patient expresses an intention to carry out a specific behaviour within a specified time frame in the near future. A further distinction

can be made in that CTC encompasses all modalities of response, including the intrapsychic, whereas in this study behavioural commitment encompasses only the modality of observable behaviours. Behavioural commitment therefore constitutes, on two dimensions, a much more specific subclass of concept than does CTC, though it is apparent that a categorical distinction between CTC and behavioural commitment remains somewhat artificial, as it exists in a continuum. This explains why some of the concepts discussed in this review of clinical theory will include discussion of some CTC-like concepts.

Mahrer (1989) explicitly includes behavioural commitment as the final step of each session of Experiential Psychotherapy in order to provide a means for the patient to experience, outside of therapy, a deeper potential for experiencing accessed during the session. This serves to promote the integration and actualization of the patient. Mahrer makes explicit a number of concrete therapeutic methods which may be used in catalyzing behavioural commitments.

Behavioural commitments are an integral part of Haley's Ordeal Therapy (Haley, 1984). They are explicitly requested, even uncharacteristically early in the course of therapy. In this therapy, commitments are made to behavioural ordeals which must be agreed to by the patient even though s/he has not first been informed of the nature of the task. Haley supplies examples of some therapeutic methods which may be used in catalyzing behavioural commitments. His theoretical rationale is that if the therapist assigns a behaviour which makes it too difficult for

the patient to have the symptom, the patient will give up the symptom.

Tosi and Henderson's (1983) Rational Stage Directed Therapy (RSDT) includes a stage of "commitment", in which the therapist is to "encourage, persuade, and reinforce the participant's initiatives in developing commitments conducive to behavior change" (p. 17). In RSDT, patients are both "encouraged to use new behavioral modifying skills developed and rehearsed in the exploration stage to counter those irrational ideas serving as resistances to implementing rational action for effective living" (Boutin, 1978, p. 53) and also expected to eventually "[realize] the desirability to take risks or make behavioral commitments" (Boutin, 1978, p. 53) on their own as a result of the preceding process. This is to be followed by a stage of "implementation", in which "constructive behavior begins to appear on a consistent basis as decisions are translated into appropriate actions. Commitments are only fulfilled through the processes of action in the environment" (Tosi & Henderson, 1983, p. 17). Tosi and Henderson's rationale for such behavioural action is that the "generalization, application, and transfer, [of] discoveries that occur...within the safe confines of the RSDT relationship are related to the participant's extratherapy environment through action" (p. 17) and that behaviours occurring in imagination during therapy must be translated into overt behaviours in order for "complete learning" to occur. They did not, however, specify any therapeutic operations usable in catalyzing behavioural commitments.

In presenting theory on psychotherapeutic change, Bakker (1975) includes "public commitment" as one of six stabilizing factors which may be deliberately used to stabilize new behaviours and personality characteristics. Bakker traces consideration of public commitment by psychologists to William James' discussion of its importance in the process of religious conversion, a public act (public commitment) serving to solidify a new set of behaviours (James, 1902). Bakker highlights public commitment as a psychotherapeutic factor which serves to consolidate what would "otherwise...only be a brief deviation from the habitual pattern" (Bakker, 1975, p. 171). "Public commitments to comply" are also identified by Levy and Shelton (1990) as serving the function of providing evidence as to how the patient intends to act and also as serving to enhance the likelihood of compliance with therapeutic tasks.

Several psychotherapies and therapists implicitly seek behavioural commitments. Omer (1985) sets tasks (such as going out and buying two new outfits of clothes and swimming thirty laps without stopping) which patients must carry out as a precondition to their acceptance into psychotherapy. Omer's rationale is that this has "a powerful facilitative effect on the therapeutic process" (p. 175) because it "[increases] patients' commitment to treatment,...[diminishes] drop-out rate,...[allows] patients to begin therapy at a higher level of functioning, thereby reducing its length" (Omer, 1985, p. 175). Omer reports that this method has been used by several other therapists: Whitaker, who set as a precondition the involvement of certain

family members in therapy; Milton Erickson, who on occasion would only accept a patient if the patient agreed to carry out a behavioural ordeal; and Haley, who would seek commitments to behavioural ordeals very early in therapy. The behavioural ordeals of Erickson and Haley were specifically selected so that they are beneficial to the patient but cause distress equal to or greater than that caused by the symptom. For example, Haley had "a professor of mathematics who wanted to have sex for the first time in his life, wake up in the middle of the night to read scientific papers for one hour unless he could find a woman to sleep with" (Omer, 1985, p. 176). Omer describes a number of concrete therapeutic techniques which may be used in catalyzing behavioural commitments. Omer's rationale for such a way of proceeding is that "The demand for immediate action has a positive effect on morale" (p. 183), relieving the patient's sense of helplessness and conveying to the patient the sense that she is capable of doing the task, whether or not she carries it out being a matter of willingness. Along a similar vein, other therapists assign tasks in order to convey to the patient the active, practical nature of change (Wells, 1982), to convey to the patient that she is responsible for active participation (Kanfer & Grimm, 1980) and to foster within the patient an "active patient orientation", which has been shown to be positively related to post-therapy outcome (Levy & Shelton, 1990).

Morita Therapy (Ishiyama, 1986) seeks to have patients engage in novel extra-therapy behaviours by "encouragement", but

does not address behavioural commitment or supply therapeutic operations to catalyze behavioural commitments. Working within a Rational-Emotive Therapy framework, Bass (1984) provides examples of psychotherapeutic operations which may be used to produce behavioural commitments when dealing with motivational deficits, the operations specifically being aimed at overcoming patients' resistances to committing themselves to the carrying out of extra-therapy behaviours due to lack of sufficient motivation.

Finally, behavioural commitment is implicitly relevant to any therapeutic approach which makes use of homework assignments or assigns tasks, examples including Behaviour Therapy (e.g., Bandura, 1969; Goldfried & Davison, 1976), Instigative Therapy (Kanfer, 1979) and Task-centered Casework (Reid & Epstein, 1972).

To summarize, several psychotherapeutic approaches value behavioural commitments, whether these are for the purpose of developing a commitment to psychotherapeutic change, demonstrating a commitment to the psychotherapeutic process, aiding the in-session psychotherapeutic process, having the patient carry out a psychotherapeutically valuable behaviour outside of therapy, reinforcing patients' initiatives, boosting the patient's morale, or simply in order to directly change a problem behaviour. Such a valued in-session event as behavioural commitment calls for the development of a rich armamentarium of psychotherapeutic operations which promote its occurrence.

B. Research Literature:

In-Session Behaviour Change Commitments Correlate With Extra-Therapy Behaviour Changes

Despite some mixed results and qualifications (e.g., Fendrich, 1967; Levy & Clark, 1980), studies examining the relation of patients' within-session behaviour change commitments to that of the actual carrying out of the behaviours between sessions have generally found the two to be significantly related (Kothandapani, 1971; Levy, 1977; Levy & Clark, 1980; Patterson, 1984, as cited in Patterson & Forgatch, 1985; Prochaska, 1979; Wurtele, Galanos, & Roberts, 1980). Conversely, in-session noncompliance has been found to correlate with between-session noncompliance (Patterson & Forgatch, 1985). These findings make such a within-session outcome (in-session outcome or sub-outcome) of particular significance to behavioural assignments and treatment compliance (Shelton & Levy, 1981a) as well as to any other psychotherapy valuing new behaviours outside of therapy as either a component or stage of therapy (Andrews, 1977; Bakker, 1985; Bandura & Adams, 1977; Beck, Rush, Shaw, & Emery, 1979; Casey, 1973; Freud, 1959; Prochaska & DiClemente, 1982) or as a goal of therapy.

To summarize, if the carrying out of new behaviours outside of therapy is considered a valuable event by a number of psychotherapies and if behavioural commitments are indeed reliably associated with patients' follow-through on these commitments, then knowledge of psychotherapeutic techniques which increase the probability of occurrence of behaviour change

commitments by patients would be a valuable contribution to practitioner-relevant research.

The Current State of Knowledge on Psychotherapeutic Methods Which Catalyze Behavioural Commitments

The following two sections review technical and research literature on psychotherapy, respectively. The purpose of these reviews is to assess, from theoretical and research perspectives, the extent of psychology's collection of behavioural commitment-catalyzing psychotherapeutic operations. It should be made clear at this point that given the purpose and method of this study, the aim of this review is not to provide fodder for generating hypotheses. Rather, any findings made by this study shall be discussed in relation to the literature reviewed.

A. Technical Psychotherapy Literature

On Behavioural Commitment

Despite the fact that therapists from various theoretical orientations value behavioural commitments, researcher-theoreticians have identified our current state of knowledge on therapeutic operations catalyzing behavioural commitments as demonstrating a lacuna in the field's armamentarium of psychotherapeutic operations. A case in point is Behaviour Therapy: given its routine use of extra-therapy tasks, behavioural commitment should be among its prime concerns. Behavioural commitment is implicitly relevant to any situation in behaviour therapy in which the patient is to carry out some task outside of the therapy session. These situations occur when

patients are asked to monitor their behaviour, feelings and thoughts, practice relaxation exercises, try out new assertive responses, make new social contacts, use relaxation methods to cope with tension (Goldfried, 1982), or are asked to carry out any other tasks by behaviour therapists.

In sharp contrast to the apparent importance of behavioural commitments to these Behaviour Therapy contexts, an examination of clinical texts on Behaviour Therapy yields few operations for catalyzing commitments. Prochaska and DiClemente (1982) remarked that the silence of "traditional behaviour therapists" on the entire issue of behavioural commitment reflects an implicit expectation on their part that patients are "committed to change and [are] ready for action" (p. 285). On the matter of a more general form of "commitment" (Commitment to Therapeutic Collaboration), Harcum (1989) cites Papajohn (1982) as having stated that "The patient is expected to provide collaborative effort, trust, a willingness to take therapeutic risks" (Papajohn, 1982, p. 22) as an example of how behaviour therapists presume that commitment exists prior to the use of learning principles in therapy. The same observation applies equally well, however, to behaviour therapy's treatment of behavioural commitment.

Behaviour Therapy's presumptions or expectations that patients are already committed to change is not an oversight but stems from a practical limitation of behavioural theory (Harcum, 1989; Harcum, Burijon, & Watson, 1989): the principles of learning do not make reference to such internal factors as

personal choice (Harcum, Burijon, & Watson, 1989). Harcum further argues that patients' commitments in behaviour therapy are not explainable by behavioural theory, that "cooperation" is solicited prior to the application of therapeutic operations based on learning theory, and thus that this "cooperation" constitutes a "crucial addition" to learning principles. Finally, he states that behavioural theory proposes no psychotherapeutic techniques for catalyzing commitment:

[Skinner] has no theoretically justified plan to inculcate a commitment by the client to his plan: he merely "hopes" that his words of solicitation will interact with the person's habit system and environment to produce what he conceives to be a beneficial mutation in thinking. Therefore, the strict application of traditional learning principles gives little guidance for initiating behaviour therapy, particularly CTC [Commitment to Collaboration]. (Harcum, 1989, p. 208)

The theoretical reasons for Behaviour Therapy's neglect of behavioural commitment aside, the fact remains that behaviour therapy's paucity of behavioural commitment-catalyzing therapeutic operations remains unremediated to this day. An examination of texts on behaviour therapy yielded relatively few operations which were explicitly stated as being used for the purpose of catalyzing commitments, agreements, or decisions to carry out therapeutic tasks. The only descriptions found of operations for catalyzing behavioural commitments were couched in such terms as "the patient is persuaded to" (Agras, 1972, p.460), "the therapist...suggests that the patient" (Brady, 1972, p. 128), or "[the patient] is encouraged to" (Brady, 1972, p. 138). Other Behaviour Therapy texts describe psychotherapeutic operations in similar terms (e.g., Goldfried & Davison, 1976;

Bandura, 1969). If these are to be considered specific enough to constitute descriptions of psychotherapeutic operations, then it appears that traditional behaviour therapy has at its disposal behavioural commitment-catalyzing methods of no great sophistication.

It is not surprising that the problem of patient resistance is reported as being a significant obstacle in the practice of Behaviour Therapy. Though discussion of resistance rarely if ever arose in the early literature on Behaviour Therapy, the topic had to be addressed in the face of actual client noncompliance (Goldfried, 1982) and resistance in Behaviour Therapy has begun receiving the attention of clinical writers and researchers. Although some behaviour therapists have explained resistance as patients' lack of readiness for therapy, others (e.g., Goldfried & Davison, 1976) have proposed that it is the job of behaviour therapists to make the patient ready. As stated by Lazarus and Fay (1982, p. 116), "labeling all noncompliant behavior 'resistance' obscures the essential importance of teasing out specific antecedent and maintaining factors that generate uncooperative behaviours in specific contexts." In essence, behaviour therapists should have at their disposal a collection of psychotherapeutic operations for catalyzing behavioural commitments.

The barrenness of Behaviour Therapy's cupboard of behavioural commitment-catalyzing operations need not be the case for the therapy to remain behavioural; theoretically basic change agents may be applied using a diversity of therapeutic operations

(Karasu, 1986). More generally, schools or theories of psychotherapy share common strategies (Kazdin, 1983) but may meet these common therapeutic sub-goals (within-session outcomes or identifiable steps of process) through different psychotherapeutic operations. To cite Kazdin,

Although grounds for rapprochement [between theories of psychotherapy] might be sought at an abstract theoretical or concrete procedural level, an intermediate level of similarity has been proposed. Goldfried (1980) has referred to this level as a common set of clinical strategies or general principles of change. These strategies include experiences provided in treatment above the level of specific procedures. Different techniques may implement the strategies differently but the overall goal is achieved nonetheless. (Kazdin, 1983, p. 280)

Indeed, such a sharing of psychotherapeutic operations across theoretical boundaries is evident in more recent writings on Behaviour Therapy. An examination of these writings demonstrates a growing tendency for behaviour therapists to adopt psychotherapeutic operations from other theoretical approaches as well as to develop practical psychotherapeutic operations not derived from learning theory. The "humanistic additions" to traditional Behaviour Therapy have included, for example, operations adopted from existential therapy (Agras, 1972), Kelly's fixed-role therapy (Goldfried & Davison, 1976) gestalt therapy and transactional analysis (Montgomery & Montgomery, 1975).

What is emergent from these considerations is that schools of psychotherapy of vastly different theoretical views could productively share psychotherapeutic operations if these operations catalyze shared sub-goals, such as behavioural

commitments. This is not an inconsequential observation when one considers that of the psychotherapies with an expressed regard for behavioural commitments (Andrews, 1977; Bakker, 1975; Bandura & Adams, 1977; Chambless & Goldstein, 1979; Glasser & Zunin, 1979; Ishiyama, 1986; Mendel, 1972; Mahrer, 1989; Omer, 1985), only a few (e.g., Mahrer, 1989; McElroen and Faltico, 1977; Omer, 1985) concretely specify therapeutic operations to catalyze behavioural commitments, most (Boutin, 1978; DiClemente and Prochaska, 1982; Kanfer and Grimm, 1980; Montgomery and Montgomery, 1975; Whipple, 1985) offering up little or nothing in the line of specific procedures in their theoretical writings and some (Ishiyama, 1986; Tosi and Henderson, 1983) being entirely silent on this matter.

A review of clinical writings found relatively infrequent mention of patient behavioural commitments, choices or decisions. Some practitioners have described their behavioural commitment-catalyzing methods, however. Twenty-five distinct psychotherapeutic operations were gleaned from technical literature on psychotherapy. For the sake of a clear and structured presentation, each of these operations were labeled with a brief descriptive phrase and clustered into eight categories. It should be noted that none of these descriptions of operations were obtained from psychotherapy research publications and that few of them were identified explicitly by their authors as operations for catalyzing behavioural commitments. However, the operations are included in this review only if they were either explicitly or implicitly proposed as operations which

catalyze the relatively immediate in-session outcome of behavioural commitment, decision, intention, or agreement. It should also be noted that these 25 operations were specified by only a handful of authors. In fact, a core of three (Mahrer, 1989; Montgomery & Montgomery, 1975; Omer, 1985) contributed most of the operation specifications. The eight categories of psychotherapeutic operation are: (1) Therapist direct order; (2) Provision of a rationale; (3) Generating possible new ways of being and behaving; (4) Engaging patient activity; (5) Disinhibition, desensitization, and habituation; (6) Vaunting the advantages of being/behaving in the new way and the disadvantages of being/behaving the old way; (7) Therapist provision of punishment or reinforcement; (8) Mystification. The 25 identified psychotherapeutic operations were subsumed by the eight categories as follows:

(1) Therapist direct order.

"Authoritative order". The therapist, as authority, simply orders the patient to carry out the new behaviour.

(2) Provision of a rationale. This category includes rationales, good reasons or excuses which the therapist delivers to the patient in order to convince the patient that s/he should carry out the new behaviour.

(a) "Process excuse". The therapist tells the patient that carrying out the new behaviour is important or crucial for the process of therapy, without the implication that the new behaviour is a therapeutic goal/outcome in and of itself.

(b) "Providing a theoretical rationale". The therapist explains to the patient the theory of psychotherapy which provides a rationale for the importance of carrying out the new behaviour (Kanfer & Grimm, 1980).

(c) "Patient's ballpark". The therapist tells the patient that the success of treatment depends upon the patient's own actions and willingness to carry out the new behaviour.

(3) Generating possible new ways of being and behaving. This category includes any operation which increases the patient's awareness of potential new ways of being and behaving.

(a) "Specifying the new behaviour". The therapist makes very clear to the patient what new behaviour is to be carried out, where, when and with whom. Alternately, the therapist asks the patient to very clearly and concretely describe what new behaviour is to be carried out, where, when and with whom.

(b) "Modeling patient's new self". The therapist demonstrates or play-acts to the patient how the patient could behave outside of therapy in carrying out the new behaviour.

(c) "Addressing the patient as a new person". The therapist addresses the patient as if the patient were a new, different person.

(d) "Patient specifying ideal self". The therapist asks the patient to tell the therapist how the patient would want to behave differently, how the patient would be acting if she were different, or what it is that the

patient would like to change. As a variant, the therapist asks the patient to tell herself how she would want to behave differently, how the patient would be acting if she were different, or what it is that the patient would like to change.

(4) Engaging patient activity. This category includes operations which "hook" the patient's motivation to act either by a simple request from the therapist or by the therapist frustrating the patient.

- (a) "Involving the patient". The therapist involves the patient in selecting the new behaviour and how it should be carried out.
- (b) "The shaggy dog technique" (Haley, 1984). After having announced to the patient that she must carry out a task, the therapist builds tension by using digressions, offering several examples of other patients and generally "beating around the bush".

(5) Disinhibition, desensitization, and habituation. This category includes those operations which permit the patient to try out new ways of being and behaving in the safety of the psychotherapy session.

- (a) "The behavioural experiment". The therapist tells the patient to carry out the new behaviour as "an experiment", that it is "just to try it out", "make believe" or "not for real". The therapist may also use this operation to catalyze the patient's practicing the

new behaviour in the session (See "Practicing the new behaviour").

- (b) "Practicing the new behaviour". The therapist tells the patient to try out the new behaviour in the therapy session or to try it out in imagination during the session.
- (c) "Practicing an extreme form of the new behaviour". The therapist directs the patient to fantasize enjoying carrying out an extreme, exaggerated form of the new behaviour.
- (d) "Graduation and reassurance". The therapist as psychotherapeutic authority, tells the patient that the patient has successfully practiced or confronted carrying out the new behaviour in therapy and is now ready to carry out the new behaviour outside of therapy.
- (e) "Approaching gradually". The therapist builds the patient up to a behavioural commitment by gradually approaching the idea of carrying out a new behaviour outside of therapy. The therapist accomplishes this through such means as progressing through directing the patient to consider new behaviours, trying them out in imagination, trying them out with the therapist, fine-tuning the potential new behaviours, and ending up with a commitment to carry out the new behaviours outside of therapy.

(6) Vaunting the advantages of being/behaving in the new way and the disadvantages of being/behaving the old way. This category includes operations which highlight for the patient how disadvantageous it is to be/behave the way she currently does and how advantageous it would be to carry out the new behaviour.

- (a) "Building despair". Prior to considering a new behaviour, the therapist reviews and highlights the gravity of the patient's plight, including enumerating past failures and the patient's present helplessness (Omer, 1985).
- (b) "Highlighting potential positive outcomes". The therapist tells the patient that carrying out the new behaviour will lead to progress, improvement or correction of a patient's problem.
- (c) "Self-observation of positive response to the new behaviour". Subsequent to the patient having tried out the new behaviour in imagination during the therapy session, the therapist tells the patient to direct her attention to good bodily-felt feelings associated with having imagined carrying out the new behaviour. As a corollary, if the imagined new behaviour does not produce good feelings, the therapist tells the patient to modify the new behaviour and retry imagining carrying it out.

(7) Therapist provision of punishment or reinforcement. This category includes the therapist punishing or reinforcing the patient, or communicating to the patient (implicitly or

explicitly) that therapist punishment or reinforcement will be contingent upon the patient's behaviour.

- (a) "The carrot and stick". The therapist tells the patient that the therapist has the power to create a positive consequence for the patient, but that the therapist will withhold the positive consequence unless the patient agrees to carry out the new behaviour.
- (b) "Passivity confrontation" (Schiff & Schiff, 1971). The therapist queries the patient as to what the patient is doing right now in order to avoid changing.
- (c) "Confronting avoidance". The therapist confronts the patient with the observation that the patient is avoiding carrying out therapeutic work and tells the patient that it is necessary to carry out the new behaviour now, not later.
- (d) "Chicken". The therapist either implies or tells the patient directly that the patient is being "chicken"; that the patient is letting her bad feelings get the best of her in not being willing to try the new behaviour. The therapist may teasingly imply that the patient wouldn't ever do such a thing.
- (e) "Contracting". The therapist asks the patient to demonstrate the patient's commitment to carrying out the new behaviour by signing an agreement, contract or plan (McElroen & Faltico, 1977; Whipple, 1985).

(8) Mystification. This category includes operations which mystify the patient into committing themselves to carrying out

the new behaviour by piquing their curiosity with a seemingly absurd request.

- (a) "Paradoxical intention". The therapist tells the patient to deliberately try to bring on the feared consequences attached to a new behaviour instead of avoiding carrying out the new behaviour (Agras, 1972).
- (b) "Circumventing motivational deficit". When the patient states that she doesn't want to carry out the new behaviour, the therapist tells the patient to continue to not feel like carrying out the behaviour, but to carry out the behaviour anyhow. The therapist may also tell the patient that the patient can not be sure that she will not enjoy carrying out the new behaviour until she actually tries it.

Examples of these psychotherapeutic operations, described in technical psychotherapy literature, are presented in Appendix A.

It is important to point out that the separation of the authors' descriptions of methods into 25 operations usually required an analysis of the original descriptions into components. Most authors' descriptions of how to catalyze behaviour commitments were composed of combinations and/or sequences of the 25 operations, these combinations typically including two to three individual operations. Possibly due to the very few specific examples found in the literature, each of the combinations found was unique. This uniqueness may be due to the small number of examples found, however, as the combinations frequently gave the impression of a meaningful progression or

sequencing of operations. Other combinations found seemed rather to illustrate a "trial-and-error" approach or a "shotgun" approach to the use of individual operations, whereby the therapist either used several operations together without meaningful sequencing or tried one operation after another until a behavioural commitment was successfully obtained.

The problem of the lack of specificity concerning concrete procedures (referred to throughout this manuscript as "therapeutic operations" or, with brevity, simply as "operations") extends beyond Behaviour Therapy and indeed, beyond those psychotherapies which value behavioural commitments. Colby identified aspecificity as a limitation of theory in stating that "It is often difficult to see how specific therapeutic techniques are deducible from the theory" (Colby, 1964, p. 362). As stated by Matarazzo (1965), "Everyone interested in the technique of psychotherapy is aware of the fact that while the field is rich in sources of theoretical writing little has been published about the techniques used" (p. 181). Indeed, "In relatively few therapy techniques are the critical procedures specified to permit careful analytic investigation for dismantling, constructive, or parametric research" (Kazdin, 1983, p. 270), an issue of paramount importance to psychotherapy research.

Since the pan-theoretical review of theoretical writings on psychotherapy yielded only 25 operations, it must be concluded that the technical psychotherapy literature on the matter is not rich nor even adequate. This lack of techniques stands in stark contrast to the stated importance of behavioural commitment

across systems of psychotherapy. Most of the technical literature on psychotherapy makes little or no mention of behavioural commitment, nor does it explicitly specify any operations for the catalysis of behavioural commitment. Even in psychotherapy approaches which hold as their principal aim the carrying out of new extratherapy behaviours (such as Behaviour Therapy) supply few operations pertaining to the catalysis of behavioural commitments. It is also crucially important to note that no clinical theory could be found pertaining to the catalysis of behavioural commitments. As will be explained in the subsequent chapter, this absence of theory has a decisive implication for the choice of a research strategy. Given the paucity of technical psychotherapy literature on the catalysis of behavioural commitments, knowledge on the catalysis of this particular relatively immediate therapeutic impact is extremely rudimentary. In fact, no evidence could be found of any systematic effort to collect such knowledge in technical writings (including psychotherapy theory). It is therefore proposed that the naturalistic, observational, qualitative investigation of behavioural commitment-catalyzing operations would constitute a productive avenue of research.

B. Psychotherapy Research Literature

On Behavioural Commitment

Considering the expressed importance of behaviour change from a number of theoretical perspectives as well as the evidence of its importance in relation to post-session outcome, remarkably little research has been carried out on the concrete therapeutic

operations which have the relatively immediate therapeutic impact of catalyzing patient decisions, commitments, or agreements to engage in extratherapy behavioural changes. A review of the psychotherapy process literature was carried out in search of systematic studies on behavioural commitment in-session outcomes (within-session outcomes of identifiable psychotherapeutic operations) and closely related events.

Four psychotherapy process studies (Frank & Sweetland, 1962; Mahrer, Nadler, Gervaise, Sterner and Talitman, 1988; Seeman, 1949; Snyder, 1945) were found which made use of content analysis taxonomies including categories which incorporate behavioural commitment. In one of the earliest process studies, Snyder (1945) made use of a theoretically derived taxonomy of therapist and patient behaviours in order to test hypotheses concerning the processes involved in Carl Roger's Non-Directive Counselling theory. In Snyder's taxonomy, one behaviour category, client discussion of plans--YDP (Y = patient, X = therapist, DP = Discussion of Plans) was defined as:

Discussion of plans, decisions, possible outcomes of plans. This category is used in referring to plans and decisions which may have resulted from the counseling. Discussion of past plans are not included. Future goals are included, when they appear to have resulted from the counseling. "I'm gonna' go home and lay this thing out before her, and from now on I'm gonna' stop hidin' those little things I don't want people to know about for fear they won't have a good opinion of me." "I could get a job, I think". (Snyder, 1945, p. 201)

Unfortunately, Snyder did not mention category YDP in his reporting "Tendencies for Certain Types of Client Responses to Follow Certain Types of Counselor Statements" (Snyder, 1945, p. 210). Therefore, Snyder's study provides no answer to the

question of which psychotherapeutic operations catalyze behavioural commitments.

In a later study much like Snyder's, Seeman (1949) used Snyder's taxonomy, but subdivided some of Snyder's original categories in order to achieve a greater precision of description. A sub-category of Snyder's category YDP was YDPd ("Decisions regarding plans"). Unfortunately, Seeman (1949) did not actually use the YDPd category in any analyses, nor was the purpose of his project to statistically identify reliable associations between counselor categories and patient categories. Thus, although both Snyder's and Seeman's studies used taxonomies including behavioural commitment in-session outcomes as well as a variety of therapist operations, neither study sought to examine which categories of therapist operations reliably preceded the occurrence of behavioural commitment in-session outcomes.

In another Rogerian process study, Frank and Sweetland (1962) used a category of patient behaviour closely related to the preceding YDP categories, which they labeled "Tentative Striving".

This category is used to describe those responses implying that the client is thinking about taking a more active role or controlling responsibility in his life, in general, or in the therapeutic process, in particular. The category includes both the timorous, "Maybe I ought to..." and the more positive, "I'm going to try..." (Frank & Sweetland, 1962, p. 137)

While Tentative Striving clearly describes an element of commitment, decision or resolve, the carrying out of new behaviours is implied rather than explicit in the definition. Unlike Snyder (1945) and Seeman (1949), Frank and Sweetland

(1962) did examine statistical associations between therapist operations and the Tentative Striving category--a category which includes behavioural commitment. One category of operation among the 14 in their taxonomy was found to be reliably associated with the subsequent occurrence of Tentative Striving, i.e., Tentative Striving only appeared in any significant quantity following the "Forcing Insight" category of operation. The "Forcing Insight--I" category is described by Frank and Sweetland as

the therapist focuses on a particular cause-and-effect sequence. He offers the client either the cause or the effect and asks for the missing element. Characteristic questions are: "What do you think made you so disturbed just at that time?" "How did this effect [sic.] your social relationships?", or the simple query after the client has expressed some sentiment, "I wonder why?" (Frank & Sweetland, 1962, p. 136)

Thus, Frank and Sweetland's study provides correlational evidence for one psychotherapeutic operation which catalyzes behavioural commitments.

More recently, a behavioural commitment-like event has been defined as a category of Mahrer and Nadler's (1986) taxonomy of "good moments" in psychotherapy. This taxonomy includes categories representing "in-session good moments of client process, movement, improvement or change" (Mahrer, Nadler, Sterner, & White, 1989, p. 127). Category 10 of Mahrer and Nadler's system is "Undertaking New Ways of Being and Behaving in the Imminent Extratherapy Life Situation" and is described by Mahrer and Nadler as,

The patient is undertaking (expressing, manifesting, carrying out, undergoing) new ways of being and behaving in the imminent extratherapy life situation. The extratherapy life situation may be within the imminently recent or remote future, and may be real, imagined or fantasied. It is as if the patient is existing and being in the imminently future extratherapy life situation, and the new way of being and behaving is carried out with concrete specificity. (Mahrer & Nadler, 1986)

However, this category does not explicitly include any indication of commitment, decision, or resolve to carry out a new behaviour outside of the therapy session, but rather appears to describe a rehearsal, practice, or fantasied living-out of a new behaviour. Thus, this category is as removed from behavioural commitment as is Frank and Sweetland's (1962) Tentative Striving category. Unlike Tentative Striving, however, Category 10 makes explicit the planning or rehearsing of new behaviours to be carried out in the extra-therapy world, but makes no mention of the element of commitment, decision or resolve.

In a study of good moments in Rational-Emotive Therapy (RET), Mahrer, Nadler, Gervaise, Sterner and Talitman (1988) made use of their taxonomy as part of a discovery-oriented methodology in a study aiming at identifying RET methods of catalyzing extra-therapy behaviour change. As a result, Mahrer and his colleagues identified four therapist operations useful in catalyzing the occurrence of Category 10. The psychotherapeutic operations involved are described in the form of lay English descriptions, one example being,

The therapist opens up the underlying fear. He specifies and concretizes the feared, the dreaded, the awful, and gets the client to join in this opening up. In effect, the therapist goes with the client into thinking about, feeling, undergoing what it would mean if the fellow doesn't even remember her, what is so painful about that, what it must mean if she really is a bother to him, and so on. (Mahrer et al., 1988, p. 158)

The other three psychotherapeutic operations described by Mahrer and his colleagues may be summarized as: (a) destroying the influence of a patient's expressed fear of carrying out a new behaviour by describing the patient's fear in a manner which illuminates it as groundless and silly; (b) highlighting a way of being and thinking that is congruent with the new behaviour; and (c) stoutly encouraging the patient to carry out the new behaviour. Thus, Mahrer and colleagues' study provides well-articulated descriptions of four psychotherapeutic operations which catalyze behavioural commitment-like events in therapy.

Finally, in one recent discovery-oriented study (Mahrer, White, Howard, Gagnon, & MacPhee, 1992), one psychotherapeutic operation was identified explicitly as a catalyst to behavioural commitment, the behavioural commitment event having been defined as an in-therapy event of:

the patient's manifesting a substantively high degree of intention, readiness, willingness, and commitment to carry out a concretely specific and explicit behavior change in the prospective extratherapy world. The behavior was judged as therapeutically useful, helpful, and effective. (Mahrer et al., 1992, p. 259)

The psychotherapeutic operation was identified as follows:

The general principle is that the patient is carrying out the specific behavior with good feeling in the session, it may be carried out with good feeling in the extratherapy world. The therapist operations consisted of indicating and acknowledging the patient's readiness to have these good feelings by carrying out this explicit behavior in the extratherapy world. (Mahrer et al., 1992, p. 259)

In addition, Mahrer and his colleagues' study identified the therapeutic context or condition for the use of this psychotherapeutic operation, thus supplying knowledge on the timing of this operation's use. Quoting Mahrer and his colleagues (1992, p. 259), "The therapist operations were used when the patient was already carrying out the concrete, specific behavior in the session, that is, the patient was punching a pillow and was doing so with a substantially high level of good feeling."

Despite theoretical arguments (e.g., Kanfer & Karoly, 1972; Kothandapani, 1971; Montgomery & Montgomery, 1975; Shelton & Levy, 1981) and empirical evidence (Kothandapani, 1971; Levy, 1977; Levy & Clark, 1980; Wurtele, Galanos, & Roberts, 1980) of the importance of the behavioural commitment in-session outcome through its association with extratherapy behaviour change, no studies from a behavioural perspective could be found, which associated psychotherapeutic operations with the in-session outcome of behavioural commitment. Thus, the results of this literature review offer further support to Prochaska and DiClemente's (1982) and Harcum's (1989) conclusions that Behaviour Therapy has not made explicit any behavioural commitment-catalyzing therapeutic operations.

In summary, of the four studies examining behavioural commitment-like in-session outcomes (Frank & Sweetland, 1962;

Mahrer et al., 1988; Seeman, 1949; Snyder, 1945), three used theoretically derived taxonomies of operations based on client-centered therapy. Only two of these four studies actually analyzed for associations between this narrow range of operations and behaviour change in-session outcomes, identifying one category of operation as reliably preceding the in-session outcome. One study (Mahrer et al., 1988) used a discovery-oriented methodology to describe operations catalyzing a behavioural commitment-like in-session outcome in RET, yielding descriptions of four operations. Finally, one study was found which described one behavioural commitment-catalyzing operation (Mahrer et al., MacPhee, 1992, p. 259). One may conclude from this that there is no significant body of research-based knowledge of the therapy process closely preceding behavioural commitment in-session outcomes. The purpose of this study will be to fill this gap by attempting to identify psychotherapeutic operations which catalyze the in-session outcome of behavioural commitment.

Chapter Summary

The theoretical writings of a number of systems of psychotherapy either explicitly or implicitly acknowledge the importance of behavioural commitments to the psychotherapeutic process. Research linking process to outcome has demonstrated that behavioural commitment is associated with the subsequent carrying out of novel behaviours outside of the therapy session, thus providing evidence for the relevance of behavioural commitment to those psychotherapeutic approaches which value

extra-session behavioural changes. Therefore, knowledge of psychotherapeutic operations catalyzing behavioural commitments is of importance to all of the aforementioned psychotherapies. Despite the stated importance of behavioural commitment events in psychotherapy, psychotherapeutic operations useful in catalyzing behavioural commitments are either few or inadequately specified in psychotherapy literature. It may be concluded that studies aimed at addressing this lacuna of psychotherapeutic knowledge would constitute a productive avenue of research.

Purpose of the Study

The general purposes of this study are twofold. For one, this study aims at contributing to the technology of psychotherapy by expanding the armamentarium of operations which therapists may use in catalyzing behavioural commitments. Secondly, this study aims to contribute inductively to theory and research on psychotherapy by describing psychotherapeutic operations which catalyze the occurrence of behavioural commitments in particular in-session contexts. This would produce a research base for comparison with those operations described in the psychotherapy literature. The aim of this study is not to test hypotheses about pre-existing descriptions of the psychotherapeutic operations reported in the reviewed literature. However, psychotherapeutic operations from the reviewed literature will be compared to those psychotherapeutic operations found by this study in order to assess the quantity, quality and meaning of the findings.

In order to fulfill these aims, the methodology of this study will be designed to generate reliable and well-articulated descriptions of therapeutic operations which yield the relatively immediate in-session outcome of behavioural commitment under particular therapeutic conditions. The specific purpose of the study is to answer the questions, "What are the psychotherapeutic operations which are judged as antecedent and catalyzing patients' commitments to carry out new extratherapy behaviours?" As was noted in the review of technical literature on behavioural commitments, most of the authors' original descriptions were blends or clusters of operations rather than individual operations. Given the small number of examples found, little or nothing is currently known about the clustering or patterning of individual behavioural-commitment-catalyzing operations, although review of the examples found in the technical psychotherapy literature does produce the impression of some meaningful patterning. Although the aim of this study is not that of reliably identifying clusters of psychotherapeutic operations, given adequate data, it may be possible to derive provisional impressions about how operations are used together in obtaining behavioural commitments.

Examples of psychotherapeutic operations described on the level of abstraction of interest for this study were found in reviewing the literature, but few examples of patient context have been given. The "context" to be taken into account is the "immediate communicative context" (Heatherington, 1989), namely what the patient said and did prior to the therapist's use of an

operation, described on the same level of abstraction as the operations themselves. The aim of including the immediate communicative context is that of describing what the patient did which was judged as having contributed to the occurrence of the behavioural commitment, describing the patient-therapist interaction involved in catalyzing the behavioural commitment, or describing what the therapist did in relation to what the patient did. Stated differently, if the aim of studying operations in relation to relatively immediate outcomes is that of determining what the therapist did to contribute to the occurrence of the relatively immediate outcome, then likewise the aim of studying context in relation to operations is that of determining what the patient did which contributed to the occurrence of the therapist's relatively immediate use of a particular operation. The context to be taken into account will not include such broader or more abstract conditions as psychodiagnosis, personality characteristics, or institutional context.

In sum, the specific purpose of this study is to answer the question, "Which psychotherapeutic operations, used in which psychotherapeutic contexts, will result in the relatively direct relatively immediate occurrence of behavioural commitments?" If successful, this study should produce a collection of behavioural commitment-catalyzing psychotherapeutic operations such that the results of the study: (a) provide behavioural commitment-catalyzing operations where few if any are specified by existing psychotherapy process research; (b) are discussed in light of the operations mentioned in the technical psychotherapy literature;

(c) expand the utility and enhance the clinical meaningfulness of the operations by specifying conditions for their use; and (d) expand the utility and enhance the clinical meaningfulness of the operations by provisionally describing how they are organized as clusters or groups. The purpose of this study is not to test hypotheses about the psychotherapeutic operations reported in the reviewed literature, nor the testing of theories about catalyzing behavioural commitments.

Overview of the Research Strategy

Before the chapters which will explain at length the rationale for the general research strategy and the complete details of the research protocol this overview will introduce the research method. The methodology will be fully described in the "Method" chapter following exposition of the method's theoretical rationale.

Consistent with the preceding discussion, identified operations will be described at a level of abstraction suitable for psychotherapists of almost any theoretical orientation which values the occurrence of behavioural commitments. As discussed in the preceding review of the literature, few therapists of any orientation discuss operations catalyzing the relatively immediate therapeutic impact of behavioural commitment. Therefore, this study will examine a large number of psychotherapy sessions by therapists representing a broad array of theoretical approaches to psychotherapy, thus maximizing the yield and diversity of operations and therapeutic contexts to be identified. The general research strategy will be to identify

occurrences of behavioural commitment in psychotherapy sessions and to examine the therapist's use of psychotherapeutic operations which precede the occurrence of the behavioural commitment. This examination will be carried out by a team of researchers whose written observations will be pooled in order to provide a consensually valid composite description of the psychotherapeutic operations. In keeping with the purpose of producing descriptions of psychotherapeutic operations of potential use to psychotherapists of varying theoretical orientations, both judges' observations and the final composite descriptions shall be couched in ordinary, jargon-free language, as well as incorporating a description of the therapeutic contexts/conditions appropriate for the use of the identified operations. Results will be presented in the form of descriptions of individual psychotherapeutic operations, as well as a tabular depiction of the distribution of psychotherapeutic operations across instances of behavioural commitments.

Chapter 2

RATIONALE FOR THE METHODOLOGY

Overview

Given the unusual nature of this study's methodology, the purpose of this section is to supply a rationale for the selection of a research approach particularly suited to the technical study of therapeutic operations and their associations with in-session outcomes. An in depth presentation of such a rationale was considered necessary because the research strategy of this study is one which is not widely used nor widely understood, as is also generally the case with qualitative research methods. Although a growing number of psychotherapy process research reviewers have been signaling the potential advantages of incorporating qualitative research strategies into the collection of psychotherapy process research methods (Howard, 1983), a significant bias of opinion against such research methods does appear to remain (Shemberg, Keeley, & Blum, 1989). It was felt that a careful explication of the rationale for the use of a qualitative research method for answering the question posed by this study would serve to address commonly expressed concerns about the merits of such a methodological approach.

First, a brief general introduction to qualitative research will be presented. This general introduction will explain the philosophical and theoretical foundations of qualitative research, and the methodological commonalities associated with the qualitative research methods. The general introduction to qualitative research will be followed by a detailed discussion of

issues affecting the choice of research strategy in process research, serving as a rationale for the selection of a specific research method for this study.

It will be argued, based on the existing state of knowledge on operations catalyzing behavioural commitment in-session outcomes, and on the identified limitations of existing research approaches, that the most appropriate research strategy for this study is one which is discovery-oriented, intensive-observational, descriptive, micro-analytic, naturalistic, pan-theoretical and inductive versus one which is experimental, extensive-observational, using abstract or broad process categories, hypothesis-testing, theory-specific and using pre-determined/theoretical taxonomies of therapist operations. Detailed reviews of the arguments in favour of greater general use of such research strategies in psychotherapy process research may be found in Elliott (1983b), Mahrer (1985; 1988a), as well as in Safran, Greenberg and Rice (1988).

Discussion of issues pertaining to the general research strategy rationale will include: (a) discussion of the appropriate source of findings for psychotherapy process research, including a contrast between testing hypotheses from clinical theory as a source of findings and discovery-oriented research as a source of findings; (b) discussion of the issue of selection of an appropriate size of units of analysis, contrasting micro-analysis with macro-analysis; (c) discussion on the effects of unit size selection on the nature of applicability of the findings of psychotherapy research; and (d) discussion of

the issue of including contextual information in psychotherapy process research findings and of a research paradigm which produces practitioner-relevant findings by doing so. Based upon a discussion of these issues, a concrete research procedure will be selected for use in this study.

A Brief Introduction to Qualitative Research

The purpose of this section is to provide a general philosophical framework underlying the qualitative research methods. This general introduction to qualitative research will describe those philosophical, theoretical and methodological notions held in common by most qualitative research approaches, rather than by providing a thorough review of each approach or by comparing and contrasting the various qualitative approaches. This section should not be taken to imply that all qualitative methods fit all aspects of this general framework, or that the specific methodology of this research project will embody all of philosophical, theoretical and methodological underpinnings described herein. Qualitative research in psychology encompasses a number of distinct approaches, each of which varies somewhat in its theoretical underpinnings and varies considerably in its associated methodologies. Generally, the qualitative research approaches share a common underlying philosophy of science. This introduction will be divided into two sections; the philosophical/theoretical underpinnings of qualitative research, and some methodological commonalities of qualitative research. Rather than providing a shallow overview of the differences in method between qualitative approaches, this review will attempt

to convey a clear and deeper understanding of the foundations generally underlying qualitative research.

Qualitative research methods encompass a broad array of methodologies, the principle ones including phenomenology, experientialism, phenomenography, hermeneutics, and imaginal psychology (Aanstoos, 1987, August). Other qualitative approaches which have seen specific use in psychotherapy process research have been grounded analysis (Glaser & Strauss, 1967), discovery-oriented research (Mahrer, 1988a), task analysis (Rice & Greenberg, 1984b) and interpersonal process recall (Angus & Rennie, 1988; Elliott, 1984). In recent years, an explosion of interest in qualitative research has taken place, as evidenced by a rapid proliferation of texts on the matter (e.g., Bernard, 1994; Crabtree & Miller, 1992; Denzin & Lincoln, 1994; Erlandson, Harris, Skipper, & Allen, 1993; Fielding & Lee, 1991; Gilgun, Daly, & Handel, 1992; Gubrium & Sankar, 1993; Hamel, 1993; Hill, 1993; Lincoln & Guba, 1985; Marshall & Rossman, 1989; Miles & Huberman, 1994; Morse, 1993; Riessman, 1993a; 1993b; Silverman, 1993; Strauss & Corbin, 1990; Wolcott, 1990; Wolcott, 1994; Yow, 1994). This section will frequently cite the work of phenomenologists, which constitute the most prevalent and elaborated school of qualitative research.

A. The Philosophical and Theoretical Basis of Qualitative Research

The method, data, and purpose of qualitative research is best summarized by Giorgi in his statement that "...a phenomenologically grounded science uses a descriptive approach

in order to obtain the facts of a given experience in order to clarify their meaning" (Giorgi, 1986, p. 8). The aim of qualitative research is to produce a description of meaning (Svensson, 1986) remaining faithful to human phenomena as lived and experienced (Giorgi, 1975; 1985). The subject matter of qualitative research is "...the meaning of being human and living a human existence" (Mook, Wertz, & van Zuuren, 1987, p. ix). In order to remain faithful to human phenomena, deep, intensive study of the subject matter is followed by detailed description ("thick description") in an attempt to retain the richness, specificity, and complexity of its subject matter.

In these aims, qualitative research contrasts with quantitative research in which the complexity of human experience and behaviour is reduced to variables, quantified and statistically analyzed (Giorgi, 1985). Qualitative researchers believe that the quantitative imperative intrinsic to applying a natural sciences approach to psychological phenomena has resulted in overlooking or seriously distorting phenomena as lived and experienced (Giorgi, 1985). In a first departure from the quantitative, natural science approach, qualitative researchers (also known as human science, in contrast to natural science) believe that "Psychological research...should not limit itself to questions which can only be dealt with through statistical procedures" (de Koning, 1986, p. viii). In a second departure from the natural sciences approach, qualitative researchers believe that it is meanings as opposed to facts which are central in understanding behavioural acts (Giorgi, 1975). Consequently,

qualitative researchers consider descriptions to be a legitimate source of data in psychological research and that "...the object of perception is not necessarily exhausted by its material aspects" (Giorgi, 1986, p. 7). This has led Giorgi to define phenomenology in particular as "...the discipline that seeks the meaning of experience rather than its sheer facts" (Giorgi, 1986, p. 8).

In contrast to hypothetico-deductive research, the main focus of qualitative research is that of discovery by letting phenomena uncover themselves to the researcher (von Eckartsberg, 1971), for purposes of discovery and theory development, in contrast to research aimed at the verification of existing theories (Mook, Wertz, & van Zuuren, 1987), although qualitative research has been conducted on experimentally designed situations (Wertz & van Zuuren, 1987) and is also used in theory verification (Taylor & Bogdan, 1984). As stated by Svensson, "When meaning is not defined in advance but considered to have to be justified on an empirical basis, the research is descriptive in a fundamental sense." (Svensson, 1986, p. 23). As stated by Mahrer (1988a) the purpose of discovery-oriented research is to allow for answers to research questions that might not have been expected, predicted, or hypothesized.

In contrast to the natural sciences approach, qualitative research rejects the possibility of "objective" knowledge, based upon two principle philosophical considerations. The first of these considerations is that research findings are inextricably related to the laws that govern the methodology that brought

about the findings. Science, as applied philosophy, produces findings which are dependent upon an underlying philosophy. Therefore, scientific knowledge can never be regarded or acted upon as objective truths, having a separate existence from the philosophical position of the researcher (Gadamer, 1981). The second philosophical consideration is that knowledge is held to be inextricably part of human experience and as such is inseparable from it. Knowledge existing apart from an observer's experience ("objective knowledge"), is held to be impossible, since knowledge is viewed as an observer's act of interpretation. Without human experience of the knowledge, there is no knowledge, therefore all knowledge is subjective (Giorgi, 1970). Qualitative researchers reject the view that psychological research must be founded on a positivistic philosophy (Giorgi, 1986). In qualitative research, "...phenomena are described as they present themselves as meanings for us without taking the further step of stating that they really are what they mean to us. (This is the meaning of phenomenological reduction)" (Svensson, 1986, p. 32).

Qualitative research is interpretive and reflective, seeking "...insight into the meaning of the subject matter rather than a merely passive stock-taking of its pertinent facts" (Wertz & van Zuuren, 1987, p. 4). In contrast to a positivistic, natural science approach, qualitative research requires the researcher's enthusiasm and commitment rather than a dispassionate detachment from the phenomenon being studied (Kvale, 1987). Furthermore, in contrast to positivistic science, where objectivity requires one

correct meaning, qualitative research assumes that a plurality of interpretations is possible (Kvale, 1987).

A common characteristic of all qualitative research, according to Wertz and van Zuuren (1987) is that in contrast to extracting and observing only a limited subset of qualities of the subject matter, qualitative research approaches maintain that a true understanding of a phenomenon requires attention to all of its qualities in order to describe its full complexity. Qualitative research requires immersion into all of the details of the phenomenon, analysis of these details, and a subsequent synthesis encompassing all of the details.

Unlike quantitative research which extracts a few theoretically relevant elements removed from the context of other qualities of the phenomenon being studied, qualitative researchers are careful to situate phenomena in context. This involves the study of actual occurrences of the phenomenon in the everyday world (Aanstoos, 1987, August; Giorgi, 1975), knowledge of the person's cultural background, traditions, life experience, socioeconomic factors, and social context and especially the subject's viewpoint on the situation as a context (Giorgi, 1975). All of these elements are considered as a whole in arriving at an understanding of a phenomenon. Furthermore, qualitative researchers attempt to gain a sense of the whole interview before attempting to analyze it, in order to develop a sense of the whole as a context (Hycner, 1985). Qualitative research's attention to the whole phenomenon includes attention to the sociocultural, historical, theoretical context within which a

person, phenomenon or experience is situated, including the social context and culture of the researcher (de Koning, 1986).

Given its acceptance of a plurality of interpretations, qualitative research has different criteria for validity than positivistic research. In qualitative research, the principal criterion for validity is that another researcher, adopting the same viewpoint as articulated by the researcher, is also able to see what the researcher described, regardless of whether the two researchers agree on the interpretation (Giorgi, 1975). The validity of qualitative descriptions may be assessed by several further means. One criterion is that the method is appropriate for investigating what it intends to investigate (Hycner, 1985). A second criterion is that research subjects agree with the interviewer's interpretation. A third criterion is whether an interpretation is reasonably documented and logically coherent, as assessed by the readers of the research (intersubjective acceptability). A fourth criterion, used when a statement is interpreted within the context of a theory, is the intersubjective consensus among theoretically competent persons (Kvale, 1987). A fifth criterion is whether the findings "ring true" to the researcher. A sixth criterion is whether the findings fit with the literature in the area (Hycner, 1985).

B. Methodological Commonalities of Qualitative Research

This second part of the introduction to qualitative research will aim to impart a conceptual rather than technical understanding of qualitative research methodology. Detailing the procedural commonalities of the qualitative approaches at a

specific level would be difficult due to a greater variation in qualitative research's methodologies than in their foundation. As in the first part of this introduction, the bias of this description will be toward citing the work of phenomenologists.

Qualitative research generally begins with an in-depth understanding and explication by the researcher, of the rationale and paradigmatic underpinnings for the methods to be used. Qualitative researchers strive to maintain a dialogue between the approach, the method, and the content (de Koning, 1986, p. x). Practically, this means that qualitative researchers select, adapt or construct a method in order to answer the research question, in contrast to the natural science approach which, in studying human phenomena, generally adapts the research question to fit a methodological imperative of deduction, hypothesis testing, quantification, and experimentation.

Based upon the fundamental subjectivity of knowledge which constitutes the philosophical basis of the qualitative methods, qualitative researchers strive to "...maintain a critical dialogue with their own assumptions and presuppositions" (de Koning, 1986, p. x). Consequently, once the phenomenon to be studied is identified, qualitative researchers attempt to become aware of any past learning on their part which would lead them to preconceptions, biases and assumptions about the subject matter to be studied. In the case of psychotherapy research, for example, these influences could include theoretical knowledge of particular psychotherapeutic schools, clinical training and clinical experience with subject matter similar to that which is

to be studied. In writing about the research, qualitative researchers attempt to make their assumptions as explicit as possible.

Following the step of having identified and made explicit their assumptions about the subject matter, researchers who are using a phenomenological qualitative research method then deliberately attempt to bracket their assumptions while observing and describing the subject matter. Bracketing assumptions involves approaching the subject matter as though it were new to the researcher, or as if naive about it. It should be noted that bracketing of assumptions is characteristic of the phenomenological approach, but not of the other qualitative research methods. In the phenomenological approach, the researcher's focus of attention is on carefully and thoroughly describing the subject matter with an openness to whatever meanings emerge (Hycner, 1985), rather than examining the subject matter from the framework of pre-existing ideas, theories, or hypotheses (Giorgi, 1986). The researcher is to "...abstain...from hypothesis-testing, deductive or inferential reasoning, premature generalizing, and value judgments" (Wertz & van Zuuren, 1987, p. 16). Phenomenological researchers believe that a complete phenomenological reduction is impossible; bracketing is always an imperfect effort which is compensated for by the preceding step of being very explicit about one's assumptions (Taylor & Bogdan, 1984; Giorgi, 1975; Hycner, 1985), critical self-reflection being considered the best check on the researcher's own biases (Taylor & Bogdan, 1984). According to

Giorgi, "'pure description' is impossible because various factors enter in to contaminate it such as language, conceptualizations, the perspectival nature of experience and the existence of subjective meanings all of which require interpretation" (Giorgi, 1986, p. 11). In qualitative research methods other than phenomenology, different means than bracketing are used in order to take into account the preconceptions and prejudices of the researchers. For example, in the grounded theory approach (Glaser & Strauss, 1967), two researchers will independently carry out a grounded analysis, following which the researchers compare their results for purposes of verification. In the discovery-oriented approach (Mahrer, 1988; Mahrer & Gagnon, 1991), a team of observers is used in order to include and balance a number of different possible perspectives.

Subjects may be single individuals, groups of persons, expert witnesses, or broad samples of people (Wertz & van Zuuren, 1987). The data of qualitative research generally consist of interviews with research subjects (Mook, Wertz, & van Zuuren, 1987) in order to elicit their naive descriptions (Svensson, 1986) of their lived experience. Generally, qualitative research uses "...naive descriptions of personal experiences provided by individuals from all walks of life in situations that are easily recognizable as belonging to everyday life (Giorgi, 1985). Descriptions may be of past events, simultaneous description of an ongoing experience (Aanstoos, 1987, August), or even imaginative experiences (Giorgi, 1987). The data may also consist of written texts (e.g., hermeneutics), or multiple judges'

written descriptions of events taking place in tapes or transcripts of psychotherapy sessions.

Qualitative analysis is carried out through reflective analysis, interpretation (Svensson, 1986) and description. This process involves free exploration, innovation, creative insight, and critical self-reflection (Straus, 1980). In phenomenological analysis, the researcher attempts an "...apprehension of what it is like to live through the matter under investigation" (Wertz & van Zuuren, 1987, p. 4). Unlike quantitative research, in which a single step of coding data with preconceived meanings is carried out, qualitative analysis is a dynamic process in which researchers continually re-evaluate and refine their interpretations based on newly revealed meanings and deeper understanding of the phenomenon (Taylor & Bogdan, 1984). Describing the specific procedures of any of the qualitative research methods beyond such a general level is beyond the scope of this section. For detailed expositions of qualitative analytic procedures, the reader is referred to Giorgi (1975; 1985), Glaser & Strauss (1967), Hycner (1985) Rice & Greenberg (1984b), and Wertz (1983). Suffice it to say that in phenomenological approaches, data analysis usually proceeds through the steps of immersion into the phenomenon, attempting to gain a sense of the whole phenomenon, analysis of the phenomenon into its constituent natural meaning units, examining the meaning units in terms of the study's research questions, and synthesis of the meanings into a descriptive statement of the essential, non-redundant

themes, or an articulated structure of meanings (Giorgi, 1975, Hycner, 1985).

The nature and aim of the descriptions created in qualitative research vary, but have in common an attempt by the researcher to describe the basic essence or meaning structure of the phenomenon under study and the uncovering of the intentionality of experience (Svensson, 1986, Wertz & van Zuuren, 1987). Variations on this goal have been expressed as: describing the basic structures of lived experience (Polkinghorne, 1983); describing the essential psychological meaning-structure of the phenomenon including everything implicated in the original everyday descriptions (Aanstoos, 1987, August); and in discovery-oriented psychotherapy process research, creating a practitioner-relevant composite description of psychotherapeutic conditions, operations, and consequences (Mahrer, 1988a). Qualitative researchers attempt to stay as close to the original data as possible, usually making use of verbatim quotes from subjects in illustrating descriptions. The results of qualitative research should ideally be inherently attractive to the reader by being "...psychologically relevant, understandable, and not too abstract" (Wertz & van Zuuren, 1987, p. 21).

In summary, qualitative research encompasses a variety of different research approaches which generally have in common the characteristics of: (1) going beyond perceptual givens in studying human experience; (2) accepting meanings as valid research findings; (3) studying the full complexity of human experience rather than artificially simplifying the subject of

study; (4) letting meaning emerge from the data rather than coding data with pre-selected meanings; (5) being oriented mainly to discovery and theory building rather than theory verification and hypothesis testing; (6) rejecting the positivistic notion of objective truths in studying psychological phenomena; (7) being interpretive and reflective in its study of phenomena; (8) requiring intense involvement with the phenomenon rather than dispassionate detachment; (9) paying attention to various contexts of the phenomenon rather than studying the phenomenon in isolation or in controlled conditions; (10) accepting a plurality of possible subjective interpretations in contrast to the belief in one correct truth; (11) fitting the research approach to the phenomenon instead of selecting the phenomenon to fit the research approach; (12) in the case of phenomenology, observing and describing phenomena afresh rather than using theoretical or other preconceptions; (13) studying phenomena in natural situations rather than artificial situations; (14) having as its goal describing the basic essence or meaning structure of phenomena; and (15) producing as its research reports descriptions which are psychologically relevant and close to the original data in their level of abstraction.

The purpose of this section was to provide a general philosophical framework within which to understand the more specific methods and purpose of this study. This introduction to the general philosophical frame will be followed, in the next section, by a detailed discussion of theoretical and practical issues affecting the choice of research strategy in psychotherapy

process research, serving as a rationale for the selection of a specific research method for this project.

The Source of Findings:

Observation and Description Vs. Hypothesis Testing

Since the aim of the study is to identify specific psychotherapeutic operations which catalyze behavioural commitments, the following discussion will contrast naturalistic, observational, descriptive research (henceforth to be referred to in this manuscript as "discovery-oriented research") to hypothesis-testing research in order to demonstrate the advantages of carrying out a study which derives its findings directly from naturalistic data, through the use of empirical induction. Such a comparison involves a discussion of the role and place of descriptive research in the overall process of scientific investigation. This comparison also differentiates between theoretical and technological aspects of psychotherapy process research.

A. Clinical Theory As a Source of Findings

The familiar hypothetico-deductive research strategy involves the drawing of hypotheses from a relevant body of theory and the empirical testing of the resultant hypotheses. The results of hypothesis testing subsequently are fed back to the theory, either confirming or disconfirming aspects of the theory and thus improving the adequacy of the original model. The overwhelming emphasis in psychological research is on theory modification through hypothesis testing rather than on theory generation through descriptive research (Hill, Carter, &

O'Farrell, 1983; Rennie, Phillips, & Quartaro, 1988). Although the first method has been successful in advancing the state of knowledge in other scientific endeavors, several problems have become apparent in recent years in the exclusive use of this research strategy for psychotherapy process research (For extensive expositions of these problems, see Arthur, 1972; Hill, Carter, & O'Farrell, 1983; Kiesler, 1966; Mahrer, 1988a; Rennie, Phillips, & Quartaro, 1988; Tsoi-Hoshmand, 1989). Some of these problems apply generally to any research which neglects naturalistic observation and empirical induction, whereas others are specific to the nature of the question addressed by this study.

The first and most salient problem in attempting to study specific psychotherapeutic operations by testing hypotheses deduced from theories of psychotherapy is that the clinical technical literature frequently lacks adequate specificity on the matter of actual therapeutic operations (Colby, 1964; Kazdin, 1983; L'Abate & Colondier, 1987). That is, the organization of the theory's propositions is made explicit, but gaps are frequently present in the explicitness of associations between the theory's abstract elements and concrete psychotherapeutic operations at a fine or "molecular" level. Therefore, the technical psychotherapy literature supplies no "ready-made" hypotheses for the study of specific, concrete psychotherapeutic operations. For example, the technical psychotherapy literature review showed that the carrying out of new behaviours outside of psychotherapy is of importance to many psychotherapeutic

approaches, but that the process of arriving at behavioural commitment in therapy is addressed by very few clinical writers. Moreover, of those clinical writers who do specify their methods enough to explicitly address behavioural commitments, very few of them specify any psychotherapeutic operations to bring about this event. Finally, of the few writers who attempt to specify psychotherapeutic operations which catalyze behavioural commitment, even fewer specify their operations in a manner which does not leave the reader guessing. As an example of each of these "levels" of lack of specification a cyclical theory of psychotherapeutic change proposed by Andrews (1977), will be presented. According to this theory, (the patient's) Self-concept (affects) > Needs and feelings toward others > actions toward others > others' impressions > others' actions > (selective) perceptions of others > labeling and interpretation of others' actions > (completing the cycle to) self-concept. One of Andrews' stated principal goals of psychotherapy is "...to help the client initiate novel actions which he or she can integrate into a changed sense of self" (Andrews, 1977, p. 44). Although this statement declares the importance of patients carrying out new behaviours, it does not clarify whether these new behaviours should be "initiated" within therapy, outside of therapy, or in both of these loci. Andrews further states that "A clear sense of self can serve as a launching platform for consciously seeking out new experiences; and a novel experience, sought or unsought, can provide illumination as to who we are" (Andrews, 1977, p. 44). This statement still does not specify the loci of new

behaviours. Andrews attempts to specify "change-oriented psychotherapeutic techniques" associated with each stage of his change cycle, stating that for the "Actions toward Others" stage, corresponding psychotherapeutic techniques are: "Encourages new behaviour, via experiments (gestalt), behavioral assignments, role-playing." (p. 45). This degree of specification still refers to broad categories of psychotherapeutic operations rather than to specific operations. Given such a degree of specification, questions remaining about Andrews' methods could be: "What new behaviours?", "What does the therapist say and do in order to direct the patient through a gestalt experiment?", "What sort or manner of behavioral assignments?", "What sort of role playing and toward what specific end?", "How are these methods combined or sequenced?". Andrews' specification of his methods leaves unaddressed the questions of what therapists are to say and do to bring about the selection of new behaviours, the patient's acceptance of new behaviours, and the entire issue of behavioural commitments to carry out new behaviours outside of therapy. It should be noted that Andrews, for all his lack of specificity, is still much more thorough than most in specifying his methods. This fairly intact example was chosen because other theoretical descriptions are so lacking in specifics as to render them useless for discussion purposes.

Andrews' formulation, though more specific than most clinical authors', shares the same tendency to carefully elaborate theory (which explains why psychotherapy works) rather than to specify operations (which explicate how psychotherapy

works). Andrews' formulation was used as an example of how we cannot derive operations from theory because operations are not articulated in the theory. This problem was described by Goldfried and Davison (1976) in Clinical Behavior Therapy. They attempted to be highly specific about the psychotherapeutic operations they used:

A colleague of ours once alluded to a "therapeutic underground" among clinical workers of various orientations. He struck a resonant chord, for we are continually impressed by the distance between written descriptions of behavior therapy and what occurs in practice....as any knowledgeable student of behavior therapy can appreciate, more is required of the behavioral clinician than familiarity with well-established principles and procedures. Much of what you will find in this book will necessarily be based on clinical experience, our own and that of our students and colleagues. While some readers may be uncomfortable with an appeal to clinical experience, for the time being this seems to us the most straightforward way of talking about clinical behavior therapy. (Goldfried & Davison, 1976, p. vii)

Taking the most favorable view, it seems that theories of psychotherapy "do not always enumerate all of their operative principles or active ingredients" (Klein & Gurman, 1981, as cited in Gurman, 1983, p. 233). From a less positive perspective, the detachment of psychotherapeutic theory from its technology (viz., its specific operations) has been viewed as a serious problem. This position has been forcefully commented on by L'Abate & Colondier:

Since what is talked about (theory) is so widely separated from what is done (practice), one is led to conclude that theory fails to link itself to actual behavior, or it is so generally and vaguely stated that it fails to link itself to specific therapeutic practices. If there are links, they are weak, that is, they are either too vaguely and abstractly stated or practically non-existent. Thus far, to our knowledge, no one has been able to deduct specific propositions that may lead and link to specific therapeutic practices or consensually validated conclusions. (L'Abate & Colondier, 1987, p.22)

Such a lack of explicit associations between the various levels of abstraction of the theory constitutes a problem because it renders the drawing of hypotheses from the theory into an interpretative, speculative and creative act in and of itself. As stated by Colby, "It is often difficult to see how specific therapeutic techniques are deducible from the theory" (Colby, 1964, p. 362). This condition creates a great risk of producing hypotheses which, at large research cost, will ultimately be falsified. If, indeed, the technical psychotherapy literature contains few propositions usable as ready-made hypotheses on specific psychotherapeutic operations (operations on the same low level of abstraction as those described in the preceding literature review, viz., operations which are consensually observable), then hypotheses on specific operations must be deduced from abstract levels of the theory. Deducing tangible hypotheses from abstract levels of the theory is an inevitable, intrinsic part of ascertaining how well the abstract components of the theory explain empirical observations. However, when the aim of a study is to generate knowledge on specific operations, as is the case for this study, then this knowledge is generated much more efficiently, reliably and cheaply through descriptive-

observational study than through conjecture based upon theories. That is, when the aim of the research is to study phenomena of a consensually observable nature rather than to study highly abstract constructs, one has the choice between empirical induction and theoretical deduction. The present argument is that the discovery-oriented research strategy should logically yield findings about specific psychotherapeutic operations which stand a greater chance of being "true" than hypotheses based upon theoretically-derived conjecture. The argument is that direct observation and description of specific psychotherapeutic operations will produce more valid findings more directly than a hypothesis-testing study in part because there exists little or no grounds upon which to generate hypotheses on specific psychotherapeutic operations from either the research literature or technical psychotherapy literature. If the aim of this study were to determine the general characteristics, components, stages, or phases of psychotherapy, then the observation that specific psychotherapeutic operations may not readily be deduced from the theory would not constitute a problem. However, given that the aim of this study is to examine psychotherapeutic operations on a level of abstraction similar to those operations described in the preceding review of the literature, then the lack of specificity of theory on such a low level of abstraction clearly constitutes a problem. Perhaps an analogy would help clarify the concept. Based upon the characteristics of class Mammalia listed in Linnaeus' Systema Naturae, a biologist could hypothesize the existence of undiscovered species of mammals. The

probability of hypothesizing a specific mammal with the characteristics of a platypus would be infinitely small. However, in contrast, a biologist doing discovery-oriented research (naturalistic, observational, descriptive research) could go out into the field, investigate as many animals as possible in the environment, and could (as did indeed happen) discover the platypus, a rare "event", not predictable from the theory, but one which did indeed exist.

Aside from the issue of the explicitness of associations between abstract theoretical elements and concrete therapeutic operations, concrete therapeutic operations have traditionally rarely been described with specificity in technical psychotherapy literature. This lack of specification of operations is quite apparent in the previous literature review on behavioural commitment. It is apparent that an important number of psychotherapies explicitly value behavioural commitments or that they implicitly value behavioural commitments by virtue of valuing the carrying out of new behaviours outside of therapy. One must assume that these authors, while doing psychotherapy, do and say particular things to catalyze the occurrence of behavioural commitments. Very few of them, however, specify the psychotherapeutic operations which they use to obtain those behavioural commitments.

The widespread lack of specificity in technical psychotherapy literature has been commented on disparagingly by reviewers. For example, in a review of psychotherapy research, Kazdin concluded that "In relatively few therapy techniques are

the critical procedures specified to permit careful analytic investigation for dismantling, constructive, or parametric research" (Kazdin, 1983, p. 270)(it should be noted that Kazdin uses the term "technique" to refer to a school, a type, or a theory of psychotherapy). Moreover, when it is found, specificity in the description of therapeutic operations has received praise from psychotherapy researchers as constituting a valuable contribution to the field (e.g., Bond, 1974).

Such a lack of specificity in the description of concrete therapeutic operations and in their associations with the abstract elements of the body of psychotherapy theory have led to expressions of dissatisfaction with clinical theory, including negative remarks about psychotherapy theories such as "However interesting, plausible, and appealing a theory may be, it is techniques, not theories, that are actually used on people. Study of the effects of psychotherapy, therefore, is always the study of the effectiveness of techniques" (London, 1964, p. 32). As expressed by Prochaska and DiClemente (1982),

The content that is to be changed in any particular therapy is largely a carryover from that system's theory of personality and psychopathology. Many books supposedly focusing on therapy frequently confuse content and process and end up describing primarily the content of therapy with little explanation about the processes of therapy. As a result, they really are books on theories of personality rather than theories of therapy. (Prochaska & DiClemente, 1982, p. 282)

The frustration with psychotherapy theory has occasionally been sufficiently intense to engender the occasional public rejection of psychotherapy theory as a clinical heuristic by some clinicians (e.g., Arnold Lazarus, in Lazarus, 1971).

This first problem--lack of specificity in theories--is compounded by the fact that the more specifically defined a category of events is, the rarer the event becomes. Thus, a second problem with using a hypothesis-testing research strategy for studying specific operations is that, unlike studying broad theoretical categories (such as the content analysis categories frequently used in psychotherapy process research), examining specific therapeutic contexts, operations and in-session outcomes usually involves the study of rare events. The rarity of the events to be studied may render the gathering of sufficient data for statistical treatment impractical and/or impossible. Thus, the study of highly specific and rare categories of events in psychotherapy is often incompatible with research methods relying on quantitative hypothesis testing. Short of disregarding the study of relevant clinical phenomena simply because of their infrequent occurrence, the only alternative available is to study these rare events using methods which yield limited causal certainty. This same logic has led other psychotherapy researchers to develop research methods which permit inferences of causality through the observation of temporal contiguity between psychotherapeutic events, through description, and through replication (such as by the use of multiple case studies). This was the case with comprehensive process analysis. For example,

(Comprehensive Process Analysis) is based on two ideas: (1) There are significant or critical events which are central to the personal change process in psychotherapy; (2) Since these events are infrequent, they should be studied in detail. (Elliott, 1983a, p. 113)

The same problem is involved with studying any rare event in therapy, such as the study of good and very good moments in psychotherapy (Mahrer, Dessaulles, Nadler, Gervaise, & Sterner, 1987), "key, critical, decisive, significantly helpful or hindering sessions in psychotherapy" (Elliott, 1983a, p. 113), auspicious moments (Kelman, 1969), dramatic examples of psychological problems and their treatment (Kazdin, 1980), and rare effects of treatment (Kazdin, 1980). There is a long-standing tradition of studying rare events in psychotherapy through the case study, causal claims of limited degrees of strength more recently being bolstered through detailed description (e.g., most of the qualitative methods previously listed) and the aggregation of cases involving similar events (Kazdin, 1980). In the case of such rare events, hypotheses are induced from the observation of individual rare events, repeated observations of similar rare events constituting replications of the original finding and a test of the original hypothesis, which is that the rare event is not a random occurrence.

A third problem with studying specific psychotherapeutic operations by testing hypotheses derived from technical psychotherapy literature is that drawing hypotheses concerning concrete psychotherapeutic operations from psychotherapy theory begs the question, assuming that the answer is already known. As stated by Arthur (1972) "It is as if one assumed that all the important facts about human behaviour were already known and that therefore all we needed to do now was go to the laboratory and to test our explanations of them" (p. 329). As an example, an

attempt to derive hypotheses on specific psychotherapeutic operations from the psychotherapy literature reviewed earlier in this chapter would encounter a number of difficulties. Firstly, if one wanted to derive hypotheses from research findings, only two such operations have been identified. Secondly, if one chose to derive hypotheses from the technical psychotherapy literature, the relation between psychotherapeutic operations and behavioural commitments is not carefully specified for research purposes, but is written in a looser, conversational style. The nature of the relation between operations and behavioural commitment is not specified, other than to state with different degrees of qualification that certain operations promote behavioural commitments. Is any one operation necessary, sufficient, facilitative, ancillary, complementary, or interactive? Since none of the technical psychotherapy literature reviewed specified these relations, any derived hypothesis would constitute pure guesswork. This problem is particularly compounded by the observation that in their technical psychotherapy writings, clinicians generally describe using a number of psychotherapeutic operations together in obtaining behavioural commitments. Deriving simplistic hypotheses on the effectiveness of individual operations out of the context of adjunctive operations could result in false negative findings due to invalid hypotheses. One could test hypotheses about behavioural commitment-catalyzing psychotherapeutic operations, but no clear basis for deriving hypotheses on this matter exists.

An alternative to hypothesis testing which is compatible with a discovery-oriented approach is increasing the confidence in the findings by studying repeated natural occurrences of the same event, a procedure analogous to the aggregation of cases involving similar events (Kazdin, 1980). In this alternative form of hypothesis testing, observed instances of the phenomenon under study lead to studying further instances. Each new instance of the phenomenon being studied is compared to what has already been found in order to confirm the previous finding or to heighten the confidence with which the findings may be held. This alternative form of hypothesis testing simultaneously provides the opportunity to confirm previous observations as well as leaving room for further discovery. It should be noted that this is not the usual meaning of hypothesis testing.

To expand on the argument that hypothesis testing would beg the question of this study, the belief that a broad range of the possible therapeutic operations catalyzing a particular in-session outcome could be most productively studied by testing hypotheses derived from technical psychotherapy literature assumes either: (a) That extant clinical-theoretical writings already specify a substantial portion of the set of all possible operations (i.e., extant literature contains "ready-made" hypotheses; or (b) That the extant body of technical psychotherapy literature already incorporates abstract propositions which effectively embody the phenomenon under study (catalyzing behavioural commitments), such that a substantial

portion of the set of all possible operations may be readily identified by deriving hypotheses from this literature.

The first assumption, that extant clinical-theoretical writings already specify a substantial portion of the set of all possible operations, is demonstrably false in light of the results of the preceding chapter's literature review in which it was found that three clinical authors had contributed nearly all of the handful of explicit behavioural commitment-catalyzing psychotherapeutic operations described in the reviewed literature.

The second assumption, that a substantial portion of the set of all possible operations may be deduced from bodies of theory which already incorporate such phenomena, is unlikely to be true both generally and in relation specifically to the study of behavioural commitments. Generally speaking, the complaint has been frequently voiced in the literature that very few specific operations have been linked to theory in clinicians' writings (Kazdin, 1983; Kiesler, 1966; L'Abate & Colondier, 1987). Also, a growing number of researchers have adopted qualitative research methods because they do not believe that theory-driven hypothesis-testing research has been adequate in identifying specific psychotherapeutic operations. These descriptive research methods include, but are not limited to, the following: discovery-oriented research (Mahrer, 1988a; Rice & Greenberg, 1984a); qualitative analysis (Todd, 1987); observational research (Bakeman & Gottman, 1986); symptom-context method (Luborsky & Auerbach, 1969); state analysis (Marmar, Wilner, & Horowitz,

1984); interpersonal process recall (Elliott, 1984); intensive analysis of process (Rice & Greenberg, 1984a); inductive observation (Tsoi-Hoshmand, 1989); the grounded theory approach (Glaser & Strauss, 1967; Rennie, Phillips, & Quartaro, 1988); qualitative-phenomenological research (Bogdan & Taylor, 1975); naturalistic research (Tsoi-Hoshmand, 1989); comprehensive process analysis (Elliott, 1983a); and intensive local observation (Cronbach, 1975).

Finally, the view that clinical theoretical abstractions already embody the phenomenon of catalyzing behavioural commitments is not tenable in light of the literature review presented in the first chapter of this manuscript. There appears to be no psychotherapeutic theory directly addressing the phenomenon of catalyzing in-session behavioural commitments. In fact, though specific descriptions and examples of behavioural commitment-catalyzing operations may be found in the technical psychotherapy literature, this technological knowledge has yet to be linked to explanatory theory. Such a state of affairs actually constitutes a strong indication that the study of catalyzing behavioural commitments is in its initial stage and that a copious amount of discovery-oriented research should precede theory-testing research. As stated by Hill, Carter and O'Farrell (1983), "In 'good science', a theory should be derived only after repeated observations and confirmations of hypotheses that have ruled out competing explanations" (p. 26).

To summarize, there are several reasons why hypothesis-testing research methods appear to be ill-suited to answering the

question posed by this study. These reasons include: (a) the lack of specificity of psychotherapy theories on the matter of concrete therapeutic operations; (b) the conjecture involved in deducing specific therapeutic operations from clinical theory; (c) the alternative possibility, given the aim of studying specific operations rather than theory-testing, of alternate methods which would produce less conjectural propositions; (d) the rarity of the specific psychotherapeutic operations under study and hence the inappropriateness of quantitative study for such data; (e) that deriving hypotheses from the extant body of clinical-theoretical knowledge begs the question; and (f) the fact that hypotheses cannot be derived from the extant body of clinical-theoretical knowledge, as there exists extremely little knowledge on catalyzing behavioural commitments.

B. Discovery-oriented Research As a Source of Findings

One of the principal arguments which will be made in this section is that discovery-oriented research is crucial for the identification and study of important phenomena which would not otherwise be predicted or addressed by theory-driven, hypothesis-testing research. That is, discovery-oriented research is geared toward making surprise findings of important phenomena, without prediction of their existence, and naturalistic, descriptive research in general, is particularly suited for the study of rare events. Discovery-oriented research is a more appropriate research method than more conventional methods (i.e., theory-driven hypothesis-testing research) given the aims of the present study and the current state of knowledge on its research

question. The second principal argument which will be made is that inductive observation, effected through qualitative research methods, stands a greater chance of generating propositions which will be supported than individual, idiosyncratic, unsystematic means of observation (e.g., individual clinicians' case studies). This second argument issues forth from concerns with the empirical identification of events rather than the prediction of events from theories. Also, it will be argued that without the knowledge provided by discovery-oriented research, hypotheses deduced from theories are unlikely to test true due to being stripped of relevant contextual variables.

A qualitative research strategy which has seen productive use in recent psychotherapy process research (e.g. Barkham & Shapiro, 1986; Gervaise, Mahrer, & Markow, 1985; Hill, Helms, Spiegel, & Tichenor, 1988) has as its purpose the drawing of propositions on psychotherapy processes directly from systematic observation of the natural psychotherapy situation. Such a research strategy involves the study of relations between observed events through direct systematic observation, rather than through the testing of hypothetical predictions based on existing theory. That is, qualitative inductive observation aims to produce propositions of greater validity, both in the sense of being more complete descriptions and in the sense of increasing the likelihood of the propositions being true in an ultimate sense, due to their being derived from direct observation, rather than from insufficiently grounded theory. Yet more importantly, qualitative inductive research is particularly suited to the

discovery of specific psychotherapeutic operations (operations described on a low level of abstraction, and with a high degree of consensual observability), a task for which hypothetico-deductive research is poorly suited.

Discovery-Oriented Research and The Identification of New Phenomena

The first principal argument for the use of a discovery-oriented research method is that, given the aims of the present study and the current state of knowledge on the research question, it is a more appropriate method to use than theory-based hypothesis-testing methods. The prescriptive argument for the use of discovery-oriented research is that naturalistic, observational research is necessary for making unexpected, unpredictable discoveries of relevant phenomena. To quote Bakeman and Gottman:

It is perfectly legitimate...to begin the process of systematic observation with the simple goal of description. As we gain experience with the phenomena we are investigating, we learn which variables are important to us. We can begin our investigation with a search for order....The wonderful thing about observational research is that it maximizes the possibility of being surprised....Hypothesis-generating research can play a vital role in the process of description and in the identification of phenomena. This kind of observational research is essential in new areas of investigation. (Bakeman & Gottman, 1986, p. 17)

This is a critical distinction between discovery-oriented research and hypothesis-testing research; hypothesis-testing research is geared toward the verification of pre-conceived propositions, generally based upon theoretical conjecture, whereas discovery-oriented research is geared toward the

discovery of phenomena the existence of which are not pre-conceived nor expected (viz., newly discovered phenomena). In addition, discovery-oriented research may be used to simultaneously make new findings as well as to verify, confirm, or increase the confidence in previous findings. In fact, given that hypothesis-testing research only seeks to examine whether certain predefined propositions are correct or not, through such a narrow focus, hypothesis-testing research cannot serve the purpose of discovering new, unexpected phenomena. Discovery-oriented research, on the other hand, is geared toward the empirical induction of new propositions directly from the raw data of observation. Given that the goal of this study is the discovery and description of which psychotherapeutic operations are used by therapists in catalyzing behavioural commitments, and this without being limited to preconceived notions based on theory or non-existent prior research on the question, then the discovery-oriented method is appropriate for this study.

Discovery-Oriented Research and Rare Events

A second prescriptive argument is that in contrast to traditional hypothesis-testing research, discovery-oriented research is suited to the study of rare, naturally-occurring events. Hypothesis-testing research relies on quantitative, statistical methods applied to relatively broad classes of events considered as variables toward the end of validating the truthfulness of an hypothesis. Thus, the hypothesis-testing approach requires a relatively large number of instances of events. In contrast, discovery-oriented research bases the

validation of the truthfulness of a proposition on collecting multiple instances of similar events (replication over instances)(e.g., Elliott, 1983a, 1983b, 1984; Mahrer, 1987; Mahrer, 1988a; Mahrer, Nadler, Gervaise, & Markow, 1986; Mahrer, White, Souliere, Macphee, & Boulet, 1991; Todd, 1987), careful description (Bogdan & Taylor, 1975; Glaser & Strauss, 1967; Labov & Fanshel, 1977; Tsoi-Hoshmand, 1989), the use of detailed examples and verbatim quotes (Todd, 1987), pooling the description of a large number of trained judges (e.g., Mahrer, Nadler, Gervaise, & Markow, 1986; Mahrer, White, Souliere, Macphee, & Boulet, 1991), describing from multiple perspectives (e.g., patient, therapist, and observer descriptions of the same event)(e.g., Elliott, 1983a, 1983b, 1984), and careful description and documentation of the process by which inferences were drawn from the data (Todd, 1987). Thus, discovery-oriented research is suited to the study of rare, naturally-occurring events, whereas hypothesis-testing research is poorly suited to this task.

Discovery-Oriented Research and The "Developmental Stage" of Scientific Knowledge

One proscriptive argument is that in contrast to discovery-oriented research, hypothesis-testing research would be appropriate to a much later stage of science than that which would be appropriate for this study, given that its purpose is the testing of hypotheses which should have properly been based on a foundation of knowledge obtained from adequate naturalistic qualitative observation (Bordin, 1965) rather than with the

production of such basic knowledge (Arthur, 1972). The scientific development of psychotherapy process research in general is considered by some psychotherapy researchers (e.g., Hill, Carter, & O'Farrell, 1983) to be such that experimental research is premature.

A second proscriptive argument is that the study of natural psychotherapy situations is appropriate at the present state of knowledge on behavioural commitment. The degree to which research can depart from the naturalistic setting is proportional to the amount already known about a phenomenon, a great deal of knowledge being required before moving from the natural setting into the laboratory, where one must be able to establish the equivalence of simplified/contrived events to those of the natural situation (Bordin, 1965). The existing paucity of knowledge on psychotherapeutic operations catalyzing behavioural commitments has already been discussed above and need only be reiterated here in the form of a reminder. The reason for the difficulty of establishing the equivalence of a natural psychotherapy situation and a contrived/experimental one is that the production of an adequately analogous situation requires knowledge of relevant contextual variables in order to construct an experimental situation which is adequately analogous to the situation to which one wants to generalize results (other natural psychotherapy situations), lest the results of the study in question fail to generalize. This problem also illustrates an advantage of observational studies of natural psychotherapy situations (discovery-oriented research possessing both of these

characteristics), in that such situations include the full panoply of contextual variables present in the situations to which the results must be generalized, thus more fully allaying concerns of generalizability. Instead of testing hypotheses on possibly simplistic associations between psychotherapeutic operations out of context and behavioural commitments, discovery-oriented research permits identifying psychotherapeutic conditions and the full variety of operations actually used to obtain behavioural commitments, rather than only those few predicted. As argued earlier, confidence in the findings may be increased by studying repeated instances of behavioural commitments in order to identify recurrent patterns of conditions and psychotherapeutic operations, in their actual level of complexity. Discovery-oriented research permits not only confirming that one particular therapeutic operation produces a particular in-session consequence, but also permits discovering different sets of conditions under which the operation works, the various in-session consequences which may result from the same operation, as well as which consequences occur when the operation is used under various different conditions. Instead of artificially simplifying and constraining what can be found, the aim of discovery-oriented research is to open up and discover what may be discovered in the data.

To summarize the preceding arguments, it does not make sense to do hypothesis-testing research on a question on which so little basic knowledge exists. Under such conditions, hypothesis-testing research would be a fanciful, abstract exercise detached

from a proper foundation of naturalistic observation. Discovery-oriented research is proposed as a more appropriate alternative to traditional hypothesis-testing research.

Discovery-Oriented Research and Psychotherapeutic Context

A particular advantage of discovery-oriented research is its ability to include description of the context within which events take place in psychotherapy. Taking into account the context and consequences of a behaviour is important when trying to understand it (Elliott, 1983a; 1983b; Floyd, 1989; Jacob, 1975; Kanfer & Grimm, 1980; Rosenfarb & Hayes, 1984; Todd, 1987). Variables in the psychotherapy situation have different effects in different contexts (Auld, 1959) and individual psychotherapeutic operations have different effects in different contexts, including the "immediate communicative context" in psychotherapy (Heatherington, 1989).

From a clinical perspective, discovery-oriented research permits assessing therapeutic operations in a therapeutic context, which permits discovering facilitating conditions or necessary preconditions to the efficacy of a particular operation in catalyzing a particular in-session outcome. From a research perspective, one could conceptualize the preceding point as observational studies permitting the identification of relevant variables, the assessment of their relative importance (Auld, 1959) and of their interactions. Thus, the knowledge produced by discovery-oriented research is of critical importance to adequately informed subsequent theorizing and research. Without a full identification of the array of relevant phenomena associated

with a proposition of interest, any hypothesis-testing research on that proposition would be proceeding blindly. To summarize the preceding arguments, the study of behavioural commitment catalyzing psychotherapeutic operations by testing hypotheses derived from theory would be inappropriate given the existing state of knowledge on this question, as no adequate foundation of basic knowledge exists. Such a study would be unlikely to be productive. In contrast, a discovery-oriented approach would permit the discovery of such basic knowledge and thus produce empirically-grounded propositions likely to be true in an ultimate sense. It should be noted that what is meant by "ultimately true" here is that were the propositions generated used as hypotheses in a natural sciences approach, hypothesis-testing study, they would bear a stronger chance of leading to a rejection of the null hypothesis; "true" should not be taken to imply that only one description would be valid.

C. Discovery-Oriented Research: The Issue of Validity.

Another argument for using a discovery-oriented approach is that the approach is systematic, as contrasted to simple case studies. In essence, the argument is that systematizing this phase of research by the use of a research method rather than by relying on clinicians' idiosyncratic observations should produce propositions of greater validity. Unlike case studies, discovery-oriented research methods make use of several means of assuring the validity of its findings. To reiterate a previously presented list of some of these means, discovery-oriented approaches use the collection of multiple instances of similar events, careful

description, the use of detailed examples and verbatim quotes, pooling the description of a large number of trained judges, and describing from multiple perspectives (e.g., patient, therapist, and observer descriptions of the same event) and careful description and documentation of the process by which inferences were drawn from the data.

Conclusions on Discovery-Oriented Research

To summarize, with regard to this study's research question, qualitative inductive research has unique characteristics which make it superior to both deductive, hypothesis-testing research as well as superior to unsystematic means of inductive observation (such as case studies), which otherwise would share many of the characteristics of the discovery-oriented approach. These characteristics make the discovery-oriented research approach a uniquely advantageous manner of answering the question posed by this study. These advantages include: (a) The possibility of discovering unpredicted, unexpected phenomena which hypothesis-testing research is incapable of discovering; (b) the production of knowledge of crucial importance to adequately informed theorizing; (c) the direct verification of rare psychotherapy phenomena; (d) the conduciveness of the method to the identification-specification of the conditions or context within which particular therapeutic operations should be used; and (e) provisions for assuring validity which are not present in case studies.

Units of Analysis: Micro-Analysis Vs. Macro-Analysis

Psychotherapy may be studied using units of analysis ranging in size and complexity (Floyd, 1989) from the extremely fine (such as the study of inflections or the sentence-by-sentence analyses of speech content) to the extremely coarse (such as treatment outcome studies). The selection of an appropriate methodology is contingent upon the selection of particular units of analysis, which is in turn contingent upon the nature of the research question being posed. It is worth noting at this point that although the size and complexity of summarizing units are two distinct characteristics of the units, these characteristics are positively associated (Floyd, 1989). Thus, the greater the time span and quantity of material to be described (unit size), the greater the complexity of the material (unit complexity). Therefore, the greater the complexity of the material to be summarized by a summarizing unit, the greater the level of abstraction of that unit.

A useful framework for examining the issue of units or levels of analysis in psychotherapy research resides in Frank's (1961) categorization of psychotherapy research studies in terms of the types of questions for which they seek answers. Frank identified three types of psychotherapy research questions: (a) Does psychotherapy work?; (b) Why does it work?; and (c) How does it work? Frank categorized the corresponding research approaches as, respectively: (a) outcome research; (b) theory-focused research gleaning pertinent data from process studies and general psychology research, including "learning, motivation, perception,

feeling, and thinking" (Frank, 1961, p. 89); and (c) process research.

Frank himself stated that "theory-focused" research addresses the "why" question, the type of question which might well be answered by hypothetico-deductive research. Although he did link "process research" to the "how does it work" question, he failed to elaborate on what he meant by "process research". What is proposed here is that the "how?" type question would be best answered by "technologically oriented research". Technologically oriented research is presently distinguished from theoretically oriented research in that it is focused on the task of discovering the empirical relationships among events rather than on the task of studying the epistemic correlations (Northrup, 1947) between aspects of theory and observable events.

In demonstrating the relation between the purpose of a study and the unit size chosen for its methodology, one may compare, as examples, three groups of common psychotherapy research strategies, each strategy corresponding to a given unit size. In this comparison, each of Frank's basic psychotherapy research questions is associated with a research strategy and a unit size. The three groups of psychotherapy research strategies compared will be: (a) comparative outcome studies; (b) frequency method process studies (e.g., Russell & Trull, 1986) and the dismantling strategy (e.g., Kazdin, 1983); and (c) intensive-analytic (e.g., Elliott, 1983b; Luborsky, Singer, Hartke, Crits-Christoph, & Cohen, 1984; Marmar, Wilner & Horowitz, 1984; Mathieu-Coughlan &

Klein, 1984; Rice & Greenberg, 1984a) and sequential analytic studies (e.g., Hill & O'Grady, 1985; Russell & Trull, 1986).

At the coarsest level of analysis, comparative outcome studies serve only to establish whether a psychotherapy of brand X has worked. They yield no information on how psychotherapy works to produce these effects, or what the processes of change are (Kniskern, 1985); no information on the stages or phases of psychotherapy (as would be available from dismantling studies, for example); no information on the effects of specific operations within a type of therapy (Andrews, 1989) and no knowledge of how to improve the efficiency of psychotherapy. Studies using finer units of analysis serve to answer these latter questions. Research strategies using coarse units of analysis are oriented toward answering Frank's first question of psychotherapy, "Does psychotherapy work?".

At the intermediate level of analysis frequency-method process studies and the dismantling strategy are found. In such research strategies, brand X of psychotherapy is broken up into a priori theoretically relevant effective components. In the case of frequency-method process studies, the frequency of occurrence of a theoretically relevant unit is related to the frequency of occurrence of other theoretically relevant units or to a measure of some aspect of the session. In the case of the dismantling strategy, theoretically effective ingredients, stages, or components of brand X psychotherapy are removed or included in order to ascertain their relevance to post-therapy outcome. Though the findings of these studies may have direct implications

for the practice of psychotherapy, such studies are generally useful in assessing the validity of theoretical propositions. Research strategies using an intermediate unit of analysis are oriented toward answering Frank's second question of psychotherapy, "Why does psychotherapy work?".

Intensive-analytic strategies and sequential-analytic strategies are found at the fine-grained level of analysis. Intensive-analytic strategies have in common the detailed, focal study of certain select moments in psychotherapy. Usually, these are special or highly valued moments of change or of process. The aim of these studies is to provide detailed knowledge on therapeutic process and relatively immediate outcomes occurring within a short time span of psychotherapy. This knowledge may take the form of detailed descriptions of the "this happens, then that happens" type (qualitative sequential descriptions). Results of these studies often include limited claims of causality. Sequential analytic research strategies have been used in the quantitative description of the patterning of small, simple events in psychotherapy, such as Hill and O'Grady's (1985) study of sequences of therapist intentions, therapist operations, and immediate patient outcomes. As do intensive-analytic studies, these studies suggest causality between temporally close, "small" units. Such research strategies, using fine-grained units, are oriented to answering Frank's third question of psychotherapy, "How does psychotherapy work?".

It should be noted that the fine-grained studies of psychotherapy illustrated by these examples also typically

involve smaller "windows" of observation because they relate temporally contiguous events and that this temporal contiguity may be (and is) used to make limited claims of causality (Kazdin, 1981). These relations between Frank's third question, process studies, small units of analysis, and close temporal contiguity have been recognized as being components of the very definition of psychotherapy process research. According to Russell and Trull (1986),

A study should be considered to concern process if it provides: "[a]...molecular description or specification of the actions or operations being studied...[b]...a [molecular and] a molar description of the sequential relationships between the units...[c]...the designations of the goal(s) or end point(s) toward which it moves" (Hertel, 1972, p. 421, as quoted in Russell & Trull, 1986, p. 17)

The appropriateness of research strategies involving fine units of analysis to the answering of "How does psychotherapy work?" has been widely acknowledged by psychotherapy researchers, who have also described the role of fine-grained process studies in the scientific study of psychotherapy. Various terms have been coined to refer to the outcomes of psychotherapeutic actions on such a fine-grained level, including immediate therapeutic impacts (Elliott, James, Reimschuessel, Cislo, & Sack, 1985; Patterson & Forgatch, 1985), patient task performances (Greenberg, 1984), in-therapy patient changes (Kiesler, 1971; Mahrer, 1985) in-session outcomes (Kiesler, 1966) and suboutcomes (Elliott, 1984; Rice & Saperia, 1984). The notion of studying therapeutic outcomes may apply to different levels of analysis; process studies are a study of outcome on a smaller, more immediate level. Winder (1957) has stated that process studies

serve to connect process to outcome, thus eliminating the artificial dichotomy of process-outcome by providing a study of ongoing outcomes throughout therapy. Thus, it may be proposed that studying outcomes on various levels of analysis appears to be a scientifically appropriate manner of proceeding, in order to gain a complete understanding of the workings of psychotherapy at various levels of "magnification and resolution", to use an optical analogy.

In summary, studies involving different sizes of units of analysis are suited to addressing corresponding different psychotherapy research questions. The proper question is not whether one level of analysis is superior to another in any ultimate sense, but whether the unit size and corresponding research method are appropriate to the question being addressed. In the next sections, it will be argued that studies using very fine units of analysis are more appropriate to this study's research question than would be methods examining larger units of analysis.

Unit Size Affects The Applicability of The Findings

A. Use of Small Units is Appropriate To

a Cross-Theoretical Approach To Psychotherapy Research

A closely related issue concerns the effect of the level of analysis (selection of unit size) on the range of applicability of the findings across theories of psychotherapy. As previously stated in the introduction, one purpose of this study is to identify a broad range of psychotherapeutic operations catalyzing the occurrence of behavioural commitment. This purpose has

implications for the segmentation of the flow of psychotherapy process to be studied. This section will present the argument that finer units of analysis are a particularly appropriate choice for a pan-theoretical study of psychotherapy process.

Kazdin (1983) has stated that an examination of practices common across types of psychotherapy is appropriate given the current lack of knowledge about concrete psychotherapeutic operations and the lack of specificity of psychotherapy theories concerning concrete therapeutic operations. Moreover, he proposed that such a research strategy could also have the beneficial effect of permitting the scientific study of psychotherapy to avoid getting bogged down in the "glut" (Kazdin's term) of psychotherapeutic schools resulting from a proliferation of theory. Following Kazdin's arguments, it follows that if one disregards differing theoretical explanations of why psychotherapy works, one may identify operations common across schools of psychotherapy. Thus, Kazdin has argued for both the utility and possibility of studying psychotherapeutic operations across schools of psychotherapy. To wit,

The obvious difficulty resulting from the glut of available techniques [Kazdin uses the term "techniques" in reference to theories or schools of psychotherapy] is that their evaluation for any set of clinical problems becomes virtually impossible. Advances can be speeded greatly by integrative work that searches for commonalities among different techniques. Integrative work might look at actual practices that are common to different techniques or identify common underlying mechanisms that account for the many different ways in which interventions are implemented. (Kazdin, 1983, p. 278)

Since just such a description of a broad array of psychotherapeutic techniques is an aim of this study,

consideration must be given to the segmentation of the flow of psychotherapeutic interaction. It is proposed that the study of psychotherapy process on a moment-by-moment basis has the advantage of permitting the examination of short, simple segments of psychotherapy process which stand a greater chance of being common to and applicable to a broader range of theoretical frameworks. In contrast, longer, more complex psychotherapy process pattern segments are more likely to be common to and applicable to a limited number of theoretical frameworks. This proposal is but a slight extension of Kazdin's pronouncements (see the preceding quote) that "commonalities", "actual practices that are common", or "common underlying mechanisms" (psychotherapeutic operations) exist within and across otherwise distinct "techniques" or "interventions" (theories or brands of psychotherapy). It follows logically that these described commonalities of psychotherapy process are "smaller" in temporal span and complexity than is the entire nominal psychotherapy. Following this train of thought, it stands to reason that the larger and more complex the unit of observation, the more the particular unit approaches the uniqueness and distinctiveness of a nominal psychotherapy, thus less likely being common to different nominal psychotherapies. Conversely, the smaller and less complex the unit of observation, the more the particular unit approaches being common to all nominal psychotherapies.

It is therefore proposed that when studied on a "microscopic" level, or by "local observation" (Cronbach, 1975) operations may best be identified and operationalized across

therapies, therapists, patients, and sessions. This assertion is consonant with the view that therapies may be integrated on a technique level rather than on a theoretical level (Parloff, London, & Wolfe, 1986; Prochaska & DiClemente, 1982), that identifiable commonalities exist among the operations used by therapists of different theoretical persuasions (Kazdin, 1983), that operations common across therapies may be described in neutral language acceptable to all orientations (Hill & O'Grady, 1985), that ingredients of psychotherapy may cross theoretical boundaries, and that some technical operations may be potent even outside of their original theoretical framework (Klein & Gurman, 1981).

In sum, it is concluded that the study of psychotherapeutic operations across schools of psychotherapy is desirable, possible, and best carried out by using small units of analysis and intensive local observation in order to study relatively immediate therapeutic impacts. Examining psychotherapy on a moment-to-moment level addresses the question of how treatment operations immediately influence patients (Floyd, 1989; Gottman & Bakeman, 1979; Patterson & Forgatch, 1985; Thoresen & Anton, 1974).

B. Use of Small Units Aids Making Valid Claims of Causality

The problem of identifying contingent relations between therapist operations and in-session outcomes is, to some extent, similar to that of identifying which components of a course of therapy are related to outcome. A crucial difference between these two otherwise analogous research problems is the greater

separation in time between the events to be related in outcome research, as well as the greater unit size and unit complexity involved in outcome research. It should be noted at the outset that a concern with causal relations departs from the concerns of qualitative research. In contrast with a natural sciences perspective, qualitative research (the "human sciences approach") is concerned with discovering the essential meaning structure of the phenomenon being studied. As such, interrelations among meaning units are relevant to qualitative researchers, whereas causal relations are relevant to natural sciences researchers. By virtue of its concern with contingent relations among phenomena, this study is not a qualitative research study. This study adopts a natural sciences perspective, but makes use of a descriptive methodology.

In discussing the making of causality inferences from multiple case studies, Kazdin (1981) identified close temporal proximity of events, among a number of factors, as permitting more valid inference of causal relation between them. Thus, "the more immediate the change, the less likely alternative sources of influence coincident with treatment account for the change" (Kazdin, 1981, p. 187). The large temporal separation between components of therapy (stages, phases, sub-goals, methods, and other larger segments of therapeutic interaction) and outcome, results in a situation in which a considerable degree of theoretically-based assumptions must be pressed into service in claiming a causal association between the related measures, beyond the finding of a mathematical/probabilistic association

between them. In contrast, shorter, simpler segments of therapy pattern contain fewer possible elements which could constitute alternative explanations for the observed relation to in-session outcome. The size and complexity of units of observation (Floyd, 1989) is also of relevance to the validity of determining causal relations between the identified units. Short segments of therapist operation and short segments of in-session outcome (e.g., one to several statements in a psychotherapy transcript) are easier to causally relate to one another. That is, claims of causal association between longer and more complex segments are subject to internal validity threats from the numerous interceding elements which could constitute alternative explanations for the subsequent ("caused") event. In the context of a methodology without experimental manipulation, this is in fact a matter of drawing more versus less valid propositions rather than a matter of more versus less valid tests of hypotheses.

C. Use of Small Units, Contextual Judgment
And "Intensive Local Observation"

In the case of short, simple segments/units which are temporally proximal, theory is still used in hypothesizing or claiming a causal association between the two events, but the theory involved is more consensually held, consisting of notions of social influence common to the shared culture of the observers. Such theory may be tacitly (Polyani, 1966) held and thus impossible to specify. The act of using tacit theory in hypothesizing or claiming causal associations between two

temporally related events is also what is involved in a procedure which Floyd (1989) refers to as contextual judgment.

most of the coding systems that have been widely adopted for marital and family research contain codes that require relatively complex, contextual judgments by observers. At the same time, however, these contextual factors usually are not noted explicitly in the coding guidelines....The fact that adequate interobserver agreement is obtained for such codes suggests that coders can efficiently consider all of these factors and can agree on a choice between labels for the behaviour. However, it is unlikely that independent measurements of each of the contextual factors could be combined statistically to reach the same conclusion about the event. Thus, the need for contextual judgment by coders probably can never be eliminated from common practice. (Floyd, 1989, p. 23-24)

A similar conclusion was arrived at by Rice and Greenberg (1984a) in the process of carrying out psychotherapy research:

After reviewing existing methods and trying out some of them on our data, we concluded that the best instrument for pattern identification was the "human integrator," who in psychotherapy research would be the disciplined clinical observer. The human ability to identify complex performance patterns and their changes at an appropriate level of subtlety seemed to be far superior to any preexisting combination of category measures and computational tools. (Rice & Greenberg, 1984a, p. vi)

Inductively generating causal hypotheses when observing the occurrence of certain therapist behaviours and subsequent patient behaviours goes beyond the coding tasks described in the above quotes by Floyd (1989) or by Rice and Greenberg (1984a), however, these tasks are similar in requiring the use of cultural knowledge of social behaviour to draw conclusions on the likely contributors to a target behaviour. This knowledge of social behaviour, when carried out by the clinically trained observer, also includes tacit as well as conscious knowledge of psychotherapy theory, psychological research, clinical lore, and

personal clinical experience (including the ongoing testing of clinical hypotheses in the course of practice). The usefulness of drawing upon such knowledge is an acknowledged component of coding observational data in psychotherapy research as well as in general observational research.

An issue which has been addressed in previous sections of this chapter concerns the frequent lack of specificity of psychotherapy theories on the matter of concrete operations. To briefly reiterate the complaints produced by reviewers of psychotherapy research, theories lacking specificity about operations have resulted in existing works on psychotherapy inadequately answering technical questions necessary for the conduct of therapy and training of therapists (Arthur, 1972; Elliott, 1983b), led to complaints that psychotherapy research has had virtually no impact on the practices of psychotherapists and fostered a dissatisfaction with the scientist-practitioner model (Arthur, 1972; Elliott, 1983b; Floyd, 1989; Kazdin, 1983).

A number of researchers have proposed "intensive local observation" (Cronbach, 1975) of psychotherapy process as a productive research endeavour and remedy to the aforementioned ills (Barlow, 1981; Elliott, 1983b; Mahrer, 1985; Mahrer, 1988a; Rice & Greenberg, 1984a; Todd, 1987). Such research methods share the common characteristic of attempting "to understand the unique aspects of the situation that may affect the phenomena being observed...seeking to...understand patterns of behaviour and experience and their relationships to internal and external events...formulating hypotheses on the basis of observations (and

theory and other experience)" (Todd, 1987, p. 520). Such observation is necessary in order to determine variables of potential importance in the process of therapy (Auld, 1959; Bakeman & Gottman, 1986; Ford, 1959).

In sum, intensive local observation is particularly productive in the process of technological psychotherapy research rather than for psychotherapy theory-verification research. It should be noted that systematic observation is not to be confused with case studies by individual clinicians. During systematic observation rigorous intensive analysis is carried out with corroborating evidence, such as by objective process raters (Elliott, 1983b). Propositions based on corroborated observations made by a team of observers are more likely to be reliable by a criterion of replicability than are propositions based on the observations of individual clinicians. Replicability is the criterion which earns systematic observation the appellation "scientific" (Bakeman & Gottman, 1986). Moreover, generally, observability and replicability are the fundamental defining characteristics of scientific investigation (Parloff, 1986; Gurman, 1983). Finally, collecting individual similar cases or instances may be used in making a case for causal relations of limited certainty (Kazdin, 1981). It should be noted that, as in the case of a concern with causal relations, concerns about replicability are not characteristic of qualitative research approaches, but rather is a characteristic of the natural sciences approach.

To summarize, the usefulness of drawing upon cultural knowledge of social behaviour to draw conclusions on the likely contributors to a target behaviour is an acknowledged component of coding observational data in psychotherapy research as well as in general observational research. Such a process is involved in research methods making use of intensive local observation. Research methodologies involving intensive local observation have been proposed by several reviewers of psychotherapy research as being particularly productive in the process of research which is technological research rather than strictly theoretical. Thus, such research methods may be useful in ameliorating an identified crisis in the technological applicability of the existing body of psychotherapy research.

Immediate Therapeutic Impacts and Context

A major reason for the recent growing interest in intensive-observational methods on the part of psychotherapy process researchers involves the issue of accounting for context in the study of psychotherapy process. A number of psychotherapy process researchers and reviewers have discussed the importance of attending to the context of psychotherapeutic events under study, as well as in observational research in general (e.g., Bakeman & Gottman, 1986; Elliott, 1983a; 1983b; Floyd, 1989; Friedlander & Heatherington, 1989; Greenberg, 1986; Heatherington, 1989; Kiesler, 1966; Kniskern, 1985; Mahrer, 1988a; Patton, 1989; Russell & Trull, 1986; Todd, 1987; Tsoi-Hoshmand, 1989). Historically, psychotherapy process research studies have largely ignored the context of the in-session events which they were

studying (Elliott, 1983a; 1983b; Heatherington, 1989; Kiesler, 1966), and many process investigators have completely ignored this issue (Kiesler, 1966). It has been argued that conventional quantitative and frequency-count research methods minimize the use of contextual information (Russell & Trull, 1983) and oftentimes completely strip observations of their context (Heatherington, 1989; Rennie, Phillips, & Quartaro, 1988). As explained by Russell and Trull,

The overwhelming majority of studies of language variables in psychotherapy employ one basic strategy, which we will term the frequency approach. Basically, the frequency approach consists of defining a set of categories or rating scales in terms of language variables, scoring predetermined units (e.g., clause, sentence, utterance and theme) of therapist or patient speech in terms of the categories or scales, summing scale values or instances of category behavior over sessions, and testing hypotheses about psychotherapeutic processes against the obtained summary scores or against their correlation with other variables. The frequency approach has been applied in research concerning almost all aspects of psychotherapy and continues to be the most often utilized approach in process studies. (Russell & Trull, 1986, p. 16)

Ultimately, frequency-count studies are not true process studies. Though a frequency-count study does provide knowledge about intratherapy behaviour and outcome, such a study "tells us nothing specific at the molecular or molar levels about the contingencies between the units it tabulates, nor are designations of endpoints typically provided" (Russell & Trull, 1986, p. 17).

A number of research ills have been identified as resulting from the omission of contextual information. The most common which results from this omission is the production of sterile research findings. Several process researchers and reviewers

(Floyd, 1989; Friedlander & Heatherington, 1989; Greenberg, 1986; Heatherington, 1989; Pearce & Cronen, 1980) have argued that the meaning as well as the function of behavioural events may only be understood in relation to their context. Moreover, omitting context through the use of frequency-count and coding research methods results in ignoring the social and dialogical aspects of speech (Russell & Trull, 1986). As has been argued above, cultural knowledge may be used in postulating causal hypotheses, whether this knowledge is tacit or conscious, or is general social knowledge or specialized knowledge of psychotherapy. Contextual information from the social and dialogical aspects of speech contains information relevant to inferring causal relations between elements of dialogue through the use of cultural knowledge.

A second problem resulting from omission of context is the lack of generalizability of findings, or rather, the lack of knowledge of the specific situations to which findings may be generalized. Findings taken out of their original context may entirely fail to generalize to other situations. If context is not specified, the conditions under which the results may apply remain uncommunicated to consumers of the research findings.

Floyd cited Jacob (1975) as follows:

...measures that assess only "quantitative" dimensions of interactions, such as the frequency and duration of elemental behaviours, produce ambiguous and inconsistent findings. For example, quantitative measures of interaction processes...take on different meanings in different contexts. The failure to identify these meanings at the time of coding obscures the ultimate meaning of the study's findings. (Floyd, 1989, p. 23)

A third problem resulting from omission of context is that knowledge of context essential to the proper timing of psychotherapeutic operations is lost (Elliott, 1983a; 1983b; Russell & Trull, 1986). Without such timing information, technical questions on the conduct of psychotherapy remain unanswered and the practitioner-relevance of process research is adversely affected (Elliott, 1983b).

One method of correcting these problems, which has been undertaken in more recent research, has been the use of analyses examining the sequential nature of events in psychotherapy. One particularly promising form has been the "intensive" (Barlow, 1981; Cronbach, 1975; Elliott, 1983b; Rice & Greenberg, 1984a; Todd, 1987; Thoreson & Anton, 1974; Tsoi-Hoshmand, 1989) or "local" (Cronbach, 1975) analysis of events in psychotherapy as conditions/context, operations, and consequences (e.g., Elliott, 1983a; Greenberg, 1986; Mahrer, 1985, 1988a). The term "intensive observation" refers to the examination of a short segment of psychotherapy interaction surrounding the occurrence of an event or phenomenon of interest. Kiesler described this research strategy in 1966, when he wrote:

the basic skeleton of a paradigm for psychotherapy seems to be something like the following: The patient communicates something; the therapist communicates something in response; the patient communicates and/or experiences something different; and the therapist, patient and others like the change. (Kiesler, 1966, p. 129)

Several process researchers have adopted such an analytical strategy, variously examining "conditions", "operations" and "consequences" (Mahrer, 1985, 1988a), "context, therapist

intervention, and impact" (Elliott, 1983a, p. 126), "client markers" of problem states amenable to intervention", "therapist operations" and "episodic changes" (Greenberg, 1986). What all of these research methods have in common is a descriptive examination of the context within which psychotherapeutic operations are used and that the relatively immediate impacts of these operations are observed. In such a research paradigm, one level of context, the immediate communicative context (Heatherington, 1989) is examined and findings on events in therapy include their situation in context. As previously defined "immediate communicative context" or "immediate patient context" refers to what the patient said and did prior to the therapist's use of an operation, described on the same level of abstraction as the operations themselves. Including the immediate communicative context has as its aim that of describing what the patient did which contributed to the occurrence of the behavioural commitment, describing the patient-therapist interaction involved in catalyzing the behavioural commitment, or describing what the therapist did in relation to what the patient did.

The research strategy of examining conditions, operations and consequences constitutes research which directly addresses the question, "what operation, carried out in which therapeutic context/condition, will result in a particular desired immediate consequence". This question is similar to Paul's (1967) famous proposed ideal state of knowledge on the specificity of therapeutic impacts; "What treatment, by whom, is most effective

for this individual with that specific problem, and under which set of circumstances?" (Paul, 1967, p. 111), only on a smaller scale. The nature and format of such findings makes them particularly well suited to answering practitioners' technical questions on the conduct of psychotherapy.

In summary, increasing attention has recently been placed on the issue of taking context into account in psychotherapy process research. Problems associated with failing to take context into account include the production of sterile research findings, research findings which generalize to unknown contexts and the production of process research findings which lack information on the "timing" of psychotherapeutic operations. A psychotherapy process research paradigm which avoids these ills is one which studies patient conditions, psychotherapeutic operations, and relatively immediate therapeutic impacts.

Summary of Methodological Issues

The following is a global summary of the issues and arguments presented in the theoretical rationale for this study's research strategy. The first issue addressed was that of the relative merits of answering this study's question by generating propositions inductively, based on direct observation, versus that of deriving and testing hypotheses from technical psychotherapy literature. It was concluded that deriving hypotheses from technical psychotherapy literature would be a procedure of dubious validity, that it would be unnecessary, and that a hypothesis-testing study is likely unfeasible due to a

practical limitation of data availability. The reasons for these conclusions were that:

- (a) The technical psychotherapy literature contains few ready-made hypotheses concerning the research question. Few psychotherapy theorists have addressed catalyzing behavioural commitments even though behavioural commitment is valued within their theory of psychotherapy. Hypotheses derived from such literature would thus be vague guesses without the benefit of preparatory direct empirical observations.
- (b) The research question involves consensually observable events at a relatively low level of abstraction rather than the study of highly abstract theoretical constructs. The research question does not involve the testing or verification of theoretical postulates. Drawing hypotheses from a body of theory is thus not necessary to the answering of the research question.
- (c) Studying events described and defined at such a level of specificity results in the events being rare. Such events are likely too rare in occurrence to permit the quantitative treatment required in a hypothesis-testing study.
- (d) Testing hypotheses about a question for which there exists virtually no theoretical or descriptive knowledge begs the question.
- (e) Inductive, observational, qualitative research is considered extremely productive for generating foundational knowledge necessary for theory building and further

research. There exists very little knowledge on the research question posed in this study.

Based upon these considerations, it was concluded that the most appropriate research strategy is one involving the inductive generation of propositions through qualitative research.

The second issue addressed was the selection of an appropriate size of unit of analysis, contrasting micro-analysis and macro-analysis. This issue included the effects of unit size selection on the nature of applicability of the findings of psychotherapy research. It was concluded that a research method dealing in very fine units of analysis was more appropriate than one using larger units of analysis. Thus, the appropriate methodology should be one which gathers data on a moment-by-moment, statement-by-statement level rather than one using larger abstract categories such as content analysis categories or theoretical components of psychotherapy. The reasons for this conclusion were that:

(a) This study's research question is of a similar nature to the essential psychotherapy process research question--"how does psychotherapy work".

(b) Psychotherapy process studies use small units of analysis by definition.

(c) The use of very fine units of analysis is appropriate to the pan-theoretical nature of the research question. This conclusion is based upon the logical argument that smaller, simpler segments of psychotherapy process are more likely to

be common to a variety of psychotherapies than are large segments.

It was further concluded that a method involving intensive local observation should be combined with the use of small units of analysis in that limited inferences of causality may be facilitated by the use of small and temporally contiguous units of analysis.

The third issue addressed was the importance of including contextual information in psychotherapy process research findings. It was concluded that a particular merit of descriptive observational research was its ability to situate events in context. A specific research paradigm which was proposed as taking context into account and being suited to the research question was that of studying therapeutic conditions, operations and consequences. The reasons for this conclusion were that:

- (a) Psychotherapy process research has historically neglected the context of in-session events.
- (b) Psychotherapy process research studies which ignore context may produce findings which are sterile, unclear as to which situations they can be generalized, and produce no information on the timing of psychotherapeutic operations.
- (c) Psychotherapy process research which produces findings following the conditions-operations-consequences paradigm produces highly practitioner-relevant findings.

Based upon all of the above considerations it may be concluded that a practical, feasible and appropriate research method for addressing this study's research question should

include the following elements: (a) The method should involve the inductive generation of propositions using qualitative methods rather than the testing of hypotheses derived from psychotherapy theory; (b) The method should involve the analysis of psychotherapy using very fine units of analysis (a small "window" of observation and a low level of abstraction), such as individual statements, rather than broad, abstract, "large" units of analysis such as traditional content analysis variables or post-therapy outcomes; (c) The method should be such as to produce results with an explicit, consistent and methodical reference to the context of psychotherapeutic events or phenomena.

Conclusions and Overview of A Research Strategy

Based on these conclusions, a research method has been selected for this study which falls within the family of the "intensive-analytic" or "local-observational" research methods. Although the method will be described in detail in the following chapter, an overview of the method is presented in order to draw a clear link between the above conclusions and the selected research method itself. To reiterate, the specific purpose of the study is to answer the questions, "What are the psychotherapeutic operations which are judged as antecedent and catalyzing patients' commitments to carry out new extratherapy behaviours?"

The research method involves identifying occurrences of behavioural commitment in records of psychotherapy sessions and examining the antecedent therapist statements in order to identify what the therapist did to catalyze the behavioural

commitment (hereafter called the event). The procedure is carried out in four steps. In the first step, a large collection of psychotherapy session recordings is studied in order to identify psychotherapy sessions which contain at least one occurrence of behavioural commitment. For the purposes of this data-reduction step, behavioural commitments are identified liberally rather than stringently. In the second step, a team of researchers independently study the retained transcripts in search of occurrences of the event. Applying the event definition more stringently, each team member reports the location of identified events. Events on which adequate inter-rater agreement is obtained are retained for the next step of the procedure. In the third step, research team members are instructed to examine what the therapist and client did in therapy relatively immediately prior to the occurrence of the event. Each team member supplies an independent description of what the therapist did which catalyzed the occurrence of the target event. The descriptions are to include a description of the psychotherapeutic context in which the psychotherapist's actions were effective. In the fourth step, a single composite description is generated from the set of individual descriptions by means of an analysis of common and distinctive components. The three elements included in the final composite description are the therapeutic contexts/conditions, the psychotherapeutic operations carried out, and the nature of the behavioural commitment obtained. In the fifth step, an ongoing provisional consensually valid category system of psychotherapeutic operations is produced by the two co-

investigators by analyzing the composite descriptions for distinct psychotherapeutic operations. In the sixth step, the provisional category system is verified and finalized by the team of researchers, who also rate which of the operations in the category system were involved in catalyzing the behavioural commitment.

Implications of The Findings of This Study

A. Implications for Practice

On a general level, the principal implication of the study's findings for the practice of psychotherapy is the potential addition of new psychotherapeutic operations to the armamentarium of any individual consumer of the findings. This study aims to produce descriptions of specific psychotherapeutic operations, described in such a manner as to be immediately understood and ready to be used by practitioners. These descriptions of specific operations will not include broad content analysis categories or abstract theorizing, but rather will stay as close to the data as is possible. As such, this project has the potential of providing empirical answers to practitioners' purely technical concerns over the conduct of psychotherapy. As shown in the preceding review of the literature, neither the psychotherapy research literature nor the technical psychotherapy literature contain any significant body of knowledge on psychotherapeutic operations for catalyzing behavioural commitments. As discussed in the theoretical rationale for this study's research strategy, the current lack of such technologically-oriented research on psychotherapy constitutes a serious enough gap that there exists

insufficient knowledge for a true scientifically based (versus clinical-lore or oral-tradition based) technological training of psychotherapists (Arthur, 1972; Mahrer, 1988a). The findings of this study should lend answers to practical, technical questions on catalyzing behavioural commitments.

The global question, "What can a psychotherapist do to catalyze patient behavioural commitments?" can be broken down into a number of component questions. For example, what can a psychotherapist do and say which will catalyze the patient's acceptance of behavioural commitments as a valued component of psychotherapy? What can a psychotherapist do and say which will catalyze a recalcitrant, resistant, non-compliant, ambivalent or unwilling client to commit herself to carrying out a new behaviour? What can a psychotherapist do and say which will catalyze spontaneous behavioural commitments on the part of patients? What can a psychotherapist do and say which will catalyze a patient who is on the verge of deciding on a behavioural commitment, to finalize her decision in favour of going ahead with it? How can psychotherapists successfully "negotiate" new behaviours associated with behavioural commitments? What therapeutic contexts/conditions are propitious for the use of behavioural commitment-catalyzing operations? What particular things can a psychotherapist do and say in order to catalyze particular types of behavioural commitments? These are the principal kinds of questions which may be answered by this study, as determined and limited by the particular conditions, operations, and types of behavioural commitments identified in

the data set used. The principal questions to be answered concern the psychotherapeutic conditions and operations. Although an impressionistic examination of the nature of behavioural commitments may be afforded, this is not the main purpose of the study. These sorts of questions may be answered through conceptualized descriptions accompanied by concrete examples taken from actual psychotherapy sessions, as was done in the description of operations provided in the literature review.

The nature of these results will provide for easy and clear communication of findings to consumers of the research. In fact, the format of the findings is one which is highly compatible with the micro-strategy approach to teaching psychotherapeutic skills, in which specific skills and their timing are taught to enable the student therapist to acquire a wide repertoire of therapeutic operations and to be able to examine their apparent effects (Small & Manthei, 1986). Generally, the therapeutic skills taught to therapists in training through the micro-strategy approach are drawn from clinical lore rather than research. The results of this study could provide research-based answers to technical psychotherapy questions. Careful description of the operations observed could be used for learning and repeating the operations by consumers of the resulting research literature. For example, given the desired end-goal of obtaining a behavioural commitment, particular operations may be used. Given a condition, such as the patient "resisting" a homework assignment, particular operations may be used to successfully overcome the "resistance". Or, given the goal of obtaining spontaneous patient commitments to new

behaviours (instead of therapist-suggested behaviours), particular operations may be used to promote this type of behavioural commitment.

The difference which level of analysis (unit size) creates in terms of the applicability of findings from this study is that rather than proposing that an entire theory, "school", or type of psychotherapy is appropriate or inappropriate in the context of a certain categorization of patient and problem/disorder, the findings instead will propose that a particular operation in a particular relatively immediate therapeutic context is likely to produce a particular relatively immediate in-session outcome. Thus, the findings should be relevant to any therapist, of any theoretical orientation, who values the occurrence of behavioural commitments. A proposal for inserting new operations within various schools of therapy with such abandon may seem odd at first blush, but it is a fundamental assumption of psychotherapy process research that "...some technical operations...may be potent wherever they appear, even when they appear outside of their original theoretical framework" (Klein & Gurman, 1981, as cited in Gurman, 1983, p. 233).

The accessibility and relevance of this study's operation descriptions to psychotherapists of various theoretical orientations may contribute to a beneficial sharing of operations between therapies as well as between individual therapists. The operation descriptions can logically be divided into two categories: (a) those operations which, though already specified in psychotherapy literature, have been inadequately described.

"Inadequate" descriptions, for the purpose of the present argument, include those descriptions written in theory-bound language, descriptions which are incomplete or too short, and descriptions which lack contextual information necessary for the proper timing of the operations in the course of psychotherapy; and (b) those operations which, whether tacitly or consciously, are used by any individual psychotherapist whose work was studied, and have not been described in any published psychotherapy literature. The latter category of operations would constitute entirely "new" findings, whereas the former would constitute "new" findings by adding to their accessibility, completeness and general utility by a broader group of psychotherapists.

On a more specific level, the description of new behavioural commitment-catalyzing psychotherapeutic operations implies improved psychotherapeutic practice due to the importance of behavioural commitment in psychotherapy. Behavioural commitment is posited as a valuable component of psychotherapy for the purposes of: developing a commitment to psychotherapeutic change (Kanfer & Grimm, 1980); specifically demonstrating a commitment to behavioural change (Montgomery & Montgomery, 1975; Tosi & Henderson, 1983); demonstrating a commitment to considering behaviour options (McElroen & Faltico, 1977); demonstrating a commitment to the psychotherapeutic process (Omer, 1985); catalyzing the patient's making a commitment to herself (Whipple, 1985); aiding the in-session psychotherapeutic process, having the patient carry out a psychotherapeutically valuable new

behaviour outside of therapy (Mahrer, 1989); specifically having the patient carry out a behaviour so difficult as to cause the patient to give up her symptoms (Haley, 1984); reinforce patients' initiatives, boosting the patient's morale, reducing patients' feelings of helplessness (Omer, 1985); directly changing a problem behaviour; and promoting the transfer, generalization, and application of in-session discoveries to the extratherapy world (Tosi & Henderson, 1983).

Finally, expressions of behavioural commitment are associated with the increased likelihood that the patient will actually carry out the proposed behaviour(s) (Kothandapani, 1971; Levy, 1977; Levy & Clark, 1980; Patterson, 1984, as cited in Patterson & Forgatch, 1985; Prochaska, 1979; Wurtele, Galanos, & Roberts, 1980). This association makes the findings of this study of particular significance to psychotherapists who use behavioural assignments, relevant to therapists having behavioural changes as a therapeutic goal, relevant to the issue of treatment compliance (Shelton & Levy, 1981a) as well as relevant to any other psychotherapy valuing new behaviours outside of therapy as either a component or stage of therapy (Andrews, 1977; Bakker, 1975; Bandura & Adams, 1977; Beck, Rush, Shaw, & Emery, 1979; Casey, 1973; Freud, 1959; Prochaska & DiClemente, 1982) or as a goal of therapy.

To summarize, the implication of this study for psychotherapeutic practice is one of providing a collection of procedural or technical psychotherapeutic knowledge in a format of, "what operation, carried out in which therapeutic

context/condition, will result in a particular desired relatively immediate consequence (immediate therapeutic impact)". This knowledge will be relevant to any practitioner valuing the occurrence of behavioural commitments and providing the proper contexts/conditions for use of the discovered operations in her/his particular psychotherapeutic practice. Finally, given its provision of more operations for catalyzing behavioural commitments, this study should improve psychotherapeutic practice due to the benefits of in-session behavioural commitment. Considering the applicability of the study's findings on both general and specific levels, it is apparent that the results are likely to be relevant to a considerable number of psychotherapists.

B. Implications for Theory

The simple quantitative implication of this study for theory is that it may supply empirical material for generating theory where none currently exists. As was described above, there is no theory on bringing about relatively immediate behavioural commitments in psychotherapy. Although the purpose of this study is not one of contributing to theory building but rather of one of answering a technical question, the findings may be usable as initial impressionistic clues which may serve to guide further research. Theoretical questions may be posed about three sets of events in psychotherapy, these concerning: (a) the nature of the behavioural-commitment-catalyzing psychotherapeutic operations themselves; (b) the nature of the behavioural commitment events; and (c) the nature of the therapeutic contexts/conditions within

which the psychotherapeutic operations are used in catalyzing behavioural commitments. The first set of these theoretical questions concerns the nature of the psychotherapeutic operations themselves. What do the various psychotherapeutic operations which therapists use in catalyzing behavioural commitments have in common?

A second theoretical question concerns the patterning or particular sequencing of psychotherapeutic operations which catalyze behavioural commitments. As was pointed out in the review of the literature, those few clinicians who specify behavioural commitment-catalyzing operations rarely report the use of any one operation in isolation, but report the use of several operations chained together. Is there a universal sequence of types of operations used in a behavioural commitment-catalyzing chain of operations? If, as was found in reviewing the psychotherapy literature, a number of distinct operations seem to be chained in order to catalyze behavioural commitment, is there some central theme or pattern which unifies each of these chains? Are there several distinct chains of behavioural commitment-catalyzing operations, or are these totally unique and/or idiosyncratic to the work of a particular therapist?

A third theoretical question concerns the use of particular behavioural commitment-catalyzing operations across schools of psychotherapy. Are there ways of catalyzing behavioural commitments which cut across schools of psychotherapy? Do therapists ascribing to some particular school of psychotherapy demonstrate the use of a broader range of behavioural commitment-

catalyzing operations, or more effective behavioural commitment-catalyzing operations? Is the effective use of a broad range of behavioural commitment-catalyzing operations particular to certain psychotherapists rather than to any particular school of psychotherapy?

A fourth theoretical question concerns the nature of the behaviour commitment events. What distinctly different types or quality of behavioural commitments occur? What psychotherapeutic operations tend to be associated with the occurrence of spontaneous, patient-generated behavioural commitments in contrast to prescribed, therapist-generated behavioural commitments? Can any specific class of psychotherapeutic operations be identified as catalyzing spontaneous behavioural commitments, or do these take place unpredictably, as a cumulative result of all that has taken place in therapy?

A fifth theoretical question concerns the therapeutic contexts/conditions under which particular behavioural commitment-catalyzing operations are used. Are particular classes of behavioural commitment-catalyzing operations used in particular classes of psychotherapeutic conditions? Do psychotherapeutic conditions preceding the use of behavioural commitment-catalyzing operations share common characteristics? Is there any "universal" condition which psychotherapists interpret as signaling the appropriateness of using a behavioural commitment-catalyzing operation?

A sixth theoretical question concerns the issue of patient "compliance" and "resistance", as a particular psychotherapeutic

condition. Are certain types of operations associated with initial patient refusal of behavioural commitment and other operations more successful in gaining relatively immediate commitment? What operations do therapists use to catalyze behavioural commitments when a client balks at the therapist's prescription of a new behaviour?

A seventh theoretical question concerns the implications, for theories of psychotherapeutic change, of the answers to the six previously listed theoretical questions. The theory of behavioural commitment may, in turn, have implications for more general theories of psychotherapeutic change. How could the operations described be adapted for use by psychotherapists of various schools of psychotherapy? What theory of behavioural commitment catalysis could be created based upon the answers to the six previous theoretical questions? Can such a theory of behavioural commitment catalysis be integrated with existing theories of psychotherapeutic change, and if so, how?

It should be noted that the aim of this study is to answer the question "Which operations, used in which psychotherapeutic context, will result in the relatively immediate occurrence of behavioural commitments?", rather than to develop a theory based on the answers obtained through this study. Although this study should be capable of providing some minimal empirical basis for a theory of behavioural commitment where no such material currently exists, theory-development is not the aim of this study. It is the opinion of this author that much more empirical study of behavioural commitment catalysis

would be required to justify theory-development in this area, lest groundless theory be generated with undue haste.

C. Implications for Research

The principal implication of this study for psychotherapy research is that the descriptions of behavioural commitment-catalyzing psychotherapeutic operations produced by the study will constitute propositions which could inductively feed into theorizing, as well as constituting ready-made, well-articulated potential hypotheses on the use of specific psychotherapeutic operations. As was discussed earlier, however, serious practical problems would exist in attempting to test hypotheses postulated with such specificity.

Another more feasible potential avenue of research would be for further research to search other sources of data in order to locate more of the rare behavioural commitment events. One further research avenue would be to use this study's findings as a starting point in a search for enough instances of behavioural commitments to gain greater confidence in identifying patterns of concurrent operation use. For example, more transcripts or recordings of psychotherapy sessions could be examined in order to determine which of the operations previously discovered by this study were used in obtaining each behavioural commitment. Further studies would permit eventually gathering enough instances in order to apply statistical clustering procedures, in order to identify if certain operations tend to be effectively used in conjunction with others. This strategy could also permit identifying certain patterns of operation use which may be common

to certain therapies, therapists, or therapeutic philosophies or styles.

A second avenue would be to study the nature and types of behavioural commitments themselves. For example, if in the course of this study the research team observed that different types or qualities of behavioural commitments occurred, this would indicate that it might be productive to carry out a study with the purpose of identifying and describing the different types of behavioural commitments or behavioural-commitment-like events which occur in therapy. It is possible that different operations or groups of operations may be used in obtaining different types of behavioural commitments and that this could be addressed in future studies.

A third avenue would be to gather enough instances to examine with greater confidence whether certain types of behavioural commitment are associated with certain types of psychotherapeutic operations. As previously discussed, a discovery-oriented research approach may be used not only to identify new conditions or operations, but also to find multiple new instances of what has previously been found, thus increasing the confidence with which the previous findings may be held. For example, another research team could locate unpublished transcripts or recordings of psychotherapy sessions and in the process of describing what therapists did to obtain behavioural commitments, may make findings synonymous with those of this study.

A fourth avenue would be to examine whether a link exists between any of the therapeutic contexts encountered, psychotherapeutic operations used, types of behavioural commitments, and whether or not the behavioural commitments were actually carried out by the patients. For example, a process-outcome study may be carried out which would study the relation between the operations used to obtain the behavioural commitment and whether or not the patient actually carries out the post-session behaviour, or other post-session behaviours.

Overall, continued study of this question may produce knowledge of enough links between psychotherapeutic conditions, operations and the consequence of behavioural commitments, that a truly comprehensive, step-by-step scientifically-based technology of behavioural commitment catalysis may result. Finally, it is hoped that exposition of the problems involved in studying rare psychotherapeutic events may have a stimulating effect on the development of new methodologies for psychotherapy process research.

To summarize, the results of this study may have their most direct implications for psychotherapy technology, more remote implications for psychotherapy theory, and may have marginal implications for hypothesis-testing research, due to the methodological difficulties inherent in testing hypotheses of such specificity.

Chapter 3

METHOD

The previous chapter addressed theoretical issues related to the selection of a general research strategy for answering the question, "What do therapists do which catalyzes the occurrence of behavioural commitments?" Based upon the conclusions reached, an existing research method was selected. The purpose of this chapter is to present the specific research method in detail, addressing the issues of sample composition, obtention of data, data medium, segment of psychotherapy to study, and the selection of process raters. Finally, the protocol of the study will be described, the detailed steps to be executed being preceded by an overview of the principal stages of the protocol.

General Research Strategy

In keeping with the expressed purpose of the study, the general research strategy was to identify occurrences of behavioural commitment in psychotherapy sessions and to examine the therapist's use of antecedent psychotherapeutic operations judged as facilitating or catalyzing the occurrence of the behavioural commitment. This examination was carried out from the standpoint of a team of researchers whose written observations were pooled in order to provide a composite description of the psychotherapeutic operations.

Sample

The selection of a sample of psychotherapeutic session material for study involves five major issues, these being: (1) source of psychotherapy data--generating new psychotherapy

session material versus collecting existing data; (2) type, school, or theoretical approach of psychotherapy studied; (3) data medium; (4) segment of psychotherapy interaction to study; and (5) sample size. Each one of these issues is addressed, in the following sections, in order to explicate the rationale and decision-making process which went into the final choice of data.

A. Generating Data Versus Collecting Data

The first issue concerns the study's source of data. This study used published records of psychotherapy sessions, in the form of transcripts. The considerations and rationale for this choice of data is explicated in this section.

Psychotherapy process research generally uses three data source options, which are: (a) contriving a psychotherapy analogue situation; (b) contriving a "real" psychotherapy situation and (c) collecting existing verbatim records (potentially transcripts, audio-, or video-recordings) of natural (uncontrived) psychotherapy situations. Studies which contrive a psychotherapy analogue generally involve the creation of a laboratory situation in which non-patients (usually undergraduate college students) and non-therapists are involved in an interaction taken to be analogous to some actual psychotherapeutic situation (e.g., Hudgins & Kiesler, 1987; Kazdin & Krouse, 1983). Such studies are generally used in the experimental testing of hypotheses about psychotherapeutic methods or aspects of psychotherapeutic theory. Studies which contrive a "real" psychotherapy situation generally involve patients and therapists in an actual psychotherapeutic

interaction. These studies, as in the case of analogue studies, are generally used in the experimental testing of hypotheses about psychotherapeutic methods or aspects of psychotherapeutic theory (e.g., Bandura & Adams, 1977; Beck & Strong, 1982; Dell, 1973), including the further clinical testing of hypotheses tested in prior analogue studies (e.g., Wardlaw, 1979). Studies which collect existing verbatim records of natural psychotherapy are generally used in the "soft" testing, through correlational means, of hypotheses on psychotherapeutic methods or theory. These studies are also used in the descriptive investigation of psychotherapeutic interaction, whether quantitative or qualitative (e.g., Elliott, 1983b; Fortune, 1979; Frank & Sweetland, 1962; Friedlander, Thibodeau, & Ward, 1985; Henry, Schacht, & Strupp, 1986; Hill & O'Grady, 1985; Jones, Cumming, & Horowitz, 1988; Zimmer & Pepyne, 1971).

The first two data sources share the advantage of providing the possibility of "hard" causal evidence due to the introduction of experimental manipulation. Of these two data sources, the psychotherapy analogue is far less expensive than the contrived "real" psychotherapy situation, and is more compatible with stringent experimental controls. The disadvantages of both of these data sources are their expense and their requirement of pre-existing hypotheses. Furthermore, the "raw data" of the sessions is usually not publicly accessible to other researchers as are many verbatim records of natural psychotherapy situations. When considered in the context of this study's research question,

such data sources may also involve an undesirable homogeneity of psychotherapeutic situations.

The advantages of using records of natural psychotherapy situations are the relative cheapness, the plentifulness and the almost unlimited accessibility to other researchers of such verbatim records. Some research evidence suggests that conclusions derived from the study of natural psychotherapy situations may generalize better to overall psychotherapeutic practice than the study of analogues, analogues being poor predictors of real therapy behaviour (Kushner, Bordin, & Ryan, 1979). Finally, when considered in the context of this study's research question, natural psychotherapy situations provide a desirable heterogeneity of psychotherapeutic interactions for study. The foremost disadvantage of using existing records of natural psychotherapy situations as a data source is that such data does not permit any experimental manipulation or control and thereby only permit the "soft" testing of hypotheses. As previously mentioned, however, some evidence exists that such a lack of controls may result in better rather than inferior generalizability. Another liability of using existing records, which must be factored into the total "cost" of using such a data source, is the considerable amount of time expended in searching these records in order to find sessions containing the events of interest.

Evaluating these three data sources in the light of the inductive and descriptive aims of this study, the use of existing records of natural psychotherapy situations appears to be the

most appropriate choice. This is not an experimental study; no variables are to be manipulated or controlled for, nor are hypotheses being tested. This obviates the need for pre-determining and contriving therapeutic contexts and operations. On the contrary, inductive empiricism seeks to derive propositions by disciplined observation of natural situations, thus rendering any artificial construction of therapy situations undesirable for such a study. Considering how little is presently known on psychotherapeutic operations for catalyzing behavioural commitments, drawing hypotheses and contriving psychotherapeutic situations to test them would be a difficult, poorly informed and speculative task.

Another reason for the appropriateness of using existing records (potentially transcripts, audio- or video-recordings) of natural psychotherapy situations is that contrived or analogue situations (as have been used in some process studies of psychotherapy, using students as "therapists" and other elements unlike real psychotherapy) may systematically differ in process from natural therapy situations. The effects of such systematic differences on findings is presently unknown. Until inductive studies have identified and adequately described potentially relevant variables, and thus potentially relevant confounds to experimental studies involving manipulation of variables, it is safer to study natural situations. Bordin (1965) has addressed this consideration: "...the degree to which you can safely depart from the naturalistic setting is proportional to the amount you already know about the phenomena in question. It takes a great

deal of knowledge to move from the natural setting into the laboratory--to be able to give the answers that establish the equivalence of simplified events to those of everyday life" (Bordin, 1965, p. 495).

Finally, several practical limitations dictate the choice of existing published psychotherapy session records, instead of beginning the recording of psychotherapy sessions anew specifically for this study. What is meant by "existing published psychotherapy session records" is those transcripts, audiorecordings, or videorecordings of psychotherapy sessions which already existed prior to this study; these sessions were recorded prior to this study and for purposes unrelated to those of this study. First and foremost, it is impractical or more likely unfeasible for a project of this scope to gather an adequate number of new psychotherapy sessions for study, a preliminary examination of psychotherapy session records having found behavioural commitment to be a surprisingly rare event in psychotherapy sessions. Catalyzing the occurrence of an adequate number of instances of behavioural commitment for study would require hundreds of psychotherapy sessions to be carried out, recorded and transcribed. Such a proposition is clearly not only unnecessary but also unfeasible. Secondly, obtaining existing records of psychotherapy sessions from a broad array of psychotherapeutic approaches is feasible, whereas proactively collecting new session records from an adequate variety of therapeutic approaches would be unfeasible. Thirdly, published records of psychotherapy sessions are virtually all sessions by

experienced practitioners, a desirable characteristic given the aim of studying sessions representative of psychotherapeutic practice in general. Gaining access to new psychotherapy sessions by experienced practitioners (versus students) in one geographical location would be impractical and unnecessary as published psychotherapy sessions by seasoned therapists, exemplars, or originators of therapeutic approaches are readily available. Fourthly, transcribing new psychotherapy sessions would be an expensive, labour-intensive proposition while most published records of psychotherapy sessions are in the form of transcripts or are accompanied by published companion transcripts. Fifthly, ethical problems of confidentiality would be largely avoided by using existing, publicly available psychotherapy session records. Based upon these methodological and practical considerations, it was concluded that collecting existing published records of psychotherapy sessions was most suitable given the purpose and scope of this research project.

B. Type, School, or Theory of Psychotherapy

A second basic choice to be made concerns the type(s) of therapeutic approaches to study. This study used psychotherapy sessions of any and all types of therapy with individual, adult patients. The choice to be made in this regard was also dictated by the purpose of the study, which was to study operations across types of psychotherapy, as well as by practical considerations.

The purpose of the present study is to contribute to the technology of psychotherapy by expanding the armamentarium of operations which therapists may use in catalyzing behavioural

commitments. As a sub-goal, the identified operations are to be described at a level of abstraction rendering them suitable for adoption by psychotherapists of almost any theoretical orientation which values the occurrence of behavioural commitments. This goal is better served by examining sessions by therapists representing a broad array of theoretical approaches to psychotherapy, as this should maximize the diversity of operations and therapeutic contexts to be identified. Such a diversity is good not only for its own sake, but also because certain theoretical approaches may involve the occurrence of particular types of relatively immediate patient contexts. The study of a restricted sample of psychotherapeutic approaches may yield operations which are relevant in contexts occurring with any significant frequency in only certain types of therapy, thus restricting the usefulness of the findings to a limited group of therapists.

A second goal of the study is to contribute to theory and research on psychotherapy by generating propositions concerning psychotherapeutic operations which catalyze the occurrence of behavioural commitments in the context of particular patient states, therapeutic contexts and interpersonal therapist-patient contexts. This goal is not restricted to contributing material relevant to only one theory of psychotherapy. Thus, the aim is to generate propositions on generic change-catalyzing operations which could be applied independently from particular theories of psychotherapy. As long as a particular psychotherapeutic context/condition occurs in a given theory of psychotherapy, the

operations identified as catalyzing behavioural commitment in that context should be of relevance to that particular theory of psychotherapy and any other theory of psychotherapy in which that context/condition is pertinent. The same statement could be made concerning the operations themselves, as well as the target event of behavioural commitment. Thus, studying multiple types of psychotherapy is consistent with the second goal of this study.

A further purely practical constraint is the rarity of behavioural commitment events in published records of psychotherapy. Preliminary work suggests that of all obtainable published psychotherapy records, selection of any single school or type of psychotherapy for examination would likely yield at most three or four sessions containing behavioural commitments. Therefore, the rarity of data renders the study of any one type of psychotherapy unfeasible. Even though it appears that many psychotherapy process studies have been based on single cases (e.g., Elliott, 1984; Hill & O'Grady, 1985; Luborsky, Singer, Hartke, Crits-Christoph, & Cohen, 1984; Marmar, Wilner, & Horowitz, 1984) or few (less than 10) cases (e.g., Duncan, Rice, & Butler, 1968; Greenberg, 1984c; Lichtenberg & Hummel, 1976; Martin, Martin, & Slemon, 1987; Ullmann, Krasner, & Collins, 1961), it is presently assumed that collecting multiple instances of events to study is desirable (if not necessary) in order to achieve the stated aims of this study.

Several characteristics of psychotherapy records remain as potential selection criteria. Criteria commonly used in psychotherapy research include patient characteristics, therapist

characteristics, and diagnosis/problem. A few considerations dictate the selection of all available sessions rather than a subset limited by these criteria. The first consideration is that information on these characteristics of the recorded sessions is typically either unavailable or haphazard. A second consideration is that none of the clinical writings on behavioural commitment reviewed suggested any theoretical reasons for selecting or excluding any such specific criteria. These clinical writings referred generally to individual psychotherapy with adult patients, without implying that the methods which they were discussing applied only to a more limited subgroup of patients or therapists. A third consideration is this study's goal of studying as heterogeneous a collection of psychotherapy situations as is possible. A fourth consideration is that of the rarity of behavioural commitment events (As stated earlier, of 241 appropriate transcripts examined during preliminary work, only 31 contained one or more instances of behavioural commitment). As in the case of selecting records of only one type of psychotherapy, selecting records according to these criteria would render the obtention of sufficient data unfeasible. A fifth consideration involves the assumption that the process surrounding the catalysis of such a highly local event as behavioural commitment should be relatively similar across records differing on these characteristics. Alternately, describing the context within which psychotherapeutic operations are used should take into account differences in process by describing these as a component of the results.

Three considerations have led to the inclusion of only individual psychotherapy with adult patients. One consideration is that, as previously mentioned, the clinical writings reviewed for this study referred to individual psychotherapy with adult patients. A second consideration is that it was felt that child, couple, or group sessions involved sufficiently different processes from individual psychotherapy that inclusion of such records would overextend the reach of this study. A third consideration is based on the practicality of intensively studying process involving couples or groups. That is, multiple participants in the psychotherapeutic interaction greatly increase the complexity of the task of examining such process.

In summary, a number of considerations based on goals of this study, theory, and the practical limitations, led to the conclusion that only psychotherapy records of individual psychotherapy with adult patients were selected for use. Records of psychotherapy with children, couples or groups were excluded.

C. Medium: Transcripts, Audiotape, or Videotape?

A third basic choice which must be made concerns the medium of psychotherapy records which are used: direct/live observation, video, audio, and/or transcribed records. This study used transcripts of psychotherapy sessions exclusively.

It is obvious that the most information-rich medium consists of live sessions. The information content of various media is generally considered progressively inferior for video, audio and transcripts. One consideration which is relevant in this decision is the nature of the research question. Whereas some process

studies study events or variables requiring visual or auditory information (e.g., voice quality or strength of feeling), detection of the micro-outcome of interest in the present study is based on information which is conveyed adequately through the content of speech (rather than its quality) and which does not rely exclusively or in large part on nonverbal communication. Second, transcripts have the advantage of presenting an interaction already segmented into objective units, whether the units selected are words, sentences, complete statements, or exchanges. Third, audio or video records of psychotherapy sessions are extremely difficult to obtain in any adequate quantity for research purposes. In contrast, large numbers of transcripts have been published. Fourth, the use of such publicly available data leaves the raw data easily open to scrutiny by other researchers. In contrast, video- and audiotapes involve serious ethical restrictions in their distribution and use, owing in part to their rich information content. All of the above factors being considered, it was concluded that transcripts are adequate for the purposes of this study.

D. Segment of Psychotherapy Interaction to Study

A fourth basic choice dictating the selection of data for the study concerns which segment size of psychotherapy interaction should be selected for study. Possibilities range from session excerpts to entire courses of psychotherapy. A search for published records of psychotherapy made it obvious that practical constraints in the availability of data limit this study to an examination of complete sessions only. No published

transcripts of complete courses of psychotherapy could be located. However, over 200 transcripts of complete psychotherapy sessions were obtainable. Thus, the individual session is a practical, feasible source of data. The study of individual sessions appears to pose no limitation given this study's question. Preliminary work suggests that virtually all behavioural commitments occur towards the middle or end of sessions, assuring that in studying individual sessions, a reasonable but not excessive amount of context may be examined by the research team. The quantity of context available in complete courses of therapy is quite likely unnecessary given that the aim of the study is to examine psychotherapeutic operations which have the relatively immediate effect of catalyzing behavioural commitments. Context relevant to the occurrence of such an event is likely contained within a much smaller segment than an entire course of psychotherapy. In contrast to entire sessions, published session excerpts are plentifully available, but too short to be of use for research purposes.

In summary, the use of complete individual sessions of psychotherapy is deemed more appropriate to the purpose of this study than would be the use of session excerpts or complete courses of psychotherapy. The entire session is not an unreasonably long segment of psychotherapy for judges to examine, published records of entire sessions are readily available and entire sessions contain an amount of context suited to the question and research strategy of this study.

E. Sample Size

The issue of how much data to collect appears, at first consideration, to reduce to "How many instances of behavioural commitment must be studied in order to answer this study's question?" The answer to this question has, in turn, a bearing upon the question, "How many transcripts should be collected?" To reiterate, the study's purpose is to generate propositions concerning the psychotherapeutic operations (and any associated conditions) which psychotherapists of various theoretical orientations use in catalyzing patients' behavioural commitments. Thus, the study is inductive and descriptive, seeking to generate propositions. The study's purpose is not, given the state of knowledge on the question at hand, one of testing hypotheses in order to provide hard evidence of causality, but rather one of carrying out a study in such a way as to identify as complete a set of therapeutic operations as is possible.

The protocol of this study involved applying a rigorous descriptive method to each identified instance of behavioural commitment. Thus, the study of each instance resulted in the description of one or more psychotherapeutic operations. Studying further instances of behavioural commitment may either add new operations to those already found, new psychotherapeutic conditions for the use of particular operations, greater detail on operations, or may merely identify previously found psychotherapeutic operations.

Given that preliminary work suggested that behavioural commitments were probably rarer than initially expected, all

available published transcripts were studied, as well as transcripts from the American Academy of Psychotherapists. In order to assess whether we could be reasonably confident that the study's question was adequately answered with the available amount of data, an index of incremental productivity was created. The index consists of the frequency of new operations identified for each new behavioural commitment instance studied. Plotting the appropriately grouped frequencies permitted an assessment of the adequacy of the data set. The predicted curve was inverse exponential. The adequacy of the data set in answering the question was to be determined by how close to zero the frequency of new operations discovered had dropped to, at exhaustion of the data set.

A possibility was that the rarity of behavioural commitment events in published transcripts would mean that the data set could be exhausted before the criterion of incremental productivity dropped to zero. A preliminary examination of published transcripts suggests that exhaustion of the data set is a distinct possibility, as behavioural commitment events appear to be relatively rare in these transcripts.

The answer to the second question, "How many transcripts should be collected?", has already been determined by the aforementioned preliminary work. Based only on the rarity of these instances and on the relatively manageable number of published transcripts, it was decided to collect all readily available published transcripts.

F. Data Selected For Study

Given the inductive and descriptive objectives of the study as well as the previously mentioned considerations on the characteristics of different sources and formats of data, it was decided to use all obtainable published transcripts of complete psychotherapy sessions with individual adult patients. Edited, abridged and other non-verbatim transcripts were excluded. Transcripts were gleaned from an exhaustive search of publications (books and periodicals) on psychotherapy (186 transcripts), as well as from the American Academy of Psychotherapy Research Tape Library (55 transcripts), for a total of 241 sessions.

The transcripts included the work of therapists practicing: Behavioural Therapy (11%); Client-Centered Therapy (4%); Cognitive Therapy and Rational-Emotive Therapy (4%); Eclectic (6%); Gestalt (16%); Hypnotherapy, Hypnodrama, Ericksonian (4%); Psychoanalytic, Dynamic, Psychodynamic (28%); Miscellaneous or idiosyncratic forms of psychotherapy (Brief Therapy, Process Work, Cognitive-Experiential, Humanistic, Single-Session, Transactional Analysis, Couples--individual sessions, Psychodrama) (15%); and Unspecified types of psychotherapy (12%).

The sessions included 46% male therapists and male patients, 52% male therapists and female patients, and 2% female therapists (with male or female patients). It must be noted that these figures are representative of the characteristics of published transcripts of complete sessions rather than being an equally balanced sample of these characteristics.

Most of the transcripts were published in the 1970s and 1960s, with the number of transcripts studied breaking down by year of publication as follows: 1990- (0 transcripts); 1980-1989 (46 transcripts); 1970-1979 (80 transcripts); 1960-1969 (72 transcripts); 1950-1959 (39 transcripts); and 1940-1949 (4 transcripts).

Judges

Most psychotherapy process studies use only one or two judges (e.g., Elliott, 1984; Friedlander, Thibodeau, & Ward, 1985; Lichtenberg & Heck, 1979; Lichtenberg & Hummel, 1976; Marmar, Wilner, & Horowitz, 1984; Martin, Martin, & Slemon, 1987; Ullmann, Krasner, & Collins, 1961) as qualitative psychotherapy process research generally also does (e.g., Elliott, 1984; Marmar, Wilner, & Horowitz, 1984; Martin, Martin, & Slemon, 1987). Qualitative research in other areas of psychology usually make use of only one judge. For example, in the recent edited book Advances in Qualitative Psychology: Themes and Variations, five of six research chapters described studies using only one judge, one project having used two judges. In psychotherapy process studies, two judges tend to be used in quantitative studies using rating scales, for the purpose of establishing the reliability of the ratings (e.g., Luborksky, Singer, Hartke, Crits-Christoph, & Cohen, 1984).

An alternative to using only one or two judges which is frequently recommended both in qualitative psychology research (e.g., Glaser & Strauss, 1967; Hycner, 1985; Wertz, 1986) and qualitative psychotherapy research (e.g., Elliott, 1984;

Greenberg, 1984; Luborsky et al., 1984; Mahrer, Paterson, Thériault, Roessler & Quenneville, 1986; Rice & Saperia, 1984) is the involvement of multiple judges in producing descriptions, usually in the form of a research team. Various means have been used to involve several judges in the creation of a description. Several of these means involve one researcher creating the description in consultation with a team of judges.

One form of using multiple judges has been for the one researcher to informally discuss the subject matter with a research team, the researcher taking into account the team's input in creating the description (e.g., Rice & Saperia, 1984). A second option has been for the researcher to write a description taking into account her/his own perspective on the subject matter, as well as the individual perspectives of both the therapist and client involved in the therapeutic interaction observed (e.g., Elliott, 1984). A third option has been to have two researchers create the description in consultation with a team of judges (e.g., Mahrer et al., 1986). Glaser and Strauss (1967) have observed that the research team contributes identifying points missed, points from their own experience of the subject matter, and the possibility of cross-checking researchers' points, allowing for greater flexibility in the descriptive process. A fourth option is for one researcher to create the description and to use a team of judges to verify the description. From a phenomenological perspective, Hycner (1985) uses such a procedure in verifying that the units of relevant

meaning in a phenomenon are thoroughly discovered, and in verifying the final clustering of relevant meanings.

A second form of using multiple judges has been for the description to be created directly by the multiple judges as a consensual process. Under this rubric, we have the fifth and sixth options for creating descriptions using research teams. The fifth option, from a phenomenological methodology (Wertz, 1986), is for the researcher and subject to create a description integrating three separate perspectives; that of the subject describing their experience, that of the researcher observing the subject, and that of the subject and researcher's perspectives together. In this method, the subject and researcher begin by independently writing their descriptions, following which they write a description together during the course of an interview, and then finish by creating a description integrating these three perspectives. The sixth option is for a research team to generate a consensual description as a group (e.g., Greenberg, 1984; Luborsky et al., 1984; Rice & Saperia, 1984).

Based upon this brief review of the use of judges in qualitative research and more specifically, in qualitative psychotherapy process research, it appeared that the use of multiple judges presented certain advantages over that of single judges. These advantages include contributing multiple perspectives to a description (Elliott, 1984; Wertz, 1986), insuring a more complete description (Glaser & Strauss, 1967), providing a means of verifying the identification of relevant meaning units (Glaser & Strauss, 1967; Hycner, 1985), and

verifying the final clustering of relevant meaning units (Hycner, 1985). Although consultation of the qualitative research literature revealed that most qualitative research is carried out using single judges who may or may not informally discuss their descriptions with peers, no literature was found which pointed out specific advantages of using single judges rather than multiple judges. It should be noted, however, that in phenomenological qualitative research, bracketing of assumptions and a deliberate adoption of multiple points of view by a single observer is considered to be sufficient for avoiding bias and limited perspectives in description. Different qualitative research methods use different means of avoiding bias and limitations of perspective. Phenomenological research uses bracketing for purposes of curbing personal preconceptions and biases. In addition, phenomenological researchers deliberately attempt to adopt a multitude of different possible points of view or interpretations of the phenomenon under observation. These same two goals (limiting biases and multiperspectival description) are achieved, in other qualitative research methods, by means of using multiple observers; the results may be considered equivalent, in that the two concerns of bias and limited perspective are addressed in either case.

In contrast to using single judges, many qualitative researchers, especially psychotherapy process researchers, have vaunted the advantageousness of using multiple judges (e.g., Elliott, 1984; Glaser & Strauss, 1967; Greenberg, 1984; Hycner, 1985; Luborsky et al., 1984; Mahrer et al., 1986; Rice & Saperia,

1984; Wertz, 1986). In considering the qualitative research literature (especially that of psychotherapy process research) it was concluded that using multiple judges presented distinct advantages over the use of a single judge. One may argue that this is especially the case in psychotherapy process research, in that despite the fact that clinically trained observers possess skills remarkably similar to the research attitude required in phenomenological research (Wertz & van Zuuren, 1987), they also tend to hold strongly to their personal theoretical conceptions about psychotherapy. The multiperspective descriptions created through the use of a research team, as well as the team's verification of descriptions, may serve to provide some insurance against the creation of descriptions viewed from one theoretical perspective. This insurance is particularly important when one considers that a complete phenomenological reduction is impossible (Giorgi, 1975; Hycner, 1985; Taylor & Bogdan, 1984).

Accordingly, study of the transcripts was carried out by the University of Ottawa Psychotherapy Research Team, a team of 12 individuals experienced in the conduct of psychotherapy process research. These judges ascribed to a broad variety of theoretical perspectives on psychotherapy, including behavioural (2), cognitive (2), experiential (5), interpersonal (1), dynamic (3), gestalt (1), client-centred (3), systems (1) and eclectic/-integrative (4) (numbers sum to greater than 12 because some members expressed affiliation with more than one approach). The research team included seven clinical psychology doctoral students from the University of Ottawa, two Ph.D. clinical

psychologists, one extramural Ph.D. in electrical engineering, one clinical psychology post-doctoral student and one individual with an M.S.W. Six of the Ph.D. students were interns at University of Ottawa Psychological Services Centre, three of the clinical psychologists were in private practice, as was the M.S.W. One of the clinical psychologists is also a faculty member of the University of Ottawa. Team members' experience with psychotherapy process rating ranged approximately from 10 to 500 hours, with a mean of 200 hours.

Protocol

A. Overview

The purpose of this overview is to provide a point-form overview of the research protocol. The protocol is described in detail in a subsequent section. The study proceeded through the following six steps:

- Step 1: The purpose of this step was to reduce the entire data set to those transcripts which were likely to contain a behavioural commitment. Selecting liberally, one of two co-investigators read through all of the available transcripts and retained only those transcripts containing one or more behavioural commitments. All subsequent steps of the research protocol were carried out using the selected subset of the transcripts which contained at least one behavioural commitment.
- Step 2: The purpose of this step was to identify and locate behavioural commitments in the transcripts which were selected in step 1. This second step was carried out by

the research team, using a stringent definition of behavioural commitment. Subsequent steps of the research protocol were carried out using only those instances of behavioural commitment on which adequate inter-rater agreement was obtained. Once a behavioural commitment was identified, all of the subsequent steps of the research protocol were applied to that one instance before an examination of another behavioural commitment was undertaken.

Step 3: The purpose of this step was to observe and describe the therapeutic operations which catalyze behavioural commitments as well as the relevant patient conditions for the use of these operations. Each research team member independently produced a written description of what the therapist and patient did to catalyze the instance of behavioural commitment.

Step 4: The purpose of this step was to create a consensually valid description of the therapeutic operations and patient conditions which catalyzed the occurrence of the behavioural commitment. This step was carried out by the principle investigator and a co-investigator. Using the collected individual team members' descriptions, a composite description of the psychotherapeutic operations and conditions was generated.

Step 5: The purpose of this step was to incrementally create an ongoing provisional consensually valid category system

of distinct psychotherapeutic operations identified as catalyzing behavioural commitments. This step was carried out by the principle investigator and a co-investigator. The composite description created in step 4 was analyzed for distinct psychotherapeutic operations. Any psychotherapeutic operation not previously identified was described and added to the category system.

Step 6: The purpose of this step was to verify the provisional category system of psychotherapeutic operations modified in step 5. This step was carried out by the team of judges. The judges were supplied with the composite description created in step 4 and with the provisional category system of psychotherapeutic operations created in step 5. Judges were to accept or modify the category system, and to identify which of the psychotherapeutic operations in the provisional category system had been involved in catalyzing the behavioural commitment instance under study. Upon the completion of this step, steps 3-6 are applied to the next instance of behavioural commitment.

B. Full Description of the Protocol

Step 1

The first step of data processing, after having collected all available transcripts of complete psychotherapy sessions, was the perusal of the entire data set in a search for behavioural commitments (these will also be referred to as the "target

event"). This was carried out by the principal investigator and a co-investigator. This first search for behavioural commitments made use of the same definition used by the research team in the next step of the procedure, except that in step 1, the identification of behavioural commitments was carried out very liberally in order to reduce the data set to some manageable volume for the research team while still retaining any transcripts which could potentially be judged, by the team, to contain a behavioural commitment event (See Appendix B for the research definition of behavioural commitment). If both judges agreed that a transcript contained at least one behavioural commitment, that transcript was then submitted to the research team for the next steps of the procedure. Any transcript identified in this step as possibly containing a behavioural commitment event had each of its statements numbered sequentially.

Step 2

The ultimate decision as to whether or not a behavioural commitment is present rested upon the judgment of the entire research team in step 2. In this step, the research team (excluding the principal investigator who had previously selected the transcripts) was supplied with transcripts which were tentatively selected in step 1 as possibly containing a behavioural commitment; the team was not appraised as to the position of the behavioural commitment within the transcript. The research team was supplied, as part of the instructions (See Appendix C), with guidelines for identifying behavioural

commitments and also with a research definition of a behavioural commitment (See Appendix B). This definition acted as an ongoing reference to team members as well as an initial training document for the judges. The research team was instructed to read through the transcript and to report any behavioural commitments found. Research team members were instructed to work individually in identifying the location of any behavioural commitments. Team members were to report their findings to the team at weekly meetings, quoting the behavioural commitment statement from the transcript and reporting the corresponding statement number. If a criterion level of 70% of the judges agreed that a behavioural commitment event is present at a particular location, that event was retained for further analysis. Behavioural commitment events identified with adequate inter-rater agreement were passed on to step 3 for further processing.

In order to maintain continuity and avoid rater fatigue, each individual behavioural commitment event was worked through steps 2, 3 and 4 of the protocol before the next instance of behavioural commitment was examined. In instances where two or more target events occurred in one transcript, each target event was worked through all steps of the protocol before the next target event was examined. That is, the research team finished processing the first behavioural commitment found through all of the steps, then they took the second behavioural commitment found through all of the steps, and so on. In order to minimize rater fatigue, only one or two steps of the protocol was assigned to

the team per week: team members were requested to submit their findings in writing at the weekly meetings of the research team.

Step 3

The purpose of this step was to observe and describe the therapeutic operations preceding behavioural commitments as well as the relevant patient condition for the use of this operation.

Previous research procedures. The procedure of examining the relatively immediate sequencing of events in psychotherapy in order to draw soft causal inferences is a longstanding tradition in psychotherapy process research, whether done quantitatively (e.g., Hertel, 1972; Lichtenberg & Hummel, 1976; Wampold & Kim, 1989; Patterson & Forgatch, 1985; Snyder, 1945, Frank & Sweetland, 1962) or qualitatively (e.g., Gervaise, 1983; Mahrer, Nadler, Gervaise, & Markow, 1986; Mahrer, Nadler, Gervaise, Sterner and Talitman, 1988; Mahrer, White, Souliere, Macphee, & Boulet, 1991; Greenberg, 1984). All of the quantitative studies make use of pre-existing category or codification systems. Although on first consideration the use of a pre-existing category system appears to offer the nearly irrefutable advantage of established reliability and validity, there are two major reasons why the use of a pre-existing category system would not be suited to this study. The principal reason for the inappropriateness of using a pre-existing category system is the same reason for having already eschewed a theory-driven approach; this is an inductive and descriptive study with the avowed purpose of studying a phenomenon on which there exists essentially no research. Moreover, the aim of this study is to

identify psychotherapeutic operations in a highly specific manner. An examination of existing process research category systems readily reveals that none of these systems contain categories bearing a resemblance to the psychotherapeutic operations described in this study's literature review, nor are any of these systems designed to identify psychotherapeutic events with such specificity.

In addition, the rejection of the use of a pre-existing category system may be supplemented by empirical evidence in support of the claim that the level of abstraction and generality of content analysis systems renders them unsuitable for "detecting" the specific methods of interest to this study. The empirical evidence in question may be found in a 1984 study by Gervaise, one purpose of which was to identify previously undiscovered operations which psychotherapists use in catalyzing strong patient laughter. In order to fulfil another purpose of her study, Gervaise used the Hill Counselor Verbal Response Category System (Hill, 1978) to code therapist operations antecedent to strong patient laughter. Only two of the general categories of this system predicted patient laughter, these categories being "Other" and "Direct Guidance". These results are clearly not specific enough to yield any useful information on specific psychotherapeutic operations. Although the Hill System was designed to code comparatively specific therapist operations, it was still too general to be of use in studying operations to catalyze specific in-session outcomes.

In contrast to the use of pre-existing category systems, the open-ended examination and description of therapist operations antecedent to behavioural commitments has several advantages which make this method suitable to the aims of this study: (a) description is capable of yielding information on a desired level of specificity; (b) description is sufficiently flexible to identify operations of various "sizes", spanning from one to several statements, or varying time spans; (c) description may permit identifying idiosyncratic chains of operations; and (d) description permits taking context/condition into account. For these reasons, this study will identify psychotherapeutic operations which catalyze behavioural commitments by use of open-ended descriptions rather than by the use of any pre-existing category system.

Procedure for identifying and describing operations. In step 3, the research team was supplied with an instance of a behavioural commitment event which had been identified with an adequate level of inter-rater agreement. Transcripts were submitted to the research team as in step 2 but with the instructions to examine what took place in therapy prior to the occurrence of the behavioural commitment instance being examined. Team members were then to independently produce conceptualizations and descriptions of the therapeutic operation(s) which they believe catalyzed or contributed to the occurrence of the behavioural commitment. In addition, they were to situate these operations in a therapeutic context by supplying conceptualizations and descriptions of whatever the patient said

or did which they consider as having contributed to the therapist's subsequent use of those particular operations (See Appendix C for the exact wording of the instructions to the research team).

The raters were instructed that they could refer to events as far back in the transcript as they deemed relevant. Raters were also explicitly instructed that they may choose to report that they were unable to identify any operation preceding the target event. Raters were instructed to avoid the use of jargon or psychological theoretical constructs, as well as to minimize abstraction in their written descriptions of therapist operations and therapeutic context. Jargon is presently taken to mean technical terms which are bound to a particular theory of psychotherapy or terms used specifically in psychology. Beyond the instruction to avoid the use of jargon, judges were instructed to bracket their usual thinking about events in therapy in terms of theories of psychotherapy and to approach the data with the perspective of describing the observed events without reference to theoretical preconceptions (i.e., to produce a naive description). Finally, judges were also instructed to report the number of the referred-to statement(s) in order to support their description of events.

The instructions advised the judges to describe the therapeutic interaction in terms of patient conditions and therapist operations which lead to a behavioural commitment. More plainly, judges were instructed to describe the psychotherapeutic interaction in the format of "when the patient is being like

this, doing this, in this condition, then if you do this or that, it looks like maybe the consequence is this particular kind of extratherapy behavior change, with either slight or substantial likelihood of intention, readiness, commitment, resolve, decision, or determination" (Appendix C). Finally, the judges were instructed to summarize their description in one statement which described the overall principle of what had transpired, which had to be written in a condition-operation-consequence format.

In the course of weekly research team meetings, the principal investigator provided judges with feedback on the correctness of their performance in writing the descriptions, this feedback on "correctness" being based on the explicit criteria of the written instructions (e.g., avoiding jargon, linking the lay English descriptions of the operation to the actual words used in the transcript, and describing in an atheoretical conditions-operations-consequences format). In order to avoid contaminating judges' descriptions with those of the principal investigator, feedback to the judges did not contain evaluations of the judges' individual conceptualizations of observed events.

A few possible patterns of target event occurrence merit special consideration, these being: (a) Instances where two or more different behavioural commitments occurred in close succession in a transcript; (b) Instances where two or more of the same or similar behavioural commitments occurred in close succession in a transcript; and (c) Instances where different

behavioural commitments occurred concurrently (i.e., within the same patient statement) in a transcript. In instances (a) and (b), above, each behavioural commitment occurrence was to be treated as a separate event, with the special proviso that when creating their descriptions of operation and context for a target event, judges were also instructed not to refer back to transcript statements preceding the prior target event. That is, descriptions of context and operations should not be based on material which occurred prior to the previous target event in the transcript. In instance (c), above, the two behavioural commitments were to be treated as one behavioural commitment occurrence.

Step 4

The purpose of this step was to create a consensually valid and thorough description, for each identified instance of behavioural commitment, of the therapeutic operations and patient conditions. To this end, judges' independent descriptions were to be pooled through the construction of one composite description.

Previous research procedures. Generating composite descriptions from independent judges' observations and ratings is a commonly used procedure in psychotherapy research (e.g., Bandura, Lipsher, & Miller, 1960; Block & Thomas, 1955; Carson, Harden, & Shows, 1964; Chase, 1946; Cutler, 1958; Dittes, 1957; Dittmann, 1952; Elliott, 1984; Farson, 1961; Gervaise, Mahrer, & Markow, 1985; Gordon, 1957; Greenberg, 1984; Harway, Dittmann, Rausch, Bordin, & Rigler, 1955; Imber, Frank, Nash, Stone, & Gliedman, 1957; Labov & Fanshel, 1977; Luborsky & Auerbach, 1969;

Mahrer, Nadler, Gervaise, & Markow, 1986; Mahrer, Nadler, Gervaise, Sterner and Talitman, 1988; Mahrer, White, Souliere, Macphee, & Boulet, 1991; Marmar, Wilner, & Horowitz, 1984; McNair, Callahan, & Lorr, 1962; Pittenger, Hockett & Danehy, 1960; Greenberg, 1984; Rice & Saperia, 1984; Speisman, 1959; Walker, Rablen, & Rogers, 1960). Generally, older process studies achieved this quantitatively by, for example, combining judges' ratings or categorizations on scales or taxonomies. More recent studies have increasingly made use of qualitative composites. The combining of input from multiple judges has been used in constructing scales (Chase, 1946), identifying the occurrence of a defined event in psychotherapy (Gervaise, Mahrer, & Markow, 1985; Greenberg, 1984), providing corroborating evidence when measuring constructs requiring inference (Rice & Saperia, 1984; Walker, Rablen, & Rogers, 1960), providing corroborating evidence for a grounded analysis (Rennie, Phillips, & Quartaro, 1988), constructing a multiperspective description of events in psychotherapy (Elliott, 1983a; 1983b; 1984; Labov & Fanshel, 1977; Luborsky & Auerbach, 1969; Pittenger, Hockett & Danehy, 1960), and in producing taxonomies of psychotherapeutic events (Mahrer, Nadler, Gervaise, Sterner and Talitman, 1988; Rice & Saperia, 1984). The practice of generating composite descriptions is ubiquitous in the production of descriptions of characteristics associated with the results of psychological testing, such as MMPI code types (e.g., Tanner, 1990).

Of more direct relevance to the purpose of this study, several recent psychotherapy process research endeavors have made

productive use of qualitative composite descriptions based on the input of multiple judges (Greenberg, 1984; Marmar, Wilner, & Horowitz, 1984; Mahrer et al., 1987, 1988a, 1991, 1992; Rice & Saperia, 1984), including making use of composite descriptions in inductively identifying psychotherapeutic operations producing a given relatively immediate therapeutic impact (Greenberg, 1984; Mahrer et al., 1986, 1987, 1988, 1991, 1992). Whether stated explicitly or implicitly, the researchers cited herein have used composite descriptions with two aims; that of producing more comprehensive descriptions and that of producing more valid descriptions. The composite generation procedure selected for use in this study is one which has demonstrated its usefulness in a number of prior published studies of psychotherapy process by the University of Ottawa Psychotherapy Research Team (Mahrer & Gagnon, 1991) and is being used in a number of ongoing psychotherapy research projects. This procedure is described in the following section.

Procedure for generating composite descriptions. Composite generation begins by collecting the independent descriptions of a single behavioural commitment event, as produced by each member of the research team. As stated earlier, steps 2-6 of the protocol are applied for a given instance of behavioural commitment. Upon completion of all five of these steps for one instance of behavioural commitment, the same five steps of the procedure are applied to the next instance of behavioural commitment found in the data set. As also previously mentioned, the instructions to the judges stipulated that they should

produce not only a description but also a brief summary or "overall principle" of what transpired. This brief "summary" of therapeutic conditions, operations and consequences is the data to be used for composite generation rather than the lengthier process descriptions also received from the judges, the lengthier process descriptions being used to disambiguate the summaries. Thus, for each identified instance of behavioural commitment, a composite description of the behavioural commitment is generated (in step 2), as well as a composite description of the associated therapeutic operations and conditions (in step 4), a description of the distinct psychotherapeutic operations present in the composite (step 5) and a classification of which of the identified distinct psychotherapeutic operations were involved in catalyzing the behavioural commitment instance under study (step 6).

Although developed independently, the composite generation procedure used in this study bears considerable resemblance to a phenomenological descriptive method described by Hycner (1985). Composite generation progresses through a modified form of content analysis, of which the three general steps are analysis, mapping and synthesis. The first step (analysis) involves segmenting all of the judges' written descriptions into individual propositional statements classified as either context/condition, psychotherapeutic operation, or target event (behavioural commitment, in this study). Composite generation is carried out by two co-investigators working independently of the research team.

The second step (mapping) involves aligning all of the judges' propositional statements with their referred-to material from the transcript, resulting in a spreadsheet on which judges' descriptions of any particular referred-to transcript content are aligned with each other, facilitating the identification of recurrent themes and synonymous descriptions. The judges' pooled propositional statements are then analyzed for emergent themes, as in the case of phenomenological methods. This particular step of composite description involves a feature of content analysis (e.g., Holsti, 1969; Schöfer, Balck, & Koch, 1979) in that segments of text are categorized as reflecting the occurrence of particular concepts, but differs substantially from content analysis in that, like most qualitative analyses, the process is fluid and dynamic (Taylor & Bogdan, 1984); the categories emerge as an ongoing process or concurrently with the classification of text segments, rather than category formation and categorization of segments being two separate and sequential steps. Furthermore, traditional content analysis uses pre-existing theoretically-based meaning categories (Holsti, 1969; Rosenberg, Schnurr, & Oxman, 1990) and uses content categories for purposes of drawing statistical associations between categories (e.g., Schöfer et al., 1979), or statistically classifying examined texts into categories (e.g., Rosenberg, Schnurr, & Oxman, 1990). Human-scored content analysis uses human contextual, syntactic and semantic judgement to categorize text segments, whereas computerized content analysis uses large dictionaries and algorithms for the same purpose (Rosenberg, Schnurr, & Oxman, 1990). Content

analyses of psychotherapy generally use a concept dictionary organized to show the content reflected by words in a text (e.g., Zakaras & Fine, 1979).

In contrast to traditional content analysis, the qualitative composite-generation procedure of this study has as its aim the creation of the initial categories rather than the subsequent use of these resultant categories for classification of further instances or for statistical analyses. A final difference between traditional content analysis and the composite generation procedure is that content analysis classifies words as reflecting a category or concept (e.g., Holsti, 1969; Rosenberg, Schnurr, & Oxman, 1990; Zakaras & Fine, 1979), whereas the composite generation procedure identifies entire phrases as reflecting an emergent category of psychotherapeutic operation or condition.

The third step (synthesis) involves several concurrent operations. These operations are: condensing judges' synonymous descriptions; including descriptions of explicit links between conditions, operations, and the consequence (behavioural commitment); and summarizing the repeated use of therapeutic operations. The identified themes are then summarized into concise and coherent descriptions of patient conditions and therapeutic operations. The resultant composite description includes not only condensations of recurrent themes, but may also include unique alternative conceptualizations of the same referred-to events.

Safeguards are built into the composite generation method to insure its validity. First, the use of multiple judges

facilitates arriving at a complete consensually agreed-upon description in that the composite generation step involves summarizing and condensing synonymous descriptive statements rather than the careful selection of descriptive terms by one observer. Secondly, as a further guard against overly idiosyncratic conceptualizations which could enter into the procedure through the process of composite generation itself, two researchers independently produced composite descriptions for each instance of behavioural commitment. After having independently produced the composite descriptions, the two researchers compared their composites, discussing and consensually correcting any apparent contradictions, omissions, or overly idiosyncratic use of terms. Thirdly, the composite description is submitted to the research team for their verification and approval in step 6.

Step 5

The purpose of this step was to incrementally create an ongoing provisional consensually valid category system of distinct psychotherapeutic operations identified as catalyzing behavioural commitments. The composite description created in step 4 was analyzed for emergent distinct psychotherapeutic operations. As a safeguard, step 5 is also carried out independently by two researchers. Any psychotherapeutic operation which had not been identified in the study of previous behavioural commitments was described and added to the category system. The category system of psychotherapeutic operations and conditions is built up

incrementally by repeating steps 3-6 for each instance of behavioural commitment.

In practice, step 5 is carried out in lock-step with step 4. In studying the first instance of behavioural commitment, the distinctive themes identified in the judges' descriptions of the conditions and operations are described as distinctive categories of psychotherapeutic operations or conditions. The result of this step is the creation of provisional categories of psychotherapeutic operations, descriptions of the operations, and their associated conditions. The category of psychotherapeutic operation remains provisional until verified in step 6.

For all subsequent instances of behavioural commitments studied, the procedure is similar except that the distinctive themes identified in the judges' descriptions of the conditions and operations are compared to the previously created categories of psychotherapeutic operations. If a theme fits none of the previously described categories of psychotherapeutic operation, a new provisional category is created and described. If a theme fits one of the previously described categories of psychotherapeutic operation but reflects a distinctive new way of carrying out the operation, the previously created description of the psychotherapeutic operation is revised to include the new way of carrying it out. The modified category is reverted to the status of being provisional and the change must be verified in step 6, as for a newly created category. After having independently effected revisions to the category system or category descriptions, the two researchers compared their

revisions, discussing any consensually correcting any differences to add to or confirm the provisionally generated category system of therapist methods.

In practice, this composite generation procedure reveals the existence of hierarchical relations between the described operations, resulting in overlapping categories. Although overlapping categories would constitute a problem for a quantitative research study, such conceptual overlap is considered normal in qualitative research and even inevitable if the researcher is to retain the integrity/wholeness of the observed phenomenon (Hycner, 1985). New, previously undescribed elements are retained to be described as a separate operation, except in cases where completely excluding previously described elements would artificially break the gestalt of a newly described operation. Newly described elements which do not constitute a qualitatively distinct operation but which are not embodied in previously described operations are added to the appropriate previously described operation in order to render the description more complete.

Step 6

The purpose of this step was to verify the provisional category system of psychotherapeutic operations created or modified in step 5. In step 6, the results of steps 4 and 5 are reported to the research team for their verification and approval. The composite description of the methods used by the therapist in catalyzing the behavioural commitment is reported to the research team during a subsequent meeting. Team members' approval or

rejection of a composite description is based on Giorgi's (1975) criterion that another researcher, adopting the perspective of the author of the description, should be able to see what the researcher described, whether or not they agree. Experience with the composite-generation procedure (Mahrer et al., 1986, 1987, 1988, 1991, 1992) suggests that Giorgi's criterion is met by the procedure in that team members rarely object to the resultant composite.

Following presentation of the composite description, the provisional category system based on the composite is reported to the research team. The team of judges were to verify the provisional category system, modify it if needed, and finalize the category system. A 70% criterion of agreement among the judges was required in order to conclude on the category system revision. Following step 6, the procedure resumes at step 2 in order to identify the next behavioural commitment for study. The validity of the psychotherapeutic operation descriptions and category system so produced is enhanced by the fact that the final description is based upon a criterion of agreement between a comparatively large number of clinically trained judges.

C. When the Team Will Stop Studying Further Instances

As was stated previously, the criterion which was to be used to decide when to stop examining further instances of behavioural commitment was to be one of incremental productivity. When the research team arrived at the consensus that little or nothing new would be learned from the study of further instances, no further instances of behavioural commitment were to be examined. The

indicator that little or nothing new would be learned from studying further instances of behavioural commitment was to be that no new operations were found through the study of several instances of behavioural commitment. As described above, the process of determining when no new operations are being found was to be aided by graphing the number of new operations found against the number of (appropriately grouped) behavioural commitment instances examined. When the curve obtained from plotting these points dropped to zero, the study of further behavioural commitment instances was to cease. If, given the rarity of behavioural commitments, new operations continued to be found, the study was to proceed through to an exhaustion of the available instances of behavioural commitments. Based upon preliminary work, it appears that behavioural commitment is a much rarer event than one would imagine, the maximum number of instances of behavioural commitment which could be studied by the team was estimated at approximately 40. It should be presently reiterated that given the virtual absence of any research on behavioural-commitment catalyzing psychotherapeutic operations, the intensive study of even one instance would remain a contribution to scientific knowledge.

Although preliminary work raises the possibility that the study will proceed through to exhaustion of the data set, the method of assessing incremental productivity will still serve the purpose of providing a careful check on whether or not the study approached identifying most of the possible operations before running out of data. For example, if the study exhausts the data

set without the curve having dropped to zero, we would know that we would have needed much more data in order to successfully meet the study's aims. If, on the other hand, the curve dropped down to zero before exhaustion of the data set, we will be reasonably confident that the study's aim has been adequately met with the available data.

Chapter 4

RESULTS

In this section, the findings of this study will be presented, broken down by questions which may be addressed to the body of findings. The findings will be elaborated upon and evaluated in light of the reviewed psychotherapy literature in a subsequent discussion chapter. Presentation of the results will proceed through reporting the quantity of behavioural commitments found, description of the sessions studied, the nature of the behavioural commitments, the types of therapies in which behavioural commitments were found, and finally the principal findings; the psychotherapeutic operations and conditions described.

Rarity of Behavioural Commitments

Step 1 of the research protocol involved the principal investigator and a co-investigator reading through all of the available transcripts with the characteristics desired for this study (i.e., complete unedited sessions with individual adult patients). Of the original 241 appropriate transcripts, 31 were selected by both investigators as containing one or more behavioural commitments. As described in the method chapter, this initial selection was carried out using a liberal definition of behavioural commitment, in order to avoid missing the identification of potentially rare events (false negatives). In order to avoid the research team having to read through all of the 241 original transcripts, two investigators independently carried out this step. If both judges agreed that a transcript

contained at least one behavioural commitment, that transcript was then submitted to the research team for the next steps of the procedure. Selection errors were not considered a problem in that using a liberal definition would tend to result in false positives which would be "filtered out" by the research team in step 2.

As discussed in the method chapter, step 2 of the research protocol involved the research team using a more stringent definition to identify the location of behavioural commitments in the 31 session transcripts selected by the co-investigators. The research team studied all 31 transcripts and found only 13 which met the more stringent definition of an adequate level of commitment and which also met the criterion of interjudge agreement. Although a minimum level of 70% agreement was required for the identification of a behavioural commitment, the mean level of inter-judge agreement obtained was 83.34%.

Instances of sessions containing behavioural commitments were found to be rarer than was expected at the outset. Presented differently, the finding of 13 sessions containing at least one behavioural commitment among 241 sessions of psychotherapy amounts to having found that slightly over five percent of the 241 sessions examined contained one or more behavioural commitments. The reader should be reminded that the data set consisted of virtually all available published transcripts of complete, unedited individual psychotherapy sessions with adults, as well as those transcripts accompanying the audio recordings of the American Academy of Psychotherapists.

As discussed in the method chapter, in step 2 of the research protocol, research team members independently studied each transcript and reported the statement numbers corresponding to patient behavioural commitments. A minimum of 70% agreement was required for the identification of a behavioural commitment, and the mean inter-judge agreement obtained was 81.66%. In total, 27 behavioural commitments were identified by the research team. The number and nature of the behavioural commitments identified, as well as which sessions they were identified in, will be presented in a subsequent section.

Exhaustion of the Data Set

As explained in the Method chapter, the study of further instances of behavioural commitment was to cease upon exhaustion of the data set or alternately, by using a criterion of incremental productivity. The index of incremental productivity was defined as the number of new operations described by the research team for each instance of behavioural commitment examined. If the data were plentiful, the indicator that little or nothing new was to be learned from studying further instances of behavioural commitment is that no new operations are found through the study of several instances of behavioural commitment (viz., incremental productivity has dropped to zero). The process of determining when no new operations are being found was to be aided by graphing the number of new operations found against the number of (appropriately grouped) behavioural commitment instances examined. When the curve obtained from plotting these points dropped to zero, the study of further behavioural

commitment instances was to cease. As previously explained in the method section, if the data set is exhausted, the index of incremental productivity becomes an index of whether or not the data was sufficient to adequately and fully answer the study's question. This latter scenario was to be the case, since the data set was exhausted.

All instances of behavioural commitment identified by the research team were studied; the data set was exhausted. This raises the question of whether the study's question was adequately answered with the available data. In order to answer this question, incremental productivity was also ascertained. The process of determining the frequency of discovery of new operations was aided by graphing the number of new operations found against the number of behavioural commitment instances examined. Plotting points for appropriately grouped numbers of behavioural commitment instances resulted in a curve which clearly dropped to zero (See Figure 1). As may be read from the graph, studying behavioural commitment instances 1 - 4 resulted in finding 11 new operations, but studying behavioural commitment instances 17 - 24 resulted in finding no new operations. Thus, both criteria were attained, suggesting that the study of further instances of behavioural commitment (had more transcripts been available) would not likely have resulted in the discovery of significantly more psychotherapeutic operations. Although it would have been desirable to have found more instances of behavioural commitment, it may be concluded that the study's aim

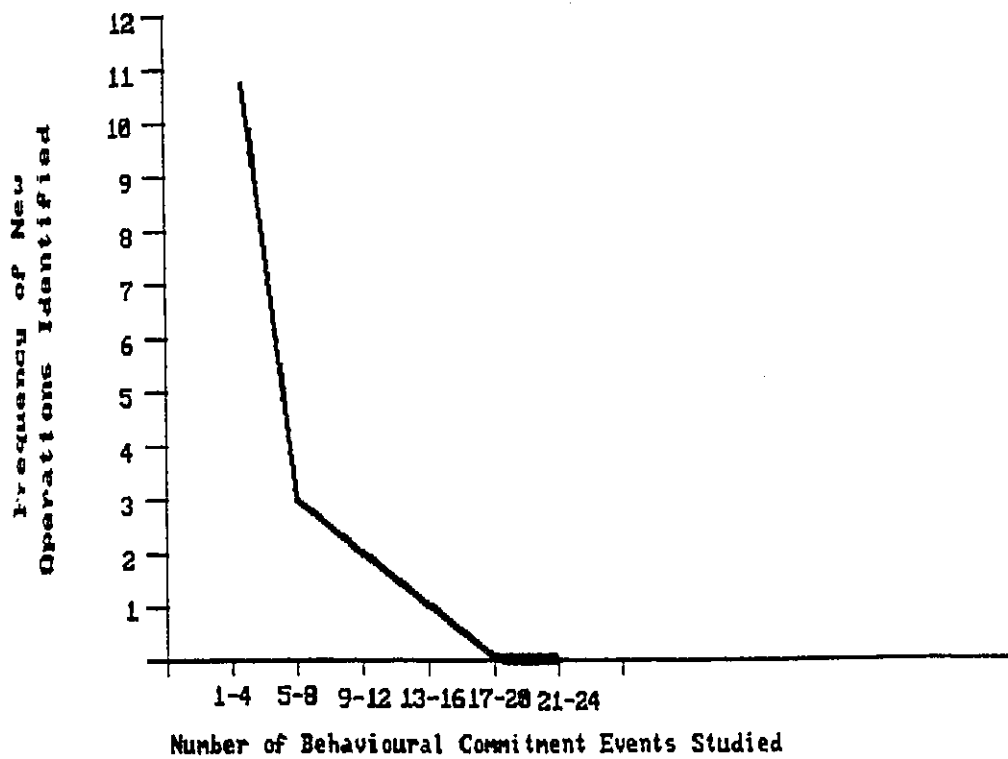


Figure 1. Frequency of new psychotherapeutic operations identified as a function of the number of behavioural commitment instances studied.

of finding psychotherapeutic operations was at least adequately addressed with the amount of data available.

Description of the Sessions

As previously described in the selection criteria for sessions, all of the transcripts studied were unedited verbatim records of complete sessions of individual psychotherapy with adult patients. Couples sessions, group sessions, or sessions with child patients were not studied. Transcripts meeting these requirements and containing at least one behavioural commitment were used regardless of type of therapy or presenting problem.

The 13 sessions studied were of: Rational-Emotive Therapy (2 sessions by different therapists), Psycho-Imagination Therapy, Client-Centered Therapy, Gestalt Therapy, Behaviour Therapy (3 sessions by two different therapists), Single-Session Therapy, Humanistic Therapy, Cognitive Therapy, Ericksonian Therapy, and Experiential Therapy. Twelve of the sessions were of male therapists with female patients, one session being of a male therapist with a male patient. Five of the sessions were of therapists who were psychiatrists, seven were by psychologists, and one by a counsellor. Most of the transcripts were published in the 1980s, with the number of transcripts studied breaking down by year of publication as follows: 1990- (0 transcripts); 1980-1989 (7 transcripts); 1970-1979 (5 transcripts); and one transcript published in 1946.

Of the 13 sessions, patients' presenting problems included: depression (8), obesity (1), test anxiety (1), self-destructive behaviour (1), alcoholism (1), anxiety (3), delinquency (2),

obsessive-compulsive problems (2), pain (1), procrastination (1), psychotic ideation (1), social anxiety (1), relationship difficulties (1), phobias (2). The total exceeds the number of sessions due to the presentation of multiple problems by some patients. Demographic data on patients accompanied the transcripts with insufficient frequency for meaningful reporting.

Most of the sessions studied were very early sessions. Eight of the sessions were initial sessions, one was session number 4, one was session number 5. No information on session number was available for three of the sessions. Two of the sessions were demonstration sessions with an audience present, the remaining 11 sessions being regular sessions. Two of the sessions were intended to be stand-alone, single-session therapies. Although information of the number of sessions intended seldom accompanied the transcripts, seven of the sessions were probably short-term therapy and three were of open-ended or long-term therapy. Information on the duration of sessions accompanied the sessions too rarely for meaningful reporting. However, the mean number of therapist-patient exchanges for the sessions was 106 (106 therapist statements and 106 patient statements, for a total of 212 statements) ($sd = 46.07$).

Behavioural Commitments by Type of Therapy

The sessions in which behavioural commitments were identified and their associated behavioural commitments were: Rational-Emotive Therapy (2 sessions by different therapists, containing 3 and 2 commitments, respectively), Psycho-Imagination Therapy (2 commitments), Client-Centered Therapy (4 commitments),

Gestalt Therapy (2 commitments), Behaviour Therapy (3 sessions by two different therapists, containing 1, 1, and 2 commitments, respectively), Single-Session Therapy (2 commitments), Humanistic Therapy (1 commitment), Cognitive Therapy (1 commitment), Ericksonian Therapy (1 commitment), and Experiential Therapy (5 commitments). In total, 27 behavioural commitments were identified across the 13 sessions.

The post-session behaviours for which commitments were obtained from the patients in the 13 sessions studied were as follows:

1. Instead of procrastinating, starting to study for exams right away, giving herself plenty of time to study.
2. Telephoning a man whom she would be interested in dating, instead of hoping that he will phone her.
3. Telephoning a man whom she would be interested in dating, and applying the methods the therapist taught her to work on her therapeutic issues if he rejects her advances.
4. Going to the dentist.
5. She wants to look into yoga or eurhythmics, instead of only working at her current job.
6. Going back home, going back to school and getting a job.
7. Going back to school and graduating.
8. Going back home and "making something of herself".
9. Taking better care of her possessions.
10. Telling a man whom she is interested in that she would like to have a sexual relationship with him.

11. Telling a man whom she is interested in that she would "like to fuck [him]".
12. Telling her estranged husband that she can accept that he had an affair, that she wants to change herself to make the marriage work, that they can obtain therapy to obtain a satisfactory sex life, that she is now much more mature, and that she would like to try to "give the relationship a go".
13. When she feels ready to lose weight, she will tell her mom that she is going on a diet, tell her that she will post a schedule of calories eaten and weight lost on the refrigerator door, and fill in the chart with false information every day.
14. Taking voice lessons.
15. Not smoking and challenging his own irrational beliefs about smoking.
16. Taking practice test questions while attempting to make herself more anxious.
17. Leaving the hospital, getting a job and working at building up a career.
18. Calling her sister and father, inviting them to a meeting, and telling him that he was stupid for having picked the worst possible wife.
19. Calling her sister and father, inviting them over to her place on the upcoming weekend, complaining to them about how awful her mother was and how they have never discussed this before.

20. Calling her brother and demanding that he give her their mother's watch.
21. Telling her husband that she hates playing tennis and that she will never play tennis with him again.
22. Telling her friend to quit managing her daughter's life.
23. If she does the prescribed imagery exercises, she will allow herself one hour of pleasurable reading. If she fails to do the exercises, she will clean the bathroom.
24. Listening to a tape of the therapy session twice.
25. Shocking herself with an electrical stimulator whenever she has a depressive thought.
26. Arranging his plates and utensils differently than he usually does at the end of a meal.
27. Continuing to move or work instead of stopping whenever he feels doubt, and trying to deliberately increase the doubt.

The judges were to identify instances in which the patients demonstrated substantial intention or resolve to carry out the post-session behaviours. The following are verbatim examples of some of the behavioural commitment events identified by the research team: "...if it would help, I'll try it.", "Okay....We have an agreement.", "...I plan to start doing that right away and give myself plenty of time.", "Yah, but then I....thought well, you know, maybe I'll call him.", "I really should do that, you know....to do that now,it would definitely be the perfect exercise in that.", "All right. I will try to try it.", "Well, I will do that."; "I want to look into Yoga, for instance, and Eurhythics. I want something which really says something to

me.", "Yeah, I will!", "I'm going to try to take those test questions and make myself more anxious than I have been doing. I think I haven't been courting anxiety in any way.", "I think I can get out and work and build up something.", "That would be a risk for me and I am going to take it.", "Not 'pretty much up to me' it's up to me--period....I'll take better care of my things this time I'm home...", "I think I'll do it!", "I'll just call them! I'll call them!", "I'm going to. Yes. Yes, I will.", "I don't want to play tennis!".

Psychotherapeutic Operations Described

The purpose of this study was to identify and describe which psychotherapeutic operations psychotherapists use to catalyze instances of behavioural commitment in sessions. As such, the psychotherapeutic operations described by the research team constitute the principal findings of this study. Study of the 27 instances of behavioural commitment identified by the research team resulted in the description of 16 distinct psychotherapeutic operations and their associated conditions. As described in the method chapter, both the categories of psychotherapeutic operations and their associated descriptions are based on the independent input of members of the research team, as well as being subject to verification, modification, and final approval by the research team. Each of the descriptions is headed by a label which was decided upon by consensus of the research team, and accompanied by an example (or examples) of the actual use of the operation, taken from the transcripts.

The composite descriptions of the therapeutic operations identified by the research team were to include a composite description of the conditions under which the operation was used, when a specific context could be identified by the research team. For example, two conditions could be "If the patient appears hesitant about carrying out the new behaviour" or "When the patient is agreeing to carry out a vaguely specified behaviour". In five of the operations, one or more conditions were described by the research team. In total, 12 conditions were identified by the research team. The locations of condition descriptions is identified by an underlined if (For example, "If a proposed behaviour..."). Of the 16 operations described by the research team, eight were not accompanied with any description of identified conditions for their use.

The operations and conditions found by the research team constitute the principal findings of this study, fulfilling the aim of finding what therapists do to bring about behavioural commitments. As described in step 6 of the method, each revision of the category system of psychotherapeutic operations required at least 70% agreement among research team members. These are the operations and conditions, exactly as finalized by the research team, and accompanied by illustrative examples:

1. Seeing patient as new person. The therapist regards the patient as a qualitatively new person, or invites the patient to be a new person, in considering and in carrying out the post-session behavior. It is as if the new person could, should, and will be committed to carrying out the post-session behavior.

Example:

T Look, I'm going to use a gimmick with you now. And I'm going to tell you the gimmick. I'm going to pretend that you really are a person who has this disarming straightforward honesty and can criticize and complain right at the person. 'You tried to fuck me up good and I kind of hate your for that, and here's what you did to me, and I am complaining and criticizing you for doing that.' Now I'm going to pretend that you are this kind of person and I'm going to talk to you and here is what I'm going to say. How would it be if you just stepped right into Nicole's life and you're going to straighten it out, any way you wanted to? Nicole's not this way, not really, but you are, and you are! Just talk in a way that makes you feel good like you did when you took a couple of strips off her mother when you were just born, and the way you laid it out straight at the restaurant, when you were being you.

2. Patient initiation. Virtually all the initiative comes from the patient. This may include selecting and defining the nature of the post-session behavior. That is, the patient is predominantly the one who comes up with the explicit post-session behavior, or with a more general behavior which may be refined into one that is more specific and explicit. The therapist neither blocks nor reduces the patient's initiative in achieving commitment-intention for carrying out the post-session behavior.

Example:

P (blurted out) I don't want to play tennis!

T Right. Really???

P (with some defiance) Yeah. I do it cause John wants me to.

T And?

P And I don't want to!

T So?

P (almost growling) Every week he drags me to the courts.

T And you go!

P I go! No more! He makes me feel like an incompetent sheep!
Yes, John! I'll try, John. Is this better, John? I HATE
TENNIS!

3. Patient readiness and control. The therapist encourages, cedes, and grants the patient opportunity to have the initiative in regard to the post-session behavior, or (if the patient shows some initiative) to have even further initiative. The therapist highlights the patient's right, readiness, willingness to carry out or to decline to carry out the post-session behavior. The therapist inquires into the patient's readiness, hesitation, or uncertainty about the post-session behavior.

Examples:

T Hey! You sound really serious about this. Are you really serious about this?

....

T How does this feel?

P GREAT.

T You going to do it?

P I am!

T Great! What else?

P (blurted out) I don't want to play tennis!

T Right. Really???

P (with some defiance) Yeah. I do it cause John wants me to.

T And?

P And I don't want to!

T So?

- P (almost growling) Every week he drags me to the courts.
- T And you go!
- P I go! No more! He makes me feel like an incompetent sheep!
- Yes, John! I'll try, John. Is this better, John? I HATE TENNIS.
- T And you're going to say this to him?
- P I am!

4. Contingent conditions. The therapist makes provision of other, sought-after parts of the treatment program explicitly contingent on the patient's agreement to carry out the post-session behavior. The therapist makes it clear that the sought-after parts, procedures, or programs will be provided on condition that the patient agrees to carry out the post-session behavior.

Example:

- T Okay. I think that there are a few things we can work on together which would be helpful for you, and hypnosis is one of them, and we can do that today, but I think for the hypnosis to work, there are going to be a few other things that you are going to have to do in terms of the dieting. Just as you know that hypnosis won't work without dieting, right. Well, dieting won't work without doing a few other things. Okay. I don't want to treat you with hypnosis now unless we can get an agreement to do these other things.
- Now, I want to run them by you.

5. Concrete specificity. The therapist is quite specific in defining the concrete and specific post-session behavior, the situational context, the other persons who might be involved, when and how to carry out the post-session behavior. Being concrete and specific may have the effect of virtually rehearsing the actual post-session behavior.

Example:

T Speak to your husband and say that you can accept what he did and that you want to do everything for yourself--to change yourself so that you can make the marriage work. Say that you have discovered that the two of you can get counsel to obtain the satisfactory sex life which you didn't have before. You would like to give it a go, that you feel much more mature, and so on.

6. Behavior/context clarification. The therapist works to clarify the behavior, or the situational context, or both. If a proposed behavior or situational context is somewhat loose or vague, the aim is to make it more specific. Or, if a behavior is proposed without an accompanying situational context, it is clarified by providing a situational context in which it is to occur. The therapist may define the situational context, and tell the patient or suggest to the patient that the new behavior is to replace the problem behavior.

Example:

P Of course, I can't wake up in the morning and press this thing.

T Why not? Keep it next to your bed.

P You mean just carry it around?

T It must be your constant companion.

P I just feel so silly. My kids are going to ask me what it is.

T You can tell them it is an energizer, an electric energizer.

P For my arm. All right. If I tell my daughter it is to stop my bad thoughts, she has enough of them herself and she will get--

T No, you don't have to tell her that. It is a new kind of energizer.

P But maybe I should tell her because then every time she has a nasty thought about me or her brother she can press it too.

T No.

P Why?

T Because it is yours, and it is only for you. Later on, if you are restored to a good emotional state, then we can think about other people.

P All right. Well then I will tell her that it is to help my muscles in my arm.

T No. They know that you are always busy. You can say it is an electrical energizer which you have to use because your great activity produces a great amount of fatigue.

7. Negotiation and custom-fitting. If the patient isn't agreeable to carrying out the initially proposed new behaviour, then the therapist negotiates with the patient in regard to the number, nature, content, and level of difficulty of the post-session behaviours. These behaviours are custom-fitted to the patient in this session based on the patient's negotiation, input, and reactions.

Example:

T Okay. That's number one, and number two, and you are not going to like this one, I don't think it would be useful to start the hypnosis unless I have an agreement from you that you are going to start practicing your singing again and your tap dancing.

P Oh, ha,ha. How about the singing? Let's make a deal. Come on. How about just singing? Tap dancing, no, not right now.

T Tap dancing later.

P Yeh.

T Now you can start by singing in your shower.

P I do that all the time.

T You do that all the time. Then, we have to make it a little harder.

P How about voice lessons.

T Voice lessons. I like that idea. Would you be willing to start those. I think that is an excellent idea. And you know, you said that you need some exercise, well, that's the exercise I prescribe to start.

8. Justifying rationale. The therapist provides ample justifying reasons, arguments, and rationales for how and why the post-session behaviours are important and desirable. Typically, this includes drawing linkages between carrying out the post-session behaviours, and the therapeutic aims, purposes, and goals. The therapist suggests, predicts, or promises that good things will happen if the patient carries out the post-session behaviours.

Example:

T You see, I think that's a problem with the strategy you have. The idea behind this strategy, I think, is wonderful, and to do it on your own for yourself. But in practice, when you're in the house with another person whose got her eyes on you, like glue, it is going to be hard to do it. Huh.

P Yes.

T Hiding it doesn't work.

P No.

T Because it's going to be visible as you lose weight. Enlisting her isn't going to work because that's going to make her be part of it. So, I would invite the people there for their consultation. But, I will tell you what idea I have on this, which is, I think you should announce to your

mom that you're going, when you are ready but not before, but when you are really ready to lose weight and keep it off, then I think you should announce to your mom that you are going on a diet, and I think that you should tell her that you are going to post a schedule of the number of calories that you have eaten each day and your weight each day on the refrigerator, okay -- Let me finish. And, I want you to fill that chart in each day, and ask her to check it, but when you fill in the chart, I want you to lie. I want you to give her the information, but give her wrong information.

P Okay.

T So that she doesn't know what's happening, but she thinks she does. Now that's true parents anyway.

9. Reluctance-counteracting rationales. If the patient is reluctant, hesitant, resistant, or negative, the therapist uses additional justifying reasons, arguments, and rationales for undertaking the post-session behaviours. The therapist also uses this method if there are expected or anticipated problems and difficulties in carrying out the post-session behaviours.

Example:

P Actually, I don't have that, anything like that kind of discomfort. In fact, when I quit, when I quit in the past, successfully for a matter of months, it was simply that I just quit. And I, I just simply said No, if it occurred to me. I did, but I didn't see the irrational ideas.

T You did the behavioral work, what we call the homework assignments--you gave yourself the active homework assignment, 'No more cigarettes! Screw it! I'm not going to

have any more cigarettes!' But you didn't get rid of, or attack very much, the magical thinking: 'But I ought to be able to get away with this! It's horrible that the world is this way! Etcetera.' Now if we can get you to do the homework assignment again, the activity--not smoke--beginning next week--and quit the magic; fight it; dispute it, actively, vigorously--challenge it, question it, then not only could you stay off the cigarettes but do yourself a great deal of philosophic and general good, and get rid of it.

10. Encouragement/pressure. The therapist pushes, presses, and encourages the patient to carry out the post-session behaviour. The therapist explicitly indicates that the patient should do it, and that the therapist wants the patient to do it. If the patient is agreeable to carrying out the new behaviour, the therapist is pleased with the patient's readiness-willingness to do it, and the therapist is disappointed, displeased, if the patient will not do it, or if the patient had not done it as agreed to in the prior session.

T O.K. There is another thing I'd like you to start trying. You say you're having more doubt during the day about whether you've done something this way or that way or another way. And you have trouble remembering it. what I'd like you to do at those times, when you normally would close your eyes and try to get it straight, I'd like you to try closing your eyes and increasing your doubt. That's what we did here when you were--

P (interrupting) That's going to be really hard.

T Uh huh, O.K., Can you live with the doubt and try to lessen the number of times you stop and think about it?

P I can try that.

T I actually think you've done that already. But I'm not sure you'd agree.

11. Acknowledgement of failure. If the therapist tries a particular method for a period of time during the session and it does not seem to work, the therapist openly acknowledges failure in regard to post-session behavioral commitment-intention.

Example:

T Now what do we do?

P (grins and shrugs) (very quietly, but grinning, also facing away from T) I don't know.

T I don't know either.

....

T I don't know what to do.

P (beaming, shrugging) I don't know either!!! (shyly) I'll go to the dentist.

12. Assigning of homework. The therapist assigns the post-session behavior as homework. The patient is simply requested, told, or instructed to carry it out.

Example:

T O.K., if you don't do your 20 minutes of RET by 10:00 p.m., you have to completely clean the bathroom before you go to bed. You have to do it.

13. Clarification and reassignment of homework. If the patient is unclear or not adequately agreeable, the therapist clarifies the assigned post-session behavior, increases commitment, and reassigns the post-session homework.

Example:

T You did the behavioral work, what we call the homework assignments--you gave yourself the active homework assignment, 'No more cigarettes! Screw it! I'm not going to have any more cigarettes!' But you didn't get rid of, or

attack very much, the magical thinking: 'But I ought to be able to get away with this! It's horrible that the world is this way! Etcetera.' Now if we can get you to do the homework assignment again, the activity--not smoke--beginning next week--and quit the magic; fight it; dispute it, actively, vigorously--challenge it, question it, then not only could you stay off the cigarettes but do yourself a great deal of philosophic and general good, and get rid of it.

P How do you do it, besides simply . . . My inclination, and this . . . I haven't been doing very well at precisely parsing the, uh . . .

T By looking for the should. Because when you feel great discomfort...

P Well my answer is usually, say, well, 'You're being grandiose.' or 'Bullshit!'

T No, you see, that's, that's shorthand.

P I know. I know. This...

T You see, that's true. But that's like saying, 'Well, you're being neurotic. Don't be neurotic!' And that will temporarily work. But you'd better zero in on the exact belief. Which is something like--and you have to find it for yourself--'The world shouldn't be this way.' The same thing those mothers are saying about their children.

P Yeah.

T O.K. You go work on that. And I'll give you the homework assignment of not smoking and challenging the magic.

14. In-Session try-out, rehearsal, and refinement-elaboration.

The therapist has the patient try out the post-session behavior in the session, enables the patient to see how it feels, and to repeat, refine, and elaborate the post-session behavior.

Example:

T If you had free rein to do anything you want when you leave here, if you were Nicole, what would you just love to do with Nathalie? Have fun doing whatever you want so you can be this great person who feels hard and strong. Tough and powerful; you know, a defiant person who stands up to. Be playful. Make it all fantasy. Absolutely unrealistic. How would you love to be with old aunty?

....

T Now see her. See her clearly. Just see her right in front of you, and when you're ready, just start saying something to her. Your way. Sounds like you have a lot to say to her.

15. Therapist accompaniment. The therapist joins with the patient in trying out and in carrying out the prospective new way of being and behaving in the session. This is more as cohort or as accompanier than as a model.

Example:

P (tough. determined.) This time you just sit down and listen! You're mom's little sister, and you NEVER stood up to her! You're a wimp! And so the hell am I! Well, now you listen. JUST LISTEN. I may let you talk later. Maybe!

T In fact, I don't think I will!

P (enjoys being tough) First, you defended her! You didn't! You changed the subject! You made me feel like it was all my fault. I think I hate you for that!

16. Contractual agreement-commitment. The therapist and patient arrive at a contractual agreement that the post-session behavior will be carried out. The therapist may initiate the idea, ask if the patient will carry out the post-session behavior, or invite the patient to accept a genuine commitment. The therapist may lock-in the commitment. The patient may recite or define the post-session behavior to acknowledge or stamp-in the commitment. If the patient indicates simple agreement, the therapist may contract for higher agreement-commitment.

Example:

T You're really serious. Look, how about making a conservative commitment. You will call Huguette and Dad. You'll call them. And you'll invite them to your place this Sunday or sometime. If they come, fine. But at least invite them.

A. Location of Behavioural Commitments in Sessions

Behavioural commitments were identified throughout sessions, but generally occurred toward the end of sessions. In order to examine the distribution of behavioural commitments in sessions, the location of behavioural commitment events in all the sessions studied was scaled onto a session standardized in length to 100 therapist-statement exchanges (200 statement numbers) and grouped by increments of 20ths of a session. The resulting frequency plot of behavioural commitment locations (Figure 2) reveals that behavioural commitments occur throughout the second half of sessions, peaking in frequency in the last tenth of sessions.

Do therapists who obtain more behavioural commitments per session begin catalyzing behavioural commitments earlier in the session? The answer, generally, appears to be yes. In Figure 3, the number of behavioural commitments found in sessions was plotted against their locations in the sessions (statement segments belonging to the same session are joined together by a

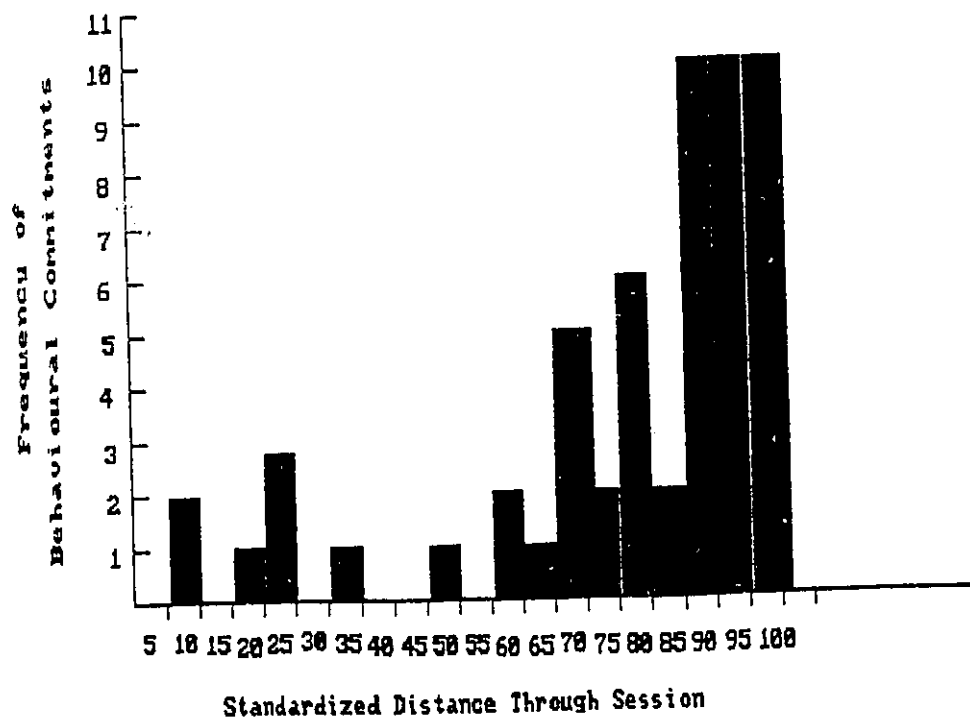


Figure 2. Frequency of behavioural commitments plotted against percentage of the psychotherapy session completed.

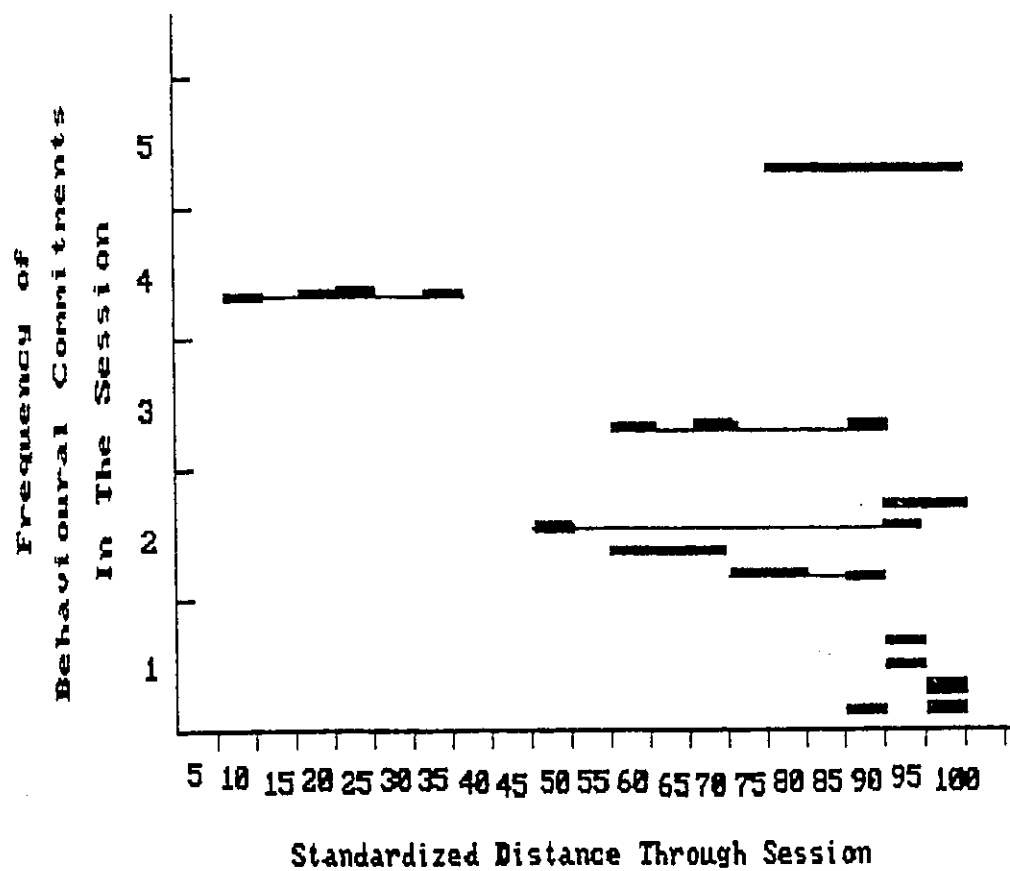


Figure 3. Location of behavioural commitments plotted against percentage of the psychotherapy session completed.

thinner line), revealing that generally, the greater the number of behavioural commitments obtained in a session, the earlier the catalysis process is initiated and the more scattered throughout the session the behavioural commitments are.

B. Concurrent Use of Operations

It was found that the operations identified are rarely used singly in catalyzing a behavioural commitment. The mean number of operations used in catalyzing a behavioural commitment was 5.59 ($sd=2.66$), with a median of 6. The modal number of operations used was 8. The frequency of use of the individual operations is summarized in Table 1 by behavioural commitment as well as by session. For example, Seeing patient as new person was used six times out of 27 behavioural commitment instances and in two sessions out of 13. A Chi-square test revealed that the operations differ significantly in their frequency of use in this sample ($\chi^2 = 47.01$, d.f. = 15). Pairwise Chi-square tests were carried out in an attempt to find which individual operations were used significantly more or less often than the mean frequency of use of all of the operations. Assuming the initial selection of an alpha error rate of .05, correcting for the experiment-wise error rate appropriate for 16 comparisons results in an alpha value of .00312. Using this corrected alpha value, none of the 16 operations were found to have been used significantly more or less frequently than the mean frequency of use across operations.

As discussed in the method chapter, in step 6, the research team rated which categories of operations were used in obtaining

Table 1
Frequency of Use of Operations

#	Operation	By Behavioural Commitment	By Session
		f/27	f/13
1.	Seeing patient as new person.	6	2
2.	Patient initiation.	14	5
3.	Patient readiness and control.	19	10
4.	Contingent conditions.	2	1
5.	Concrete specificity.	14	8
6.	Behavior/context clarification.	9	7
7.	Negotiation and custom-fitting.	2	2
8.	Justifying rationale.	13	11
9.	Reluctance-countering rationales.	9	7
10.	Encouragement/pressure.	17	11
11.	Acknowledgement of failure.	1	1
12.	Assigning of homework.	12	9
13.	Clarification and reassignment of homework.	4	4
14.	In-Session try-out, rehearsal, and refinement-elaboration.	10	5
15.	Therapist accompaniment.	5	1
16.	Contractual agreement-commitment.	15	9

each behavioural commitment. A 70% level of agreement was required for an operation to have been identified as having been used; the mean percentage inter-rater agreement obtained was 80.96%.

The concurrent use of operations is represented in Figure 4, which illustrates which operations the research team identified as having been used to obtain each behavioural commitment studied. Each column of Figure 4 represents one instance of behavioural commitment, these being numbered from one to 27. Since more than one behavioural commitment may have occurred within one therapy session, sessions are separated from one another by thicker vertical lines, each session being labeled with the type of therapy involved. For example, behavioural commitment instances one, two and three all occurred within one session of R.E.T. Each row of Figure 4 represents one of the identified psychotherapeutic operations. Bullets indicate which operations were used in obtaining each instance of behavioural commitment. For example, for the first behavioural commitment, which occurred in a session of R.E.T., the therapist used five operations: Justifying rationale, Reluctance-counterinq, Encouragement/Pressure, Assigning homework, and Contractual agreement. Different types of therapy used a greater or lesser variety of psychotherapeutic operations in obtaining behavioural commitments, as presented in Table 2. For example, in the client-centered session studied, three different operations were used, whereas in the single-session therapy session studied, 11 different operations were used.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27			
	R.W.T.			Psycho-Imagination			Silent Gestured			Gestalt Therapy		Behaviour Therapy		Stimulus-Sensitive Therapy		Humanistic Therapy		Cognitive Therapy		Ericksonian Therapy		Experiential Therapy			R.W.T.		Behaviour Therapy		Behaviour Therapy	
1 Seeing P as New Person																														
2 P Initiation																														
3 P Readiness and Control																														
4 Contingent Conditions																														
5 Concrete Specificity																														
6 Clarification																														
7 Negotiation																														
8 Justifying Rationale																														
9 Reluctance-Countering																														
10 Encouragement/Pressure																														
11 Acknowledgement of Failure																														
12 Assigning Homework																														
13 Clarification and Reassignment																														
14 In-Session Try-Out																														
15 Therapist Accompaniment																														
16 Contractual Agreement																														

Figure 4. Psychotherapeutic operations used in catalyzing the behavioural commitments studied.

Table 2

Quantity of different operations used by type of therapy.

R.E.T. (Mean of 2 sessions)	6.50
Psycho-Imagination Therapy	7
Gestalt Therapy	7
Behaviour Therapy (Mean of 3 sessions)	6.67
Single-Session Therapy	11
Humanistic Therapy	9
Cognitive Therapy	9
Ericksonian Therapy	5
Experiential Therapy	9
Client-Centered Therapy	3

Soft Impressions of The Judges

In addition to the findings obtained through methodical study, the research team volunteered a few relevant but more impressionistic observations concerning how therapists obtain behavioural commitments. These observations will be reported and discussed where relevant in the following chapter.

Chapter 5

DISCUSSION

The purpose of this study was to answer the question, "What are the psychotherapeutic operations which are judged as antecedent and catalyzing patients' commitments to carry out new extratherapy behaviours?" More specifically, the purpose was to answer the question, "Which psychotherapeutic operations, used in which psychotherapeutic context, will result in the relatively immediate occurrence of behavioural commitments?" The purpose of the study was not to test hypotheses, nor to evaluate a theory, but to describe those psychotherapeutic operations that psychotherapists actually use in bringing about behavioural commitments in their sessions. The principal findings of the study consist of these psychotherapeutic operations. Other issues addressed in the discussion are secondary to these main findings.

This chapter will begin with a discussion of the incidence of behavioural commitments, followed by discussion of the operations obtained, the degree to which the study has been successful in addressing its question, how the operations may be adopted for use by therapists, theoretical implications of the findings, the frequency distribution of operations, the use of multiple operations by therapists, the conditions identified, some impressions on the clustering of operations, the nature of the selected post-session behaviours, limitations and weaknesses of the study's method, suggestions for future research, and a summary of what practitioners could do differently based on the findings.

Incidence of Behavioural Commitments

The incidence of behavioural commitments in published transcripts of sessions was far lower than was expected, behavioural commitments having been identified in slightly more than five percent of the 241 sessions examined. To reiterate, this amounts to a mean of .112 behavioural commitments per session.

One possible reason for the low incidence of behavioural commitments may be the fact that 28% of the transcripts originally examined were of psychodynamic psychotherapy, which does not specifically attempt to obtain behavioural commitments. Moreover, psychodynamic psychotherapists may even tend to discourage such behavioural decisions as "flight into health" (Oremland, 1972; Shelly, 1985). In support of this view, none of the psychodynamic sessions examined contained behavioural commitments. It is more difficult to explain the fact that although 11% of the 241 transcripts were of behaviour therapy, only three behaviour therapy transcripts were judged as containing a behavioural commitment. A possible explanation is that half of the published behaviour therapy transcripts found are of first sessions. Perhaps behaviour therapists do not generally try to obtain behavioural commitments in first sessions, but use the session for other purposes, such as gathering background information on the patient and on the patient's problem. Despite these explanations, the finding of so few behavioural commitments leads one to think that if great concern with obtaining behavioural commitments exists, it is

certainly not reflected by the publication of transcripts likely to contain them.

Another possible explanation for the finding of so few behavioural commitments is that perhaps only a few types of psychotherapy actually value and obtain behavioural commitments, but that there happen to be few published transcripts of these types of psychotherapy. Impressionistic support for this explanation is that with the exception of a number of transcripts published by Wolpe, only one suitable (viz., complete session) behaviour therapy transcript was found. Similarly, Mahrer, whose therapy aims at obtaining behavioural commitments each session, has only one published transcript of a complete session (Mahrer, 1989). Also, few transcripts of brief or single-session therapies were found. These therapies also value rapid post-session behavioural changes (e.g., Goldring, 1980; Talmon, 1990).

Another possible explanation is that most of the original 241 published transcripts examined were from the 1970s and 1980s, dating from an era prior to the current concerns with accountability and short-term therapies directed toward rapid patient changes. Had a greater quantity of more recent transcripts been available, perhaps more behavioural commitments would have been found. In support of this possibility, 15.2% of transcripts from the 1980s were found to contain at least one behavioural commitment. In contrast, the percentages for earlier transcripts are: 1970s (6.2%); 1960s (0%); and 1950s (0%). Due to the low frequencies involved, reporting a percentage for transcripts from the 1940s would be meaningless. Since most of

the 13 transcripts used in the study were relatively new, the age of the transcripts should not otherwise constitute a biasing influence on the nature of the findings.

Another possible explanation is that behavioural commitments are rarer than instances of simple agreement. Perhaps for many of the post-session behaviours, therapists do not consider obtaining a strong commitment to be of importance. It is also possible that obtaining any sort of agreement to post-session behaviours is not relevant for all sessions, in all approaches.

An alternative explanation is that in psychotherapy in general (without regard to school of psychotherapy), behavioural commitments are a rare event. This would suggest that psychotherapists generally do not value extra-session behaviour changes, or alternately, that they expect these changes to take place spontaneously without any direct input from the therapist. Alternately, as discussed in the specific case of behaviour therapy during the introduction, therapists may take for granted that merely telling the patient to carry out a new behaviour is sufficient and that the matter of how to obtain behavioural commitments is inconsequential.

Even assuming that all of the above factors actually did reduce the number of behavioural commitments found, it remains astonishing that on average, less than one-tenth of one behavioural commitment per session was found. Behavioural commitments are either a remarkably neglected area of research, or a remarkably neglected area of practice. The implication of this for research is that it is important that each rare instance

of behavioural commitment be studied in order to unlock the secrets of obtaining them in sessions.

How do the Operations Found

Compare to Those Described in the Literature

And Which Operations Are Newly Discovered?

This section will compare each of the psychotherapeutic operations described by the research team to those previously described in the reviewed literature as operations which catalyze the occurrence of behavioural commitments. The comparison will not extend to psychotherapeutic operations which are reported without the specific purpose of obtaining behavioural commitments. Comparisons will mostly be made to operations described in the technical psychotherapy literature, since only two methods in total were reported in the research literature. The findings of this study may serve to confirm, disconfirm, add to, or elucidate previous operations reported in the reviewed literature.

A. Which Operations Are Newly Discovered?

Nearly all of the behavioural commitment catalyzing operations reviewed in chapter 1 were described in technical psychotherapy literature (e.g., theoretical writings, books and articles based on clinical lore or clinical experience, treatment manuals) and not in psychotherapy research literature. Therefore, operations described by the research team which correspond closely to those operations reviewed constitute, in most cases, the first research-based confirmation of the usefulness of these operations in catalyzing behavioural commitments. The aim of this

section is to answer the question, "Is this operation new, or has someone previously proclaimed its usefulness in obtaining behavioural commitments?"

It is difficult to judge to what degree an operation found by the research team is "new". There are a few reasons for this difficulty. First, deciding whether or not two descriptions of operations are similar or dissimilar is a judgement call. Secondly, what constitutes an established operation? Is it established if it is widely reported by clinicians as promoting behavioural commitments? If one clinician has already reported it? Only if it is reported in the research literature? Only one of the operations found by the research team had been previously reported in one psychotherapy research article, as promoting behavioural commitments (Patient readiness and control). If one applies the criterion that an operation must have been reported as catalyzing behavioural commitments at least once in research literature, then 15 of the 16 operations identified in this study are new. Moreover, for the one operation previously reported in the research literature, the research team identified one condition which had not been previously reported in psychotherapy research literature.

The criterion of what is meant by "new" in this discussion will be that an operation found by the research team has not been reported as useful in promoting behavioural commitments in any of the technical psychotherapy literature reviewed in Chapter 1. If the operation has been described by several practitioners, rather than only one or two, it will be described as a "well

established" operation. It should be kept in mind, however, that since obtaining behavioural commitments was discussed by so few authors in the clinical literature, none of the operations identified by the research team can be said to be "widely established". At most, six authors had previously described an operation identified by the research team.

Seven of the operations described by the research team had not been previously described in the reviewed psychotherapy literature as promoting behavioural commitments. These seven newly identified psychotherapeutic operations are: Patient initiation, Behaviour/context clarification, Negotiation and custom-fitting, Reluctance-countering rationales, Encouragement/pressure, Acknowledgement of failure, and Therapist accompaniment. It should be noted that these operations were not described even once in any of the reviewed psychotherapy literature, either research or technical, and as such constitute a totally original identification of operations useful in catalyzing behavioural commitments. Since these operations were not previously discussed as promoting behavioural commitments, they can not be compared to the clinical literature. These newly identified operations will be discussed in subsequent sections of this chapter, especially in the section on "Implications for Practitioners".

The other nine psychotherapeutic operations described by the research team had already been reported as promoting behavioural commitments in the clinical literature, although in all but one case only in the non-research (technical) literature. These are

not new operations. Since these operations have not been previously reported in the research literature, however, description of these previously reported operations by the research team constitutes the first research-based confirmation of the usefulness of these operations as a catalyst of behavioural commitments. The nine operations which had been previously described as behavioural commitment catalysts in the technical psychotherapy literature as contributing to behavioural commitments are: Seeing patient as new person, Patient readiness and control, Contingent conditions, Concrete specificity, Justifying rationale, Assigning of homework, Clarification and reassignment of homework, In-session try-out, rehearsal, and refinement-elaboration and Contractual agreement-commitment. Of these nine operations, two may be considered "established" operations for catalyzing behavioural commitments, having been cited by more than two authors. The other seven were reported by one or two authors and are merely previously reported.

B. Established Operations

The following three operations may be considered "established" as promoting behavioural commitments, having been reported by at least three clinical authors.

4. Contingent conditions. The therapist makes provision of other, sought-after parts of the treatment program explicitly contingent on the patient's agreement to carry out the post-session behavior. The therapist makes it clear that the sought-after parts, procedures, or programs will be provided on condition that the patient agrees to carry out the post-session behavior.

This operation closely resembles one previously described by Haley (1984) as "the devil's pact method". In Haley's method, the

therapist tells the patient that the therapist has the solution to the patient's problem, but will only tell the patient what it is if the patient is ready to commit herself to doing whatever the therapist tells her to do (Omer, 1985). Haley uses this method to obtain behavioural commitments in the initial session, although neither he nor the research team specify any particular condition for the use of this operation. The research team's version is more general and inclusive than Haley's version.

A related method is also reported as being used to overcome patient resistance to behavioural assignments in behaviour therapy, by making a subsequent therapy session contingent upon completion of the assignment (Goldfried & Davison, 1976). One difference between Goldfried and Davison's version of the operation and the one described by the research team, is that the research team's version is more carefully detailed and general. A second difference is that Goldfried & Davison make the continuation of therapy contingent not only on the patient behavioural commitment, but on the patient actually carrying out the new behaviour, whereas the research team's version makes anything within therapy (e.g., hypnosis) contingent on the patient's in-session behavioural commitment.

5. Concrete specificity. The therapist is quite specific in defining the concrete and specific post-session behavior, the situational context, the other persons who might be involved, when and how to carry out the post-session behavior. Being concrete and specific may have the effect of virtually rehearsing the actual post-session behavior.

This operation is probably the best established operation of those found in this study, having been reported by several authors as being useful in obtaining behavioural commitments. In

the case of Concrete specificity, the research team did not come up with a new operation, since it is already well established as useful in obtaining behavioural commitments. This operation is similar to "Specifying the new behaviour", as described in the review of technical psychotherapy literature. "Specifying the new behaviour" is a commonly known and used operation, probably due in part to the influence of behaviour therapy. It has been explicitly linked to obtaining behavioural commitments by a number of clinical authors (Kanfer & Grimm, 1980; Wells, 1982; Omer, 1985; Whipple, 1985; Montgomery & Montgomery, 1975; Mahrer, 1989), although this link was not reported as a research finding in any of the reviewed literature. Operations similar to Concrete specificity have been reported as useful in catalyzing behavioural commitments in behaviour therapy (Kanfer & Grimm, 1980), short-term therapy (Wells, 1982), reality therapy (Whipple, 1985), contractual psychotherapy (Montgomery & Montgomery, 1975) and experiential psychotherapy (Mahrer, 1989). The various methods described by these authors all resemble Concrete specificity in that they are all various means of making the behaviour that the patient is to carry out clear, detailed, concrete and specific. Kanfer and Grimm (1980) suggests summarizing for the patient what the therapist thinks are the most significant situations or behaviours that require change. Whipple (1985) suggests that a written description of the new behaviour be created. Montgomery and Montgomery (1975) suggest making the patient's general goals specific through questioning, such as "How would you be acting now if you were self-confident?"

Finally, Mahrer (1989) suggests that the therapist question the patient on what their life can be like, specifically, if they were to be a different person. All of these operations were reported by the above authors as promoting behavioural commitments.

This operation also indirectly includes "Practicing the new behaviour", as described in the technical psychotherapy literature, an operation described by Mahrer (1989) as the therapist instructing the patient to try out and rehearse the new behaviour in the session, in order to promote a behavioural commitment. Sometimes, in the use of Concrete specificity, the behaviour is virtually rehearsed in the course of the discussion between patient and therapist, but this is not always or necessarily the case.

C. Previously Reported Operations

The following operations are not "established", but have been previously reported by one or two clinical authors as being useful in catalyzing behavioural commitments. These are not operations which are commonly reported as useful in obtaining behavioural commitments.

1. Seeing patient as new person. The therapist regards the patient as a qualitatively new person, or invites the patient to be a new person, in considering and in carrying out the post-session behavior. It is as if the new person could, should, and will be committed to carrying out the post-session behavior.

This operation closely resembles one previously described by Mahrer (1989) in his treatment manual, as "Addressing the patient as a new person", an operation in which the therapist addresses the patient as if the patient were a new, different person. No other authors of technical psychotherapy literature described the use of this operation in catalyzing behavioural commitments. Use of this operation for the explicit purpose of obtaining behavioural commitments seems to have been restricted to Mahrer's experiential therapy, so far. The research team's description does provide some added detail to Mahrer's original description of this operation. In his description of "Addressing the patient as a new person", Mahrer states that "...the therapist can address the patient as this new person. Or the therapist and patient can agree to play a game in which the therapist talks to the patient as if she were the new person (Mahrer, 1989, p. 72).

3. Patient readiness and control. The therapist encourages, cedes, and grants the patient opportunity to have the initiative in regard to the post-session behavior, or (if the patient shows some initiative) to have even further initiative. The therapist highlights the patient's right, readiness, willingness to carry out or to decline to carry out the post-session behavior. The therapist inquires into the patient's readiness, hesitation, or uncertainty about the post-session behavior.

This operation resembles one previously reported as a research finding by Mahrer and his colleagues as "[when] the patient is carrying out the specific behavior with good feeling in the session, it may be carried out with good feeling in the extratherapy world. The therapist operations [consist] of indicating and acknowledging the patient's readiness to have these good feelings by carrying out this explicit behavior in the

extratherapy world" (Mahrer et al., 1992, p. 259). One difference between these two descriptions is that different conditions are specified for the use of the operation. Thus, the research team's description not only confirms and increases confidence in Mahrer and his colleagues' finding, but also adds one new condition. In the version produced by the research team, the operation is used with or without the preliminary condition of the patient showing initiative with regard to post-session behaviours, whereas in Mahrer and colleagues' version, the operation is carried out with the preliminary condition that the patient is carrying out the new behaviour with good feeling in the session. This operation appears to be relatively unknown to practitioners as useful in obtaining behavioural commitments, judging by the fact that only one practitioner explicitly linked this operation to the catalysis of behavioural commitments. It is interesting to note that no other authors report or describe the use of this operation in promoting behavioural commitments, either in technical or research literature. Does the lack of attention to this operation possibly reflect an underlying assumption on the part of therapists that patients should simply be ordered or told to carry out post-session behaviours and that explicitly leaving the patient free to show initiative isn't relevant to obtaining behavioural commitments? Alternately, it is possible that inattention to Patient readiness and control could reflect the fact that many therapists have stock behavioural assignments for patients, the selection of which is totally up to the therapist's

knowledge of psychotherapy, in contrast to patient-selected post-session behaviours.

8. Justifying rationale. The therapist provides ample justifying reasons, arguments, and rationales for how and why the post-session behaviours are important and desirable. Typically, this includes drawing linkages between carrying out the post-session behaviours, and the therapeutic aims, purposes, and goals. The therapist suggests, predicts, or promises that good things will happen if the patient carries out the post-session behaviours.

This operation is not an established method of obtaining behavioural commitments, but has been reported from two sources as useful for this purpose. This operation resembles and includes Kanfer and Grimm's (1980) suggestion that behavioural commitments may be promoted by explaining to the patient the theory of psychotherapy as a rationale for the importance of carrying out the new behaviour. They suggest that the therapist tell the patient that the therapist's ability to help them depends on the patient's readiness to carry out some vital tasks. Kanfer and Grimm do not include therapist predictions or promises that good things will happen if the patient carries out the post-session behaviours. Thus, the research team's description not only confirms Kanfer and Grimm's use of their operation for obtaining behavioural commitments, but adds to it. Curiously, Kanfer and Grimm (1980) were the only behaviourist source explicitly reporting this operation as useful in obtaining behavioural commitments, although one would imagine that many behaviour therapists must also make use of this operation in practice.

This operation also includes Montgomery and Montgomery's (1975) suggestion that therapists obtain behavioural commitments by telling patients that carrying out the new behaviour will lead

to progress, improvement, or correction of a patient's problem. By virtue of having identified Justifying rationale as contributing to obtaining behavioural commitments, the research team provides some confirmation of Montgomery and Montgomery's claim, as well as adding to their method by including in the operation the therapist's provision of a theoretical rationale explaining why carrying out the new behaviour will lead to good outcomes for the patient.

12. Assigning of homework. The therapist assigns the post-session behavior as homework. The patient is simply requested, told, or instructed to carry it out.

This operation is similar to a general category of psychotherapeutic operations which was labeled "Authoritative order" in the introductory chapter. Assigning of homework is probably the most commonly known and used of the operations for obtaining behavioural commitments, as well as being the simplest and most intuitively obvious. It has been listed here under "previously reported operations" due to the fact that it has been seldom explicitly linked to obtaining behavioural commitments. Examples are numerous and shall not be included here because they are relatively mundane. However, it is interesting to note that the process of obtaining behavioural commitments has been taken for granted by writers of technical psychotherapy literature to such an extent that only two sources (Wells, 1982; Bandler, Grinder, & Satir, 1976) were found which explicitly linked its use to obtaining behavioural commitments. Bandler and his colleagues (1976) described a similar operation as the "polite command method": "What I would like you to do, if you would, is

to..." (Wells, 1982, p. 187). In the case of Assigning of homework, the research team's description merely explicitly confirms what is already widely taken for granted by practitioners. Moreover, Bandler and colleagues' operation overlaps with but is distinct from Assigning of homework, by adding to a simple direct command, a statement by which the therapist acknowledges that the patient has the choice of whether or not to commit themselves to the new behaviour.

13. Clarification and reassignment of homework. If the patient is unclear or not adequately agreeable, the therapist clarifies the assigned post-session behavior, increases commitment, and reassigns the post-session homework.

This operation is similar to a general category of psychotherapeutic operations which was labeled "Authoritative order" in the introductory chapter. Like Assigning of homework, Clarification and reassignment of homework is previously reported operation; it has been explicitly linked to obtaining behavioural commitments by two clinical authors (Wells, 1982; Bandler, Grinder and Satir 1976).

14. In-Session try-out, rehearsal, and refinement-elaboration. The therapist has the patient try out the post-session behavior in the session, enables the patient to see how it feels, and to repeat, refine, and elaborate the post-session behavior.

This operation is similar to "Practicing the new behaviour", discussed in the review of technical psychotherapy literature. This operation is more commonly known as "behavioural rehearsal", from a behaviourist perspective. Curiously, only Mahrer (1989) has explicitly indicated the use of this operation for promoting behavioural commitments. The fact that only one clinical author explicitly described this operation as catalyzing behavioural

commitments may stem from behaviourism's having taken for granted the patient's readiness and commitment to carry out new behaviours (Prochaska and DiClemente, 1982).

16. Contractual agreement-commitment. The therapist and patient arrive at a contractual agreement that the post-session behavior will be carried out. The therapist may initiate the idea, ask if the patient will carry out the post-session behavior, or invite the patient to accept a genuine commitment. The therapist may lock-in the commitment. The patient may recite or define the post-session behavior to acknowledge or stamp-in the commitment. If the patient indicates simple agreement, the therapist may contract for higher agreement-commitment.

This is another operation which one assumes must be commonly used, at least by behaviourally oriented psychotherapists, but which has only been reported explicitly as useful in promoting behavioural commitments by two clinical authors. Contractual agreement-commitment resembles one operation previously reviewed in the technical psychotherapy literature as "Contracting". In "Contracting", the therapist asks the patient to demonstrate the patient's commitment to carrying out the new behaviour by signing an agreement, contract or plan (McElroen & Faltico, 1977; Whipple, 1985). Contractual agreement-commitment is another operation which one may assume is commonly used, considering its frequent mention in technical psychotherapy literature, but it has rarely been explicitly acknowledged as promoting behavioural commitments. That this link has rarely been made explicitly is likely due to behavioural commitment being generally taken for granted in psychotherapy. "Contracting" is widely known as a behavioural technique. Contractual agreement-commitment differs from "Contracting" by accepting verbal commitments, seeking strong commitments, and sometimes having the patient recite

exactly what behaviour is to be carried out, whereas "Contracting" involves requesting the patient to sign a written agreement that they will carry out certain specific behaviours. The commonality is that a commitment of some sort is finalized through a "contract", whether verbal or written.

This concludes the comparison of operations described by the research team to those described in the reviewed psychotherapy literature on behavioural commitments. Comparisons could only be made, of course, to those operations which bore some degree of resemblance to previously reported operations. Those operations which had no equivalent in the reviewed literature will be discussed in subsequent sections of this chapter.

To What Extent Was The Study Successful

In Answering The Research Question?

This study resulted in the identification and description of 16 psychotherapeutic operations used by therapists in promoting the occurrence of behavioural commitments, demonstrating, as in previous studies (Gervaise, Mahrer, & Markow, 1985; Mahrer, 1988b; Mahrer, Nifakis, Abhukara, & Sterner, 1984; Mahrer et al., 1986; 1987; 1991; 1992) the productivity of the research strategy used in identifying what therapists actually do in real psychotherapy sessions. One index of how productive the study has been is to compare the 16 obtained psychotherapeutic operations to those already described in the introductory literature review. Of the 16 operations described by the research team, eight were relatively new or contained new conditions which had not been found through a review of the literature on behavioural

commitments. The operations which were newly identified by the research team and had not been previously reported in the reviewed literature as catalysts of behavioural commitment are: Patient Initiation, Behaviour/Context Clarification, Negotiation and Custom-Fitting, Reluctance-Countering Rationales, Encouragement/Pressure, Acknowledgement of Failure, and Therapist Accompaniment. The operations identified by the research team which had been previously described in the reviewed literature and therefore were not newly identified as behavioural commitment catalysts are: Seeing Patient As New Person, Patient Readiness and Control, Contingent Conditions, Concrete Specificity, Justifying Rationale, Assigning of Homework, Clarification and Reassignment of homework, In-Session Try-Out, Rehearsal, and Refinement-Elaboration, and Contractual Agreement. Turning to the conditions associated with the operations described by the research team, six of the seven conditions obtained had not been found reported in any of the reviewed literature.

It is also noteworthy that of the 16 operations described by the research team, only one consisted of the common method in which the client is simply requested, told, or instructed to carry out a post-session behaviour as a homework assignment. Furthermore, although some of the operations described by the research team had been previously described in the technical psychotherapy literature, only one (Patient readiness and control) had been previously reported in research literature as tied to behavioural commitments.

In conclusion, for all but one of the operations which had been previously reported in the technical psychotherapy literature, this study constitutes the first research-based confirmation of these operations as being useful in promoting behavioural commitments. Finally, although the operations described in the technical psychotherapy literature were reported as promoting behavioural commitments, this study is the only source which explicitly ties particular psychotherapeutic operations with strong, clear behavioural commitments, as specified by the instructions given to the judges. It is concluded that this study has been successful in attaining its goal of contributing to a body of knowledge on psychotherapeutic operations for catalyzing behavioural commitments.

Implications of the Findings for Practitioners

The purpose of this section is to discuss how practitioners may make practical use of the findings in their attempts to catalyze behavioural commitments. Discussion may include breakdowns of operation identified operations into components, examples of how clinicians have reported using similar operations in the reviewed literature, possible further uses of the operations in psychotherapy, and possible constraints on the uses of particular operations by particular therapists. The implications have been divided into 11 subheadings.

A. Just Assigning Homework Probably Isn't Sufficient

Simply telling the patient to carry out a post-session task is likely the most commonly known, widely used and intuitively obvious operation for obtaining behavioural commitments. One may

speculate that this operation may depend on therapist prestige and credibility. As will be discussed in a subsequent section of this chapter, in the sample of therapy sessions examined in this study, Assigning of Homework was never used alone, but was always combined with the use of other psychotherapeutic operations in obtaining behavioural commitments. The research team had the impression that behavioural commitments initially obtained using only Assigning of homework were rather weak commitments or mere acquiescence to the therapist's request. Other operations were used to make the behaviour very clear to the patient, or to involve the patient in making the behaviour personally relevant.

The implication for practitioners is that although Assigning of homework is a frequently used (and necessary) component in prescriptive psychotherapies, it would probably lead to weak behavioural commitments if used alone.

**B. Provide The Patient With a Plausible
Explanation of Why They Should Carry Out a
Post-Session Behaviour**

Justifying Rationale was among those operations most frequently used in obtaining behavioural commitments in the transcripts examined for this study. This operation has as its core the therapist providing the patient with a link between something that the patient would view as a desirable outcome, and the proposed new behaviour, which the patient may feel unsure about, scared of, or may fail to see any reason for. Justifying rationale is somewhat analogous in operation to Contingent conditions, although less explicit and with no element of

therapist coercion. In Contingent conditions, the therapist tells the patient that if the patient wants this certain therapeutic procedure, then the patient will have to commit themselves to the post-session behaviour. Likewise, in Justifying rationale, the therapist tells the patient that if the patient wants this certain therapeutic outcome, then the patient must commit themselves to the post-session behaviour. In the case of Contingent conditions, this deal is made very explicitly, whereas with Justifying rationale, the patient is left to infer the necessity of behavioural commitment from the therapist's theoretical justification for the post-session behaviour. Various means of justifying post-session behaviours have been reported in the literature. The therapist may tell the patient that good therapeutic work can only be done once the patient has carried out the behaviour (Omer, 1985), or the therapist may tell the patient to carry out a feared behaviour for the purpose of assessing the extent of their fear (Leitenberg, 1972). One may speculate that this operation may depend on the therapist's prestige and credibility.

The implication for practitioners is mainly that telling the patient that a good, desired outcome will result if they carry out the new behaviour, may forestall the patient balking at the new behaviour, or may make the patient look forward to carrying out the new behaviour.

C. Be Very Specific About The Post-Session Behaviour

The results suggest that it is important, in obtaining a behavioural commitment, that the therapist work toward the

patient having a very clear picture and understanding of what the new behaviour is to be. Two of the operations identified by the research team fulfill this function: Concrete Specificity and Behaviour/Context Clarification.

By using Concrete specificity or Behaviour/Context Clarification, the therapist makes sure that the potential new behaviour is clear and specific rather than vague and unsure. It appears that patients may be more ready to commit themselves to a behaviour of which they have a clear picture in mind. Other therapists have reported carrying out operations similar to Concrete specificity by: (1) summarizing for the patient what are the most significant situations or behaviours that require change (Kanfer & Grimm, 1980); (2) being very specific about the task and the criteria for its fulfillment (Omer, 1985); (3) the therapist or patient writing down what behaviour is to be carried out and when; (4) converting the patient's vague goals (e.g., being more self-confident) into specific actions by questioning the patient about how they would actually be behaving if they reached their goals (Montgomery & Montgomery, 1975); and (5) asking the patient to imagine and describe to the therapist what their life would be like if they were to become a new person (Mahrer, 1989). In a related operation, Mahrer (1989) suggests that the patient may be told to try out the new behaviour in the session, to say the words involved and to imagine carrying it out.

The implication for practitioners it is easier to obtain a behavioural commitment if the behaviour is very clear and

specific in the patient's mind. In Concrete specificity or Behaviour/Context Clarification, as described by the research team, this is done by the therapist telling the patient exactly what must be done, when, where, how, and with whom. If a behaviour is abstract, it is to be made more specific, and if the behaviour is only partially described (e.g., what, but not when or with whom), then these missing elements are to be defined. As described in the technical literature, specifying the new behaviour may also be done by the therapist telling the patient to imagine in detail what the new behaviour is to be like, what new behaviours would define their goals, or what their life could be like. The new behaviours may be further concretized by the patient or therapist writing down what the specific new behaviours are to be and the criteria for successfully carrying them out. Finally, the patient may be invited to try out the new behaviour, in imagination, in the session. As an optional component, the therapist may suggest to the patient that the new behaviour is to replace the problem behaviour, in the same situational context in which the problem behaviour has occurred so far.

D. Verbally Reward or Punish The Patient

As reflected by the research team having identified Encouragement/Pressure as an operation, it is important that the therapist communicate openly to the patient the therapist's pleasure or displeasure, depending on whether the patient is leaning towards a commitment or is hesitating. The therapist may express implied or explicit approval of the patient if the

patient commits herself to the new behaviour, and disapproval if the patient does not commit herself. In the former case, the therapist rewarding the patient may encourage the patient to stronger commitment, other behavioural commitments, or more specific commitments. In the latter case, the patient may decide to commit themselves to the new behaviour to escape the therapist's disapproval. This operation was used regardless of whether or not the patient had yet responded in any way to the therapist's proposal of new behaviours. It appears that some therapists may be deliberately expressing to patients forthcoming approval or disapproval in order to head off any reluctance on the patient's part, whereas other therapists express their approval or disapproval after the fact of patient compliance or hesitation.

Encouragement/pressure may be one of these widely used operations which may be used so automatically by therapists that it is generally taken for granted, since it was not explicitly linked to obtaining behavioural commitments in any of the reviewed literature. It should be noted that Encouragement/-pressure may be incompatible with certain approaches to psychotherapy, such as strictly Rogerian therapy, although it is doubtful that therapists can escape conveying nonverbal approval/disapproval to their patients. The implication for practitioners is that if they want to obtain behavioural commitments, they should freely express to the patient how they feel about the patient's commitment or lack thereof. Such

explicit reward and punishment (or warning that one of these will be forthcoming) appears to promote behavioural commitment.

**E. Speak to The New Patient Instead
of The Old Patient**

One operation (Seeing Patient as New Person) identified by the research team suggests that behavioural commitments may be facilitated by the therapist speaking to the patient as if the patient was a new, changed person and inviting the new patient to carry out new behaviours which reflect their new self. In order to promote a behavioural commitment, the therapist should: (1) explicitly label the patient as having/being a particular new quality; (2) tell the patient that s/he has changed to being this new quality; (3) the therapist should be and behave differently toward the patient; and (4) and the therapist should tacitly or explicitly encourage/approve of the patient's behaving in consequence of being this particular new quality.

**F. Allow and Encourage Patient Initiative
In Selecting New Behaviours**

Two operations identified by the research team (Patient Readiness and Control, Patient Initiation) suggest that behavioural commitments may be promoted by the therapist implicitly or explicitly encouraging the patient to have initiative in selecting post-session behaviours.

The therapist may explicitly encourage the patient's initiative by explicitly telling the patient that in this therapeutic relationship, the patient has the freedom to choose to carry out a proposed new behaviour. The therapist also

concretizes the decision by asking the patient how ready they feel to engage in the new behaviour. As previously mentioned in the case of patient initiation, this operation may be limited in its applicability to therapies which take a non-prescriptive stance with regards to new behaviours.

Conversely, the therapist may implicitly encourage the patient's initiative with regard to post-session behaviours by "getting out of the patient's way" when the patient is already considering post-session behaviours. In instances where patient initiation was identified as having been used, the research team was impressed by how the therapist carried forward, nurtured and left open room for the patient's selecting, defining and deciding to carry out, the new post-session behaviours. In contrast, the research team reported that in many other instances, therapists were subtly censorious or non-supportive of patient attempts to define or choose new post-session behaviours. In the context of frequently perceived subtle therapist discouragement of patient behavioural instigations, the research team described patient initiation as a distinctive operation for obtaining behavioural commitments.

The implication of this finding for practitioners is that if the practitioner values patient behavioural commitments, the therapist should encourage, support and allow the patient to select new behaviours. This involves the therapist adopting a "hands-off" stance with respect to the nature of the new behaviours and the patient's freedom to choose those. It should be noted that while such a stance may be compatible with many

forms of therapy which value the very fact that the patient instigates new behaviours, without the therapist specifying the behaviour (e.g., Whipple, 1985; McElroen & Faltico, 1977; Mahrer, 1989; Tosi & Henderson, 1983; Boutin, 1978) such a stance may conflict with a more prescriptive approach to new behaviours in psychotherapy, or with forms of psychotherapy where the theory of psychotherapy dictates that specific behaviours are to be requested from the patient (e.g., Haley, 1984; Omer, 1985; Wells, 1982; Kanfer & Grimm, 1980; Levy & Shelton, 1990; Bandura, 1969; Goldfried & Davison, 1976).

G. The Patient And The Therapist Should

Carry Out The New Behaviour In The Session

Two operations identified by the research team (In-Session try-out, rehearsal, and refinement-elaboration, Therapist accompaniment) suggest that other effective ways of promoting behavioural commitments are to have the patient try out the proposed post-session behaviour in the session and for the therapist to try out the post-session behaviour along with the patient, rather than acting as a mere observer, coach, or commentator. The implication of this finding for practitioners is to have patients try out, rehearse, modify, clarify and experience in-session how the proposed new behaviour feels. It may be helpful to ask the patient how they feel after each complete rehearsal of the behaviour, in order to bring into their awareness the good (or not-so-good) feelings experienced as a result of carrying out the new behaviour. These feelings may then

be used to guide the modification or elaboration of the potential new behaviour.

The research team reported the impressions that the patient trying out the post-session behaviour in the session held its effectiveness in promoting behavioural commitments by: (1) the patient imagining carrying out the new behaviour and having a good understanding of what it is; (2) the patient experiencing the new behaviour to see how it feels to carry it out concretely; (3) the patient repeatedly correcting and modifying the new behaviour until they are pleased and comfortable with it; and (4) doing all of the above in the safe confines of the psychotherapy session.

As an unusual but effective variant of the patient trying out the post-session behaviour in the session, the therapist may also choose to join the patient in trying out the post-session behaviour. In this unusual operation, the therapist rehearses the new behaviour in the session at the same time as the patient; both patient and therapist carry out the new behaviour at the same time, as though they were working on a similar task. The therapist fully engages herself in carrying out the behaviour. The research team's impression was that although this operation resembled modelling, it was distinctively different, since in modelling, the patient observes the therapist carrying out the new behaviour, then the patient tries it out. The research team reported the impression that Therapist accompaniment held its effectiveness from a synergistic action of therapist and patient both coaxing each other on to trying more exaggerated, outlandish

forms of the new behaviour, while generating considerable amusement and good feeling in the process. In this limited respect, Therapist accompaniment contains elements of Lazarus and Wolpe's "exaggerated role taking" method, whereby patients are requested to rehearse an exaggerated role representing a potential new way of behaving (Lazarus, 1971; Wolpe & Lazarus, 1966). One may speculate that Therapist accompaniment includes all of the elements of In-Session try-out, rehearsal, and refinement-elaboration, but in addition, the fact that the therapist carries out the behaviour along with the patient seems to make carrying out the behaviour more playful and pleasure-producing, as well as directing the patient's attention to potentially pleasurable aspects of the new behaviour. A successful, pleasurable behaviour is co-constructed by the therapist and patient.

The implication of this finding for practitioners is that behaviours may be rehearsed in the more traditional manner (In-Session try-out, rehearsal, and refinement-elaboration) or the therapist may choose to accompany the patient in trying out the behaviour along with the patient. The latter method may generate better patient feelings about the new behaviour, may broaden the new behaviour beyond what the patient would have imagined, and may lead to stronger behavioural commitments.

H. If The Patient Balks, Try Repeating Yourself,

Or Negotiate The Post-Session Behaviour

Three of the operations identified by the research team (Behaviour/Context Clarification, Negotiation and Custom-Fitting,

Reluctance-Countering Rationales) involved doing more or more thoroughly of what the therapist had previously done until a behavioural commitment was obtained. The research team was impressed by how patients seemed more willing to commit themselves to behaviours which were more clearly specified and detailed. Clarifying the behaviour until the patient understands the behaviour completely seems to lead to increased levels of commitment by the patient. The implication of this finding for practitioners is that if a patient manifests only a weak commitment, clarifying the exact nature of the new behaviour may be sufficient to increase the patient's level of commitment. To promote getting a commitment, the therapist may try making the behaviour even more clear and specific than it currently is.

The therapist may also offer the patient further rationales or repeat and elaborate a therapeutic rationale which she has already told the patient (Reluctance-Countering Rationales). This operation is generally similar to Justifying rationale, but differs in two ways. First, this operation was described with accompanying conditions by the research team. Reluctance-countering rationales is explicitly described as being used when the therapist foresees that the patient will be hesitant about carrying out the new behaviour, or when the patient is being reluctant or resistant. Secondly, the research team was impressed with how persistent and forceful therapists were in presenting their therapeutic rationales to patients under these conditions of hesitation or resistance. In Reluctance-countering rationales, the therapist does not merely calmly once present a therapeutic

rationale to the patient, but insistently, persistently, and forcefully continues to, until the patient gives in. Sessions by Albert Ellis typify this approach, in which the therapist unrelentingly bombards the patient with the therapeutic rationale. The research team volunteered the impression that patients may commit themselves to new behaviours under such conditions simply to get the therapist "off their back", and that what may be necessary for a therapeutic rationale to work is simply to incessantly bombard the patient with rationales and justifications until the patient gives in and agrees to carry out the new behaviour.

Finally, if clarifying the behaviour and offering further rationales fails, the therapist then discusses potential new behaviours with the patient until an a behaviour is found which is felt to be suitable by both therapist and patient. The idea is for the therapist to haggle with the patient over the behaviour in order to obtain a behaviour as close as possible to what the therapist wants the patient to carry out.

I. The Therapist May Use A Power Play

One operation identified by the research team involved obtaining a behavioural commitment by holding the patient's therapeutic wishes for ransom. Contingent conditions is an explicit therapist power grab which places this operation as philosophically opposite to patient initiation and patient readiness and control. The implication of this finding for practitioners is that if the patient expresses a desire for certain therapeutic procedures (e.g., hypnosis, or even therapy

itself) then the therapist may readily make use of this information in order to create instant therapeutic leverage with the patient. Therapists wishing to use this operation could potentially even inquire as to the patient's wishes in therapy in order to use this information to gain influence which may be used for other therapeutic aims, such as obtaining behavioural commitments.

J. If All Else Fails, Giving Up May Be

The Solution

In one unusual operation identified by the research team (Acknowledgement of Failure) a behavioural commitment occurs after the therapist openly "gives up" and admits that the therapist has failed to be able to get the patient to commit themselves. One may imagine several different ways in which the therapist could carry out this operation, or how or why this operation works. One reason for this is that it is easy to imagine several different ways in which the therapist could acknowledge failure, with different expressions, intonations, non-verbal messages, statements, or actions. The research team's impression was that in the instance studied, the patient was being passive and that Acknowledgement of failure by the therapist forced the patient into the role of doing something active, resulting in the behavioural commitment. The research team's impression is that the therapist abdicated responsibility for thinking of what to do next in the session, thereby placing the patient in the position of either having to do something, or sit there dumbly waiting for the therapist to do something.

The implication of this finding for practitioners is that if other operations have been tried and failed to produce behavioural commitments, the therapist should switch out of her usual role and simply acknowledge openly to the patient that the therapist has failed to get them to commit themselves. The therapist may make a big show of "giving up".

K. Finish With Obtaining A Definite Commitment To

A Clear And Specific Behaviour

Regardless of the other operations used by the therapist in obtaining a behavioural commitment, Contractual Agreement-Commitment was a frequently used operation for finalizing a clear, definite, strong commitment. The aim is to make clear to both therapist and patient that the patient is not just "talking about" or imagining what new behaviours could be, or that the behaviours may be carried out sometime in the future, but rather that the new behaviours will definitely be carried out within a specified time frame. One condition under which Contractual agreement-commitment could be used was described by the research team: If the patient indicates mere agreement (such as to assigned homework), then the therapist should seek a stronger commitment.

The implication of this finding for practitioners is that not only must the potential new behaviour be specific, but the patient's commitment to carry it out must be stated explicitly by the patient.

L. Use Many Operations And Be Persistent

The findings suggest that therapists are probably better to use a number of operations in order to obtain behavioural commitments, rather than one or few. For example, only one of the 27 behavioural commitment instances studied had been brought about using a single operation, and only four brought about using two operations. As previously mentioned, the modal number of different operations used in obtaining a behavioural commitment was eight. Moreover, the research team was impressed with how persistently therapists worked at obtaining behavioural commitments. Therapists not only used a number of different operations, but repeatedly used operations and in most cases tenaciously worked at obtaining behavioural commitments until they were obtained. In a few cases, therapists began working on obtaining a behavioural commitment early in the session and worked persistently throughout the session until a commitment was obtained.

This completes the discussion of the practical technical implications of the study's findings for practitioners. Theoretical implications, including speculation about why the identified operations may be effective in catalyzing behavioural commitments, will be discussed in the following section.

Implications of The Findings for Theory

Why do the operations identified by the research team contribute to obtaining behavioural commitments? What are some basic components of the process of obtaining behavioural commitments? The purpose of this section is to propose some

tentative theoretical answers to these questions. It should be noted that the content of this section is pure theoretical speculation and, unlike the identified operations, is not the work of the research team.

**A. Expanding The Patient's Awareness of
Behavioural Possibilities**

One possible influence on the process of obtaining behavioural components is expanding the patient's awareness of new behavioural possibilities through teaching, modelling, or description. Expanding the patient's awareness of behavioural possibilities may explain why several of the identified operations contribute to obtaining behavioural commitments. In Concrete Specificity, Behaviour/Context Clarification, Assignment of Homework and Clarification and Reassignment of Homework, the therapist describes new behaviours to the patient, directly introducing new behavioural possibilities. New behavioural possibilities are also introduced by the therapist in the course of Therapist Accompaniment, an operation in which new behaviours are co-constructed by the therapist and patient, in the process of their both carrying out potential new behaviours in the session. The therapist's elaboration of the potential new behaviours may provide different behaviours than what the patient would tend to imagine on her own.

Another way of expanding the patient's awareness of behavioural possibilities may be jogging the patient's imagination into play through explicit therapist permission and through concentrated effort. This may be taking place in the

course of discussion between therapist and patient in Concrete Specificity, Behaviour/Context Clarification, and Negotiation and Custom-Fitting, all of which involve the patient using her imagination in discussing potential new behaviours.

B. Patient's Taking Responsibility For New Behaviours

A second possible influence on the process is communicating to the patient that changes in her life are up to her, that she is responsible for changes and should change. This may be an element at work when using Patient readiness and control and Acknowledgement of failure. It appears likely that this aspect of the behavioural commitment catalysis procedure works in conjunction with other aspects of the procedure. For example, when, as in Acknowledgement of Failure, the therapist abdicates responsibility for what to do next in the session (and stops trying to obtain a behavioural commitment), why should the patient finally commit themselves to a post-session behaviour? One must assume that the patient believes that the therapist is capable of helping them and that they patient is desperate enough to commit themselves to carrying out an unappealing behaviour. It is also possible that patients are much more willing to commit themselves to carrying out behaviours when they have the feeling that the choice is theirs rather than the therapist's, which could explain the sudden turnaround observed in Acknowledgement of Failure; the choice is now turned over to the patient, so the patient decides to act. The same dynamic may be at work in Patient Readiness and Control. In the psychotherapeutic relationship, the patient is allowing herself to be controlled by

the therapist somewhat, so the therapist explicitly turning control over to the patient may leave the patient more willing to commit themselves to a post-session behaviour because it is now their own choice.

Another operation which may be explained by the patient's taking responsibility for new behaviours is Patient Initiation. In the case of Patient Initiation, however, the therapist communicates to the patient that the patient is responsible for new behaviours by not thwarting or hindering the patient's initiative. In instances where patient initiation was identified as having been used, the research team was impressed by how the therapist carried forward, nurtured and left open room for the patient's selecting, defining and deciding to carry out, the new post-session behaviours. In contrast, the research team reported that in many other instances, therapists were subtly censorious or non-supportive of patient attempts to define or choose new post-session behaviours. In the context of frequently perceived subtle therapist discouragement of patient behavioural instigations, the research team described patient initiation as a distinctive operation for obtaining behavioural commitments.

C. Patient's Wanting To Please The Therapist
Or Fear of The Therapist's Disapproval

A third possible influence on the process is instilling patient guilt, remorse, or fear of therapist disapproval for not carrying out the new behaviour or conversely, expectation of therapist's approval, pleasure, and rewarding of the patient if the patient does carry out the new behaviour. This may be an

element at work when using Encouragement/pressure, Acknowledgment of failure, and Contractual agreement-commitment. Assuming that this interpretation is correct, these operations may be capitalizing on a positive therapeutic relationship.

D. Inducing A New Role In The Patient

A fourth possible influence on the process may be inducing a new role in the patient by labelling the patient or by the therapist deliberately interacting with the patient so as to elicit a particular way of being and behaving in the patient. For example, the operation Seeing The Patient As a New Person includes: (1) explicitly labelling the patient; (2) telling the patient that s/he has changed to being this new quality; (3) the therapist being and behaving differently toward the patient; and (4) and the therapist's tacit or explicit encouragement/approval of the patient to behave in consequence of being this particular new quality. It is possible that the patient takes on the label as a good, approved way of being and that the therapist's treating the patient accordingly "pulls" for the patient to fall into the new role.

A role-switch may also be occurring in Acknowledgement of Failure when the therapist "gives up" on trying to obtain a behavioural commitment and abdicates responsibility in the session, leaving the patient as the only other person in the room to take it. This would leave the patient in the position of having to take an active role, which may then contribute to the patient committing themselves to carrying out a new behaviour.

E. Making The New Behaviour Seem

Good, Safe, and Pleasurable

A fifth possible influence on the process is that several of the operations contribute to the patient perceiving the post-session behaviour as good, pleasurable, comfortable, rewarding, and safe. Overall, these operations contribute to changing the emotional valence of the post-session behaviours or to changing the patient's expectations that the behaviour will provide good feelings and positive consequences rather than bad feelings or negative consequences. Some of the ways in which this change in emotional valence or expectations may be carried out:

Providing Some Motivation For

Carrying Out The Behaviour

Assuming that a patient feels neither particularly drawn to or repelled by a potential post-session behaviour, some motivation must exist for carrying out the behaviour, otherwise, why do it?. Providing the patient with motivation to carry out a novel behaviour without any apparent gain in itself may underlie the operations of Justifying Rationale and Reluctance-Countering Rationales. These operations may promote behavioural commitments by linking a behaviour for which the patient has no pre-existing motivation to the patient's existing motivations. This link is forged by telling the patient that carrying out the post-session behaviour will lead to positive consequences which the patient is motivated to obtain, thus linking the post-session behaviour to some motivational system.

Familiar Behaviours May Feel Safer Than Unfamiliar Behaviours

Increasing the patient's awareness of the specific behaviour to be carried out may increase the patient's familiarity with the behaviour, which may reduce the patient's fear of the unknown new behaviour. This may be an element at work in using Concrete specificity, Behaviour/context clarification, Clarification and reassignment of homework, In-session try-out, rehearsal, and refinement-elaboration, and Therapist accompaniment. All of these operations involve making the behaviour concrete, specific, detailed, and would tend to assure that the patient has a clear picture in mind of what the exact behaviour is to be. This clear picture may also contribute to making the post-session behaviour safer by reducing any performance anxiety, since the patient may feel capable of carrying out a clearly specified behaviour, rather than wondering what they are to carry out, if they will be able to ad-lib the new behaviour outside of the session, or if they will be capable of carrying out an as yet unspecified behaviour.

Increasing The Patient's Confidence in Their Ability to Carry Out The New Behaviour

Familiarity with the post-session behaviour may be sufficient for obtaining a behavioural commitment in some cases, but even if the patient is quite clear about the nature of the post-session behaviour, the patient may still not necessarily feel confident of being able to carry out the new behaviour. Familiarity may be necessary, but not sufficient, in some cases.

Increasing patient belief that they can behave differently and are capable of particular new behaviours may be achieved in such cases by modifying the proposed new behaviour until one is selected which the patient feels they may carry out. This may be an element at work in using Seeing patient as new person, Patient readiness and control, Negotiation and custom-fitting, In-session try-out, rehearsal, and refinement-elaboration.

Overriding Patient's Fears of Carrying Out

The New Behaviour

An alternative to increasing the patient's level of comfort with the new behaviour or to selecting a behaviour that the patient is confident in being able to carry out is to override the patient's fear of the new behaviour. Even if the patient doesn't fear the new behaviour, they may have no attraction or motivation to carry it out. Motivation to carry out the new behaviour or motivation to override their own fear and carry it out anyway may be the dynamic underlying increasing their logical belief that the new behaviours are desirable. This may be an element at work in using Justifying rationale and Reluctance-counteracting rationales. In these operations, the patient is given justifications and reasons for why carrying out the behaviour will lead to positive consequences and good feelings for the patient. Also, the patient is given justifications and reasons as to why carrying out the new behaviour is crucial to the process of therapy, which again is a promise of positive end results.

Overriding the patient's fear of the new behaviour may also underlie the Contingent Conditions operation, in which the

patient is directly bribed to accept a behavioural commitment thorough a promise of reward. In this case, the pleasure is to be obtained from some other source than from the new behaviour itself.

Having The Patient Experience Pleasure in Carrying Out

The New Behaviour in The Session

An alternative to modifying the patient's expectation that carrying out the post-session behaviour will be pleasurable or lead to good consequences is to have the patient experience comfort or pleasure in carrying out the new behaviour in the session. This could explain the action of In-Session Try-Out, Rehearsal, and Refinement-Elaboration and Therapist Accompaniment. The research team reported the impression that the more patients tried out carrying out the new behaviour in the session, the more confident they got and the more pleasure they seemed to obtain from the rehearsal. In some cases, patients which initially seemed reluctant, hesitant, or fearful of carrying out the proposed post-session behaviour manifested considerable pleasure, comfort and satisfaction as a result of trying out the behaviour in the session, and consequently expressed willingness to actually carry out the behaviour post-session. Also, the patient may feel more confident about being able to carry out the new behaviour post-session, having already carried it out in the session. In trying out the behaviour in the session, we may produce a confluence of effects resulting from increased familiarity with the behaviour, increased feeling of ability to carry it out, and experienced pleasure in carrying it

out (which would in turn modify expectations of future pleasure in carrying it out). The end result of this confluence may be that the new behaviour and its accompanying feelings begin to become integrated into the patient's sense of self, that the patient begins to be a somewhat different person, who is readier to carry out the post-session behaviour because the behaviour is now a part of who the patient is.

F. Passing The Cusp

A cusp, mathematically, is a turning point. A sixth possible influence on the process of obtaining a behavioural commitment may be a psychological analogue to a cusp, in the form of a moment at which the patient makes a firm decision, which they have no intention of revoking. Use of Contractual Agreement-Commitment may have its effect through provoking such a phenomenon in patients. This operation formalizes or finalizes the decision by an act whereby the patient agrees very clearly that they are not merely considering carrying out the post-session behaviour, but that they irrevocably and certainly intend to carry it out. The effect of Contractual Agreement-Commitment may not be so much to let the therapist know that the patient intends to carry out the behaviour, but for the patient to become explicit with herself that she will carry out the behaviour. In this regard, this decision point bears some resemblance to taking an oath. This moment of decision may constitute a dynamic which is at least intuitively understood by therapists who obtain behavioural commitment, since Contractual Agreement-Commitment

was among the most frequently used operations identified by the research team.

H. A Comment On Assignment Of Homework

As previously discussed in the section on the relevance of the findings for practitioners, using Assigning of Homework alone is probably insufficient in obtaining a behavioural commitment. In fact, none of the behavioural commitment instances studied were obtained using only Assigning of Homework. Examining the theorized underlying reasons for the effectiveness of the identified operations may yield an explanation for the inadequacy of using Assigning of Homework in isolation. Assigning of Homework involves only two of the theorized mechanisms for promoting behavioural commitments: (1) Expanding the patient's awareness of new behavioural possibilities and (2) The patient's wanting to please the therapist or fear of the patient's fear of the therapist's disapproval. Assigning of Homework does not include the patient's taking responsibility for new behaviours, inducing a new role in the patient, or any of the various dynamics of making the new behaviour seem good, safe, and pleasurable. Since Assigning of Homework does not involve any of the dynamics which alter a patient's attraction toward the potential new behaviour, it makes theoretical sense that the sole use of this operation should promote mere agreement with the therapist's request rather than an intention strong enough to be labeled a "commitment". This theoretical prediction is confirmed by the research team's impression that behavioural commitments initially obtained using only Assigning of homework were rather

weak commitments or mere acquiescence to the therapist's request. Other operations were used to make the behaviour very clear to the patient, or to involve the patient in making the behaviour personally relevant.

I. Commitment vs. Mere Agreement

The research team volunteered the soft impression that various levels of commitment were apparent from patients, ranging from being dead-set against carrying out the post-session behaviour, to being noncommittal, to mere agreement with the therapist or acquiescence, to commitment, and to stronger commitment where the patient sounds eager, determined, and resolved, to carry out the post-session behaviour. How important is obtaining a strong commitment (rather than mere agreement) to the process of obtaining behaviour change? Although a number of clinical authors consider behavioural commitments to be an important part of psychotherapy (Bakker, 1975; Bass, 1984; Boutin, 1978; DiClemente & Prochaska, 1982; Haley, 1984; Kanfer & Grimm, 1980; Mahrer, 1989; McElroen & Faltico, 1977; Montgomery & Montgomery, 1975; Prochaska & DiClemente, 1982; Tosi & Henderson, 1983; Whipple, 1985), no discussion of the various levels of commitment was found in the reviewed literature, either technical or research. None of this literature distinguishes between levels of commitment. All that is known from research is that studies examining the relation of patients' within-session behaviour change commitments to that of the actual carrying out of the behaviours between sessions have generally found the two to be significantly related (Kothandapani, 1971; Levy, 1977; Levy &

Clark, 1980; Patterson, 1984, as cited in Patterson & Forgatch, 1985; Prochaska, 1979; Wurtele, Galanos, & Roberts, 1980).

Conversely, in-session noncompliance has been found to correlate with between-session noncompliance (Patterson & Forgatch, 1985).

The technical psychotherapy literature is replete with clinicians' explicit claims of the importance of behavioural commitments (e.g., Bakker, 1975; Bass, 1984; Boutin, 1978; DiClemente & Prochaska, 1982; Haley, 1984; Kanfer & Grimm, 1980; Mahrer, 1989; McElroen & Faltico, 1977; Montgomery & Montgomery, 1975; Prochaska & DiClemente, 1982; Tosi & Henderson, 1983; Whipple, 1985), but none of them differentiate different levels or strengths of commitment. What is clear is that some level of behavioural commitment is considered crucially important to therapy by a number of practitioners, representing a number of approaches to psychotherapy. These clinical authors present a number of different theoretical reasons for the importance of behavioural commitments in psychotherapy. Whipple (1985) believes that behavioural commitments expressed to the therapist parallel an internal commitment of the patient to herself, to take control of her life. McElroen and Faltico (1977) claim that behavioural commitments are "...a key factor in any person's success with a therapy" (p. 80). And some psychotherapy theorists have claimed that behavioural commitments are a crucial stage or event in therapy which causally precedes patients' behaviour changes (Kanfer and Grimm, 1980; DiClemente and Prochaska, 1982; Tosi and Henderson, 1983, Boutin, 1978). Finally, Bakker (1975) considers "public commitment" to be a stabilizing factor for new behaviours

and personality characteristics, without which the new behaviours or characteristics would be but a brief deviation from the patient's habitual way of being and behaving.

What one may draw from these clinicians' observations and theorizing is that behavioural commitments are an important stepping stone in translating ephemeral potential new ways of being and behaving into post-session behavioural changes. The fact that the research evidence on the link between in-session behavioural commitments and patients actually carrying out the behaviours post-session is generally positive but mixed (e.g., Fendrich, 1967; Levy & Clark, 1980), may be due to the lack of distinction between levels of commitment which has been the norm in research so far.

**J. Are There Post-Session Behaviours For Which
Commitments Are Especially Appropriate?**

One soft impression which the research team reported stands out as an issue of theoretical relevance in the matter of the

occurrence of new ways of being and behaving which the patient experienced in the session and which the therapist and/or patient wanted to extend to outside of the therapy session. The former type of post-session behaviour seemed to require only agreement, generally to therapist-assigned tasks. The latter type of post-session behaviour seemed generally much riskier in the patients' estimation and seemed to require commitment rather than mere agreement.

K. Conclusion on Theoretical Implications

Of what use is this speculation? The theoretical relevance of this speculation is that these hypothetical components of the behavioural commitment catalysis process may be used as explanatory and predictive entities. That is, if these hypothetical components are correctly identified, any number of other psychotherapeutic operations fulfilling the functions of these components may be generated which should also promote the occurrence of behavioural commitments. As such, these hypothesized components constitute fodder for further research and practice by proposing more general classes of operations which go beyond the specific operations identified in this study.

More specifically, there are possible practitioner implications of the preceding theoretical explanations. If the theoretically effective dynamics of behavioural commitment catalysis are taken as more abstract recommendations about what practitioners may do to catalyze behavioural commitments, we would have the following list:

1. Expand the patient's awareness of possible new behaviours by describing new behaviours to them. Alternately, direct the patient to use their imagination in creating potential new behaviours.
2. Let the patient take responsibility and initiative in considering new behaviours, or invite the patient to take responsibility for the new behaviours. If the patient won't take responsibility, the therapist may abdicate responsibility in order to leave the patient no choice.
3. The therapist may let the patient know directly that she is pleased when the patient is considering a new behaviour, and displeased or angry when the patient isn't.
4. Induce a new role in the patient by labeling them differently and treating them differently.
5. Make the behaviour seem good, safe and pleasurable. Offer a rationale for the new behaviour. Make the behaviour more familiar to the patient. Make sure that the patient becomes confident in being able to carry out the new behaviour. Patient's fears of carrying out the new behaviour may be overridden with rational promises of desirable outcomes. Let the patient experience pleasure in trying out the new behaviour.
6. Invite the patient to make a deliberate decision to switch from considering the new behaviour to being committed to carrying out the new behaviour.

These six recommendations may be acted upon using the operations identified by the research team, or creative

practitioners may try inventing other operations which would engender these six dynamics of behavioural commitment catalysis.

Finally, behavioural commitments appear to be of importance in obtaining post-session behaviour changes, particularly in the case of a class of post-session behaviours with the purpose of facilitating new ways of being and behaving which the patient experienced in the session.

Frequency Distribution of the Operations

Are certain operations used more commonly than others? The operations described varied considerably in their frequency of use across the sessions studied by the research team (See Table 1). The most frequently used operations, regardless of therapeutic orientation, are Justifying rationale (11 out of 13 sessions studied), Encouragement/Pressure (11/13), Patient readiness and control (10/13), Assigning of Homework (9/13) and Contractual Agreement (9/13). The least frequently used were Contingent conditions (1/13), Acknowledgement of failure (1/13), Therapist accompaniment (1/13), Seeing Patient as New Person (2/13), and Negotiation and custom fitting (2/13). These infrequently used operations are of particular interest, in that they may be less widely known or used by therapists, and may be of potential usefulness. An implication of this finding for research is that identifying and describing rarely used operations may be a particular strength of a research strategy which studies the work of many therapists of different therapeutic persuasions.

Use of Multiple Operations by Therapists

How many operations did therapists generally use in obtaining a behavioural commitment? In no instance did a therapist use only one operation in obtaining a behavioural commitment. All of the therapists studied generally used the same breadth of operations (Table 2). To reiterate, the mean number of operations used in catalyzing a behavioural commitment was 5.59 ($sd=2.66$), with a median of 6. The modal number of operations used was 8. The concurrent use of operations is represented in Figure 2, which illustrates which operations the research team identified as having been used to obtain each behavioural commitment studied. The fact that so many psychotherapeutic operations were used to catalyze the behavioural commitments studied suggests that behavioural commitments rarely occur spontaneously. In fact, the research team was struck with how behavioural commitments were typically brought about through considerable and sustained effort on the part of therapists. The implication of this finding for practitioners is that greater attention should be paid to the art and science of obtaining behavioural commitments, because the process of obtaining them is probably more involved than is generally believed. It is apparent that therapists do not generally limit themselves to using only one or few operations in catalyzing behavioural commitments. The fact that the modal number of operations used was eight suggests that therapists who obtain behavioural commitments work vigorously to obtain them. This confirms the research team's impression that therapists worked hard at obtaining behavioural

commitments. As previously mentioned, the research team was impressed with how persistently therapists worked at obtaining behavioural commitments. Therapists not only used a number of different operations, but repeatedly used operations and in most cases tenaciously worked at obtaining behavioural commitments until they were obtained. In a few cases, therapists began working on obtaining a behavioural commitment early in the session and worked persistently throughout the session until a commitment was obtained.

The implication of this finding for practitioners is that obtaining behavioural commitments is probably not easy or automatic. Therapists should use several different operations and be persistent, using the operations repeatedly if necessary.

Conditions Identified by The Research Team

The purpose of this study was to answer the question, "What are the psychotherapeutic operations which are judged as antecedent and catalyzing patients' commitments to carry out new extratherapy behaviours?" More specifically, the purpose was to answer the question, "Which psychotherapeutic operations, used in which psychotherapeutic context, will result in the relatively immediate occurrence of behavioural commitments?" As was discussed in the first chapter, psychotherapy process research has been faulted for producing findings which do not specify when, or in which particular psychotherapeutic context, to use certain psychotherapeutic operations. For example, none of the psychotherapy literature, either research-based or technical, reported even one condition for the use of any operations used in

catalyzing behavioural commitments. The point of this section is to discuss: (1) the success of this study in identifying conditions; and (2) what we do and do not know about conditions for promoting behavioural commitments.

A. How Successful Was The Study in Identifying Conditions?

Of the 12 conditions described by the research team as accompanying psychotherapeutic operations described, none had been previously reported in the reviewed literature on behavioural commitments. Since no descriptions of conditions were even available from the reviewed technical psychotherapy literature, these results therefore constitute the first ever description of conditions for the use of behavioural-commitment-catalyzing operations. In this regard, the study was eminently successful.

B. What do We Know About The Conditions Under Which To Promote Behavioural Commitments?

The point of this sub-section is to discuss, what, as a result of the study, we know about conditions for using the described operations, as well as which questions on conditions remain unanswered.

What We Know as a Result of The Study

What we do know about conditions for the use of operations for promoting behavioural commitments is a total of 12 conditions which apply to eight of the operations described by the research team (some operations have multiple conditions for use). All of the conditions which the research team identified indicate a

process of behavioural commitment catalysis which is already under way, none indicating when to begin the process of obtaining behavioural commitments. The implications of this will be discussed in a subsequent section.

Of the 12 conditions identified, 10 referred to problems, impediments, or blockages in the process of obtaining behavioural commitments. For example, the identified conditions refer to patients being unclear about the post-session behaviour, a post-session behaviour being too vague, or the patient being reluctant to commit herself to the post-session behaviour or refusing outright. Therefore, most of the conditions identified are "troubleshooting" conditions which point to remedies for difficulties which therapists encounter in obtaining behavioural commitments. This is reflective of the fact that in the sessions studied, considerable difficulty was encountered by therapists in obtaining behavioural commitments. Difficulty appears to be a normal or at least frequent part of the process of obtaining behavioural commitments. This being the case, the conditions found are particularly relevant in addressing questions which most practitioners probably have about difficulties obtaining behavioural commitments.

The two remaining conditions which did not refer to problems or difficulties in obtaining behavioural commitments referred to certain desirable events happening toward obtaining a behavioural commitment and point to operations for increasing the strength of these desirable events. One of the conditions refers to the patient taking initiative with regard to post-session

behaviours, whereas the other refers to the patient indicating simple agreement to carrying out a post-session behaviour.

Interestingly, we seem to know much more about conditions which occur when the process of obtaining a behavioural commitment is already manifestly going wrong than we know about conditions which point to how to keep it going right. The decision-making process for selecting operations for "troubleshooting" behavioural commitment catalysis is better elucidated than the decision-making process for selecting the next operation to use when everything is going well, or to keep it going well.

What We Do Not Know From The Study

What we do not know is any condition at all for the use of eight of the operations described by the research team. Why did the research team not succeed in finding conditions for all the operations? One possible explanation for these results is that the research method used in this study is limited to the identification of relatively specific relatively immediate therapeutic conditions and is insensitive to more remote or global conditions (this limitation and others will be discussed in a subsequent section). For example, "the proposed behaviour is vague" or "the patient isn't agreeable to carrying out the initially proposed new behaviour" are relatively immediate conditions; these are easy to identify. Other conditions may refer to earlier sessions, for example, and may not have been possible to identify in this study. A third possible explanation is that these operations have no particular condition, other than

that the therapist is attempting to obtain a behavioural commitment. These latter operations may be used in a "shotgun" approach, being generally helpful in promoting behavioural commitments under the condition "toward the end of the session". It is also possible that in the case of obtaining behavioural commitments, it doesn't matter in which order the operations are used. What may matter, instead, is that a number of the theorized facilitating dynamics (described in a previous section) are engendered by the selection of an adequate variety of operations.

We Do Not Know What Condition Practitioners Use in Initiating the Process of Obtaining a Behavioural Commitment

What condition do therapists use in determining when to begin trying to obtain a behavioural commitment? None of the conditions described by the research team specified any condition referring to the initiation of the process of obtaining a behavioural commitment. It stands to reason that therapists must be using some sort of contextual cues to begin the process. The alternative possibility is that therapists try to obtain behavioural commitments randomly or at arbitrary places in therapy sessions.

What soft guesses can we make about what cues therapists use in initiating the process of obtaining a behavioural commitment? Perhaps we may gain some clues from examining where in the session therapists obtain behavioural commitments. In order to examine the distribution of behavioural commitments in sessions, the location of behavioural commitment events in all the sessions studied was scaled onto a session standardized in length to 100

therapist-statement exchanges (200 statement numbers) and grouped by increments of 20ths of a session. This results in a composite graph of all sessions, broken into hundredths of a session instead of (non-standardized) times. The resulting frequency plot of behavioural commitment locations (Figure 3) reveals that behavioural commitments occur throughout the second half of sessions, peaking in frequency in the last tenth of sessions. Only one of the sessions studied was responsible for behavioural commitments occurring below the 47 hundredth of sessions. This alone suggests that therapeutic conditions undetected by this study are at work in the catalysis of behavioural commitments.

All that is apparent about pre-initiation context from Figure 3 is that behavioural commitments generally take place in the latter half of sessions, most frequently in the last tenth of the session, which, assuming a typical one-hour session, translates to the last six minutes of the therapy session. Since behavioural commitments are obtained throughout the latter half of sessions, it is apparent that certain therapists initiate the catalysis process as early as the half-hour mark. In Figure 4, the number of behavioural commitments found in sessions was plotted against their locations in the sessions (statement segments belonging to the same session are joined together by a thinner line), revealing that generally, the greater the number of behavioural commitments obtained in a session, the earlier the catalysis process is initiated and the more scattered throughout the session the behavioural commitments are.

The pattern made apparent in Figure 3 lends support to the idea that practitioners may time the initiation of the process to simply leave themselves enough time to obtain a behavioural commitment. One may speculate that therapists who wish to obtain several behavioural commitments may start earlier in the session than therapists who only want one behavioural commitment at the end of the session (e.g., such as when assigning homework). In support of this notion, the research team supplied the soft impression that those therapists who obtained few behavioural commitments generally prescribed or assigned the new behaviours rather unilaterally. The research team also were impressed with how the therapists who began pushing for behavioural commitments early in therapy seemed to make behavioural commitments an integral part of therapeutic movement for the patient within the session. Some of these therapists began working on obtaining behavioural commitments from the very start of the session. It should also be noted that in one session, the patient seemed to have come into the session pre-prepared to committing themselves to new behaviours, without any active suggestion from the therapist.

How could we know for sure whether more remote or global conditions dictate when to start trying to obtain a behavioural commitment? Determination of whether remote or global therapeutic conditions are at work would require a similar study using entire courses of therapy (viz., all sessions of therapy leading up to a behavioural commitment). Unfortunately, the search for raw data for this study suggests that not one single set of published

transcripts exists for a complete course of therapy. Such a study would require the extraordinarily expensive and time consuming procedure of recording and transcribing complete courses of therapy from a number of psychotherapists of various theoretical orientations.

In summary, the results of this study provide knowledge of which psychotherapeutic conditions guide the process occurring after the catalysis of behavioural commitment has already been initiated, but only guesses about the contextual cues that practitioners rely on to initiate the process. There were soft impressions from the research team that therapists who simply unilaterally prescribed new behaviours tended to obtain one behavioural commitment close to the end of the session and that certain therapists who obtained many behavioural commitments began trying to obtain them much earlier in the session.

Soft Impressions by The Researcher on

Clusters of Operations

The purpose of this study was to identify and describe the individual psychotherapeutic operations and their associated conditions which contribute to obtaining behavioural commitments. The purpose was not to identify which clusters of operations tend to be used together. Moreover, neither the method nor the sample size are adequate in answering with assurance which operations tend to reliably cluster together. Answering this question would require a quantitative study using Latent Class Analysis, a Factor Analysis analogue for categorical data (McCutcheon, 1987). This would not only constitute sufficient material for an entire

other study, but would be impossible given such a small sample size. Soft impressions or guesses about the use of multiple operations may be made through an examination of Figure 2, however. It should be noted that these impressions are only those of one investigator, not those of the research team. With this caveat in mind, the following impressions result from an examination of Figure 2, which illustrates the use of operations for each instance of behavioural commitment studied.

A. Therapists Tend to be Consistent in
Their Use of Certain Groups of Operations

One apparent pattern is that individual therapists are generally consistent in their use of particular operations across instances of behavioural commitment, within their own sessions, although therapists differ considerably from each other in which operations they use. The greater the number of behavioural commitment instances examined for any one therapist, the more readily apparent is this consistency. In five of the sessions studied, certain combinations of operations were used for all instances of behavioural commitment obtained within that therapist's session. In the client-centered session, the same operation was used for all four behavioural commitments. This also appears to be the case with gestalt therapy (three operations used for both commitments), single-session therapy (six operations used for two commitments), experiential therapy (seven operations used for five commitments) and R.E.T. (two operations used for two commitments) (See Figure 2). This observation suggests that therapists may have consistent

therapeutic styles reflected in their uses of certain groups of operations.

B. Operations 2 and 3 Tend to be Used Together

Another pattern which is apparent through visual inspection of Figure 2 is the repeated occurrence of Patient initiation and Patient readiness and control having been used together. This was the case in approximately half of the behavioural commitment instances and half of the sessions. Although operations 2 and 3 do occur singly, they generally occur together for each instance of behavioural commitment. Examining the transcripts directly leads one to the impression that the association between operations 2 and 3 is the result of Patient readiness and control promoting patients' identification of new behaviours to carry out and spontaneous personal decisions to carry out the new behaviours. In nearly no instance were Contingent conditions, Negotiation, Assigning homework, and Clarification and reassignment used concurrently with Patient initiation and Patient readiness and control. This suggests that two different and mutually exclusive therapeutic styles may exist, which could be tentatively labeled as Patient-determined versus Therapist determined.

C. Operations 8, 9, 10 Tend to be Used Together

Another pattern which is apparent through visual inspection of Figure 2 is the repeated occurrence of Justifying rationale, Reluctance-counteracting rationales, and Encouragement/Pressure having been used together. Pattern 8-9-10 appears to have the occurrence of patient resistance, hesitation and reluctance built

into it. The fact that operations 8-9-10 are sometimes used concurrently with 2-3 suggests that the 8-9-10 may not in all instances be partially responsible for resistance but might be used in response to patient resistance or when the therapist expects patient resistance. In most observed instances, 8-9-10 is not used concurrently with 2-3, suggesting that although 8-9-10 does not define a therapist-determined therapeutic style, it is associated with instances where the therapist desires that the patient commit themselves to a particular behaviour more so than the patient desires it. Use of operation Assigning of homework appears to be frequently associated with 8-9-10.

D. Operations 5 and 6 Tend to be Used Together

One final pattern is that of Concrete specificity and Behaviour/context clarification being used together. This apparent pattern is logically coherent, in that the same therapists who value the careful specification of the behaviours to be carried out also appear to value the patient's clear understanding of the specific behaviours. Pattern 5-6 does not appear to exclude the use of other operations and is used in conjunction with 2-3 and 8-9-10 in an equal number of instances.

E. Operations 1, 2, 3 Tended to be Used Together

By One Therapist

Certain other possible patterns seemed to be unique to particular therapists, at least within this particular data set. One such pattern is using Seeing patient as a new person Patient initiation and Patient readiness and control, without ever using Contingent conditions, Negotiation and custom fitting, Assigning

of homework, and Clarification and reassignment of homework.

Consistent with the proposed view of 2-3 as reflecting a patient-determined approach to therapy, direct examination of transcripts leaves one with the impression that therapists using 1-2-3 assume that patients want to carry out new behaviours, find the new behaviours attractive, want to change and have within them the source of new behaviours. Pattern 1-2-3 involves treating patients based upon these assumptions. If this impression is correct, it further highlights the difference between a patient-determined therapeutic style and a therapist-determined therapeutic style. In the latter, the therapist seems to work with a reduced level of such assumptions, or works with opposite assumptions, and does not attempt to involve the patient in a pattern of self-definition of new behaviours, nor in accessing the patient's motivation to carry out new behaviours.

F. Operations 10, 14, 15, 16 Tended to be Used Together

By One Therapist

One other possible pattern observed as unique to one therapist was using Encouragement/pressure, In-session try-out, Therapist accompaniment and Contractual agreement together. This pattern, although repeated for five behavioural commitments in one session, was never used in conjunction with Contingent conditions, Negotiation, Justifying rationale, Reluctance-countering rationales, Acknowledgement of failure, Assigning of homework, and Clarification and reassignment of homework. It should be noted that 10-14-15-16 were used in conjunction with 1-2-3 for all five behavioural commitments in that session and that

these two patterns show considerable overlap in their exclusion of other operations. This pattern involves the therapist inviting the patient to carry out a fantasied rehearsal of the new behaviour with the therapist rehearsing the new behaviour along with the patient. These operations are combined with therapist approval if the patient complies with the therapist directives and disapproval if the patient does not comply with the directives. The sequence ends with the therapist asking the patient if she will really carry out the new behaviour.

In sum, although not the purpose of this study, visual inspection of the concurrent use of operations suggests that certain recurrent patterns may exist in the concurrent use of psychotherapeutic operations in obtaining behavioural commitments. It also appears that therapists who use certain groups of operations do not use certain other groups, suggesting that certain operations may be philosophically or theoretically incompatible with the approaches of certain therapists. Finally, therapists may be consistent in their use of certain groups of operations and their exclusion of other groups. These observations constitute initial impressionistic clues that further research may be warranted on the matter of how operations are used together in obtaining behavioural commitments.

Soft Impressions by Judges on The Nature of The New Behaviours

Were distinctly different types of post-session behaviours obtained? The research team was struck with an emergent distinction between the nature of the new behaviours which

patients committed themselves to. One category of new behaviours seemed to be chosen for the purpose of reducing the patient's problem by preventing or replacing the problem behaviour. A second distinctive category of behaviours seemed to be chosen in consequence of new potential ways of being which the patient became aware of during the session. In many of these latter cases, patients spontaneously suggested surprising new behaviours without input or suggestion from the therapist.

Also, the research team reported the impression that certain operations were used with differential frequencies in obtaining the two different types of behavioural conditions. In particular, therapists who promoted problem-reducing behavioural commitments tended to supply patients with therapeutic rationales for the post-session behaviours (Justifying Rationale, Reluctance-Countering Rationales) and Assignment of Homework. In contrast, therapists who obtained the latter kind of behavioural commitment (post-session behaviours reflecting newly found patient ways of being and behaving) tended to use operations emphasizing the patient's responsibility in committing themselves to carrying them out (Patient Initiation, Patient Readiness and Control) and in-session experimentation with potential new behaviours (Behaviour/Context Clarification, In-Session Try-Out, Rehearsal, and Refinement-Elaboration, Therapist Accompaniment). These serendipitous observations were striking to the research team and warrants further research efforts, since this study was not designed to draw links between the conditions or operations and the nature of the post-session behaviours.

Limitations and Weaknesses of The Study

Although this study was successful in its aims of answering "What are the psychotherapeutic operations which are judged as antecedent and catalyzing patients' commitments to carry out new extratherapy behaviours?" and more specifically, the question, "Which psychotherapeutic operations, used in which psychotherapeutic context, will result in the relatively immediate occurrence of behavioural commitments?", the study's research strategy suffers from certain limitations. The aim of this section is to acknowledge these limitations. Limitations of this study may affect the certainty of the findings. For example, how certain are we that if the identified operations would bring about behavioural commitments in other patients and with other therapists than those studied? Limitations of the study may affect the completeness of the findings. For example, we may now have knowledge of some components of the behavioural commitment catalysis process, but still be lacking even rudimentary knowledge of other components of the process, such as more remote conditions or sequencing of operations. Limitations of the study may also point toward potentially productive research avenues. For example, shortcomings in the methodology may point towards the use of different methodologies which would add new dimensions to our understanding of how to obtain behavioural commitments.

1. Adopting the view that causal certainty may range continuously from nil to virtual certainty, the strength of causal statements which may be made using this research strategy are rather weak. The causal relations posited in the results of this study would

require further confirmation using methodologies more appropriate to such a task.

2. The results of this study are weak in generalizability. The results are based on the study of very few sessions, patients, therapists, and problems. This is a limitation inherent to any research strategy using a small sample size.

3. The study used transcripts of therapy sessions, rather than audio or video recordings. As previously discussed in the "method" chapter, although the use of published transcripts has a number of advantages, it also has the disadvantage of considerably limiting the information available to the research team; both voice quality and nonverbal communication is unavailable for study.

4. The research strategy is focused on identifying psychotherapeutic operations and conditions which are relatively immediate antecedents to behavioural commitments. As suggested by the fact that no conditions were found which signalled the beginning of the behavioural commitment catalysis process, it is possible that the research strategy used is insensitive to detecting more remote antecedents. This may also explain why the research team was unable to identify conditions for all of the operations. It may be the case that some conditions occurred earlier, such as in preceding sessions, and were therefore not studied by the research strategy used. The possibility also remains that more remote or possibly more global operations were used and that a focus on relatively immediate and localized operations failed to detect operations which may have taken place

over a large number of therapist statements, such as the development of a particular type of therapeutic relationship.

5. The research strategy did not permit studying sequences of therapeutic operations, but only permits identifying isolated condition-operation-pairs. Any sequencing in the use of the operations may only be inferred logically from their specified conditions.

6. The research strategy is focused on identifying relatively specific events in therapy, but may be insensitive to more global conditions or operations, such as "it is close to the end of the session" or "a working alliance has been established over the last three sessions".

7. The sample size used was too small to permit the use of quantitative analyses for mathematically identifying or confirming clusters of operations which may tend to be used together as a "package" in obtaining behavioural commitments. Any groups of operations tentatively identified as being used as a package were identified only impressionistically.

8. Conceptual overlap exists between the identified operations. Although conceptual overlap between distinct meaning units is considered normal in qualitative research (Hycner, 1985), conceptual overlap would prohibit the use of the identified operations as a category system for quantitative research, where mutually exclusive categories would be either desirable or necessary, depending on the analyses being carried out.

9. Beyond the limitation of not being mutually exclusive, the list of identified operations also suffers from not being

exhaustive as a category system of therapist operations. Failing being both mutually exclusive and exhaustive, the list of operations could not be used as a category system for sequential analytic research (Bakeman and Gottman, 1986). The list of identified operations is limited to being no more than a list of operations useful to the practitioner and useful as a basis for constructing a category system for quantitative research; it is not a quantitative research-ready category system.

10. Although using a team of judges with various backgrounds and theoretical beliefs with regards to psychotherapy provides a safeguard against theoretically limited or slanted descriptions of operations, the method could have included a further safeguard by requiring that the two primary authors of the composite descriptions state their theoretical assumptions about psychotherapy, since theoretical bias may have entered into the generation of the composite descriptions.

Suggestions for Further Research

Further research could usefully extend and complement the findings of this study by addressing methodological limitations or specific questions suggested by the findings. Moreover, the results of this study, including some soft impressions by the research team, suggest several possible lines of investigation.

A. Studying More Therapists, Therapies and Behavioural Commitments

Obtaining and studying more instances of behavioural commitment would be advantageous for several reasons. Studying more instances would allay concerns of generalizability to some

extent. Moreover, studying a greater number of sessions would permit examining the differential use of operations in different types of therapy, or by different therapists. This would also make it possible to assess whether patterns of operation use are particular to individual therapists or particular to certain types of therapy. Studying more instances would also permit the discovery of additional psychotherapeutic operations and conditions.

B. Avoiding Studying Many Intake Sessions

Although studying published transcripts had several advantages over other options, the present data set has been exhausted by this study. It is distinctly possible that so few behavioural commitments were found in published transcripts because many published transcripts are of initial sessions, which may have been frequently used for assessment or exploratory purposes rather than conducting therapy. It is likely that using some other source of data would make possible the obtention of later sessions, which would increase the possibility of finding more instances of behavioural commitments.

C. Studying Longer Segments Than Single Sessions

Obtaining and studying consecutive sessions may permit the identification of more remote or global conditions than those apparent in studying individual sessions. This would require obtaining transcripts or recordings from other sources than those which have been published, since published sequences of complete sessions are very rare. Complete published courses of

psychotherapy (all continuous sessions with one patient) appear to be non-existent.

D. Adopting Another Position Than Third-Party Observer

Attempting to identify conditions and operations by observing a psychotherapy interaction involves attempting to identify the lawfulness in psychotherapeutic interactions. Stating this lawfulness in terms of conditions which therapists use to determine when to use a particular operation involves inferring the rules by which therapists decide on their actions in therapy. A third-party observer perspective may be useful in identifying therapist decision rules or operations of which the therapists would not be consciously aware. The third-party perspective may, however, fail to identify rules or operations of which the therapist may be aware but which may remain hidden to third-party observers. For example, the research team identified no condition which made clear when the process of behavioural commitment catalysis was to be initiated. It would be interesting to repeat the same study using a method such as Interpersonal Process Recall (Elliott, 1979; 1984; in press; Kagan, 1975) or Knowledge Engineering (Chorafas, 1990; Gott, 1988; McLeod, 1988-89; Rouse, Hammer, & Lewis, 1989; Wiggs & Perez, 1980) in order to compare what answers would be obtained by studying the question from the therapists' perspectives. Such a study might be able to "see" things which this study's methodology was insensitive to.

E. Testing or Confirming the Tentative Findings of This Study

The findings of this study may be viewed as tentative in light of the weak statement of causality which may be made using this method. One option for increasing confidence in the findings would be to study other naturally occurring behavioural commitment events in order to replicate the results of this study. Collecting repeated instances of rare events has been suggested by (Kazdin, 1981) as a means of increasing confidence in the findings.

A second option for increasing confidence in the findings would be to do an experimental study of the usefulness of the operations and contexts described in catalyzing behavioural commitments. This would have the advantage of resolving the problem of obtaining naturalistic data on a rare event. Moving immediately to an experimental study would be premature, however, given the extant knowledge of behavioural commitment catalysis. More naturalistic research would need to be carried out first in order to identify clusters or sequences of operations used, lest invalid hypotheses be created (Wampold, Davis, & Good, 1990) which would fail to represent operations as they are actually used (not individually, but in groups) and consequently lead to misleading conclusions about the efficacy of the operations being tested.

F. Doing a Process-Outcome Study

An interesting question was raised by the research team's impression that considerable variation existed in the strength or extent of patient's commitment. It would be interesting to study

whether clients carrying out the behaviour or conversely, failing to carry out the behaviour, bears any relation to the strength of commitment, operations used by the therapist, or the type of commitment (as discussed in a previous section on the nature of the behavioural commitments). It would be interesting to know whether different processes of behavioural commitment catalysis produce differing probabilities of the patient actually carrying out the new behaviour. For example, are patients more likely to carry out behaviours that they rehearsed in the session? Is there a greater chance of the patient carrying out the behaviour after the session if a greater number of different operations were used?

**G. Which Operations Result in Which Type of
Post-Session Behaviour**

The research team reported the impression that two distinct qualities of post-session behaviour were obtained. It would be interesting to study whether different operations are used in obtaining these two types of post-session behaviours. Another interesting question would be if there is any relation between patient actually carrying out the post-session behaviours, and the type of post-session behaviour that they had committed themselves toward.

H. Studying Patient "Resistance"

This study approached studying how therapists contributed to obtaining behavioural commitments. Conversely, it is also possible to focus on studying what therapists do which contributes to patients resisting or refusing to commit

themselves to new behaviours (Champlain et al., 1979; Mahrer, Murphy, Gagnon, & Gingras, In Press; Patterson & Forgatch, 1985; Speisman, 1959). Similarly, it may be possible to use any of the conditions identified by the research team as in-session consequences and carry out studies to identify what the therapist did which promoted the occurrence of those particular consequences. Such studies would help determine which chain of operations and conditions/consequences lead most directly to behavioural commitment, and which derail the process.

I. Studying Clusters of Operations

This study was designed to identify and describe individual operations and consequences, not to determine which combinations of operations are used together by therapists. Only soft impressions about this question could be derived. Future studies could make use of the list of operations produced by this study in combination with studying more instances of behavioural commitment in order to identify the pattern of use of operations. It may be that certain patterns of operation use are more effective, or that certain patterns may be compatible with a particular therapist's approach to therapy, whereas others would not be. Gathering more data would make it possible to reliably identify clusters of operations. This would not only tell us more about how behavioural commitments are catalyzed, but may tell us various ways in which they may be catalyzed. These studies would also make it possible to determine whether it is the type of therapy or the individual therapist which determines the patterning of operations used.

J. Confirming Our Findings

Studying more instances of behavioural commitment without using the list of operations described by the research team would permit replication or confirmation of the descriptions. As was made clear in previous sections discussing qualitative research methods, one would not expect to obtain the same list of operations as a result, even if the same transcripts were to be studied by another research team, but the convergence of description between both research teams could serve to further increase the credibility of the findings.

K. Testing Theoretical Components of The Process

As previously discussed in the section on common characteristics of the operations, hypothesized abstractions of the function of operations may be tested by deducing new psychotherapeutic operations and testing their efficacy, in turn. It is this author's opinion, however, that such research would be premature given the embryonic state of knowledge on obtaining behavioural commitments. It would be more productive to carry out many more naturalistic studies to study what therapists actually do before proceeding to studying abstractions and hypothetical deductions.

Summary of What Practitioners Could Do Differently

Based Upon The Findings

What could practitioners do differently based on the findings? The findings of this study may be used as provisional suggestions on how to bring about behavioural commitments, by practitioners who value the occurrence of this event. The

following is a list of 20 suggestions on how to proceed in obtaining behavioural commitments, as gleaned from the findings.

1. Provide the patient with a theoretical or therapeutic rationale as to why it is crucial that she carry out new behaviours after the session. Provide the patient with implicit or explicit promises that good changes will happen as a result of the patient's carrying out new behaviours.
2. Explicitly tell the patient that the patient is to carry out a particular new post-session behaviour. If the patient is unclear about the exact behaviour, clarify the behaviour further and reassign it.
3. Explicitly allow patients to take the initiative with regard to post-session behaviours.
4. If the patient has already decided that she would like to engage in new behaviours after the session or is showing initiative in constructing the potential new behaviour, do not block or reduce the patient's initiative. Encourage, support and allow the patient to select new behaviours.
5. Label the patient explicitly as having a particular new quality of being and tell her that she now is this qualitatively new type of person.
6. Behave differently toward the patient by deliberately treating the patient as if the patient did indeed have this new quality of being.
7. Approve explicitly or implicitly of this new way of being and encourage the patient to behave in consequence.

8. Be very concrete and specific in defining the post-session behaviour. Make sure that the patient is fully aware of what the behaviour is to be, with whom it is to be carried out, where, when, how, and what are the criteria for success in having carried out the behaviour. This may involve the patient or therapist writing down what is to be done. If the patient has vague therapeutic goals, elaborate these into concrete and specific behaviours with the patient.

9. The patient should have a clear picture in her mind of what the new behaviour is to be. The therapist should help define concrete and specific behaviours by questioning the patient and letting the patient come up with the specifications, so that the patient has to imagine all details of the behaviour.

10. If a behaviour or its situational context isn't fully clear, clarify and detail it with the patient.

11. Have the patient repeatedly try out the new behaviour in the session until the patient is pleased with it, is certain about what exactly they want to do, and feels good when doing it. Ask the patient how they feel after each complete rehearsal of the behaviour, in order to bring into their awareness the good (or not-so-good) feelings experienced as a result of carrying out the new behaviour.

12. Instead of having only the patient try out the new behaviour, the therapist may join in with the patient in trying it out simultaneously, doing everything that the patient would do when trying it out alone. This would include rehearsing,

refining, and changing the behaviour, as well as seeing how it feels to carry it out.

13. If the patient refuses to carry out the initially proposed new behaviour, then negotiate the nature, content, and level of difficulty of the post-session behaviour until the patient is willing to carry out the finalized behaviour.

14. If the therapist anticipates the patient being reluctant to commit herself to new behaviours, or if the patient is manifestly reluctant, insistently, persistently and forcefully bombard the patient with reasons, justifications and rationales for the necessity of carrying out the new behaviour.

15. The therapist should openly approve or disapprove of the patient, depending on whether the patient commits herself to the new behaviours or will not do it.

16. If the therapist has been unable to obtain a behavioural commitment despite having tried a number of operations, the therapist should openly concede defeat and make an elaborate show of "giving up". This may force the patient to take the initiative in the session.

17. If being very directive and wielding power over the patient is compatible with a practitioner's personal approach, the practitioner may inquire as to what the patient wants in therapy, such as any specific procedures or rewards. Tell the patient that these will only be made available if the patient carries out the new behaviours after the session. This may include telling the patient that they may only have further therapy sessions if they carry out the new behaviours. The caveat concerning the

compatibility (or incompatibility) of this suggestion with individual therapists' personal therapeutic approaches is particularly timely considering that therapists' use of power has been raised as an ethical question in recent years (e.g., Gannon, 1982). This particular suggestion is reported here because the issue of the therapist's exercise of power over the patient constitutes a matter of ongoing debate and personal choice. Moreover, such strong-arm tactics are currently explicitly being used by some popular empirically validated forms of therapy (e.g., Linehan, 1993; Young, 1984).

18. The therapist should not rely on one or two of these operations, but should use many of them in combination. Therapists should use between five and eight of these operations in obtaining a behavioural commitment.

19. If a practitioner values obtaining many behavioural commitments, start trying to obtain behavioural commitments earlier in the session, such as halfway through the session or even from the very start of the session. In some of the sessions studied, therapists obtained four or five distinct behavioural commitments in one session. Conversely, if a practitioner is only interested in obtaining one behavioural commitment (e.g., one piece of therapeutic homework), then starting about ten minutes from the end of the session is sufficient.

20. End the process of obtaining a behavioural commitment with requesting of the patient a firm, definite agreement that the patient is totally committed to carrying out the new behaviour. This may be done as a verbal or written contract.

Conclusion

This study was successful in its objective of identifying and describing psychotherapeutic operations which promote behavioural commitments, as well as associated psychotherapeutic conditions. All but one of the operations had never been reported in the research literature and none of the conditions had been reported in any of the reviewed psychotherapy literature, whether research or technical. As such, these findings constitute a significant addition to the body of knowledge on catalyzing the occurrence of patient behavioural commitments.

REFERENCES

- Aanstoos, C. M. (1987, August). Qualitative Research Methods: Themes and Variations. Paper presented at the Symposium for Qualitative Research in Psychology, Perugia, Italy.
- Agras, W. S. (Ed.). (1972). Behavior modification: Principles and clinical applications. Boston: Little, Brown and Company.
- Andrews, J. (1977). Personal change and intervention style. Journal of Humanistic Psychology, 17(3), 41-63.
- Andrews, J. D. (1989). Psychotherapy of depression: A self-confirmation model. Psychological Review, 96, 576-607.
- Angus, L. E., & Rennie, D. L. (1988). Therapist participation in metaphor generation: Collaborative and noncollaborative styles. Psychotherapy, 25, 552-560.
- Arthur, A. Z. (1972). Which is the relevant science for the scientist-professional? Professional Psychology, 3, 327-330.
- Auld, F. (1959). Comments on the relative value of observational and laboratory studies of psychotherapy. Psychological Reports, 15, 471-474.
- Bakeman, R., & Gottman, J. M. (1986). Observing interaction: An introduction to sequential analysis. Cambridge: Cambridge University Press.
- Bakker, C. B. (1975). Why people don't change. Psychotherapy: Theory, Research and Practice, 12, 164-172.
- Bandler, R., Grinder, J., & Satir, V. (1976). Changing with families (Vol. 1). Palo Alto, CA: Science and Behavior Books.
- Bandura, A. (1969). Principles of behavior modification. New York: Holt, Rinehart, & Winston, Inc.

- Bandura, A., Adams, N. E. (1977). Analysis of self-efficacy theory of behavioral change. Cognitive Therapy and Research, 1, 287-310.
- Bandura, A., Lipsher, D. H., & Miller, P. E. (1960). Psychotherapists' approach-avoidance reactions to patients' expressions of hostility. Journal of Consulting Psychology, 24, 1-8.
- Barkham, M., & Shapiro, D. A. (1986). Counselor verbal response modes and experienced empathy. Journal of Counseling Psychology, 33, 3-10.
- Barlow, D. H. (1981). On the relation of clinical research to clinical practice: Current issues, new directions. Journal of Consulting and Clinical Psychology, 49, 147-156.
- Bass, B. A. (1984). An addendum to the understanding and treatment of individuals with motivational deficits. Journal of Rational Emotive Therapy, 2, 32-34.
- Beck, A. T., & Emery, G. (1979). Cognitive therapy of anxiety and phobic disorders. Philadelphia: Center for Cognitive Therapy, Room 602, 133 South 36th Street, Philadelphia, PA.
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). Cognitive therapy of depression. New York: The Guilford Press.
- Beck, J. T., Strong, S. R. (1982). Stimulating therapeutic change with interpretations: A comparison of positive and negative connotation. Journal of Counseling Psychology, 29, 551-559.
- Bernard, R. H. (1994). Research methods in anthropology (2nd Ed.). Thousand Oaks, CA: Sage Publications.

- Block, J., & Thomas, H. (1955). Is Satisfaction with self a measure of adjustment? Journal of Abnormal and Social Psychology, 51, 254-259.
- Bogdan, R., & Taylor, S. J. (1975). Introduction to qualitative research methods. New York: John Wiley.
- Bond, J. A. (1974). Behavior therapy, learning theory and scientific method. Psychotherapy: Theory, Research and Practice, 11, 118-132.
- Bordin, E. S. (1965). Simplification as a strategy for research in psychotherapy. Journal of Consulting Psychology, 29, 493-503.
- Boutin, G. E. (1978). Treatment of test anxiety by rational stage directed hypnotherapy: A case study. American Journal of Clinical Hypnosis, 21, 42-57.
- Brady, J. P. (1972). Systematic desensitization. In W. S. Agras (Ed.), Behavior modification: Principles and clinical applications (pp. 127-). Boston: Little, Brown & Co.
- Buchheimer, A. (1963). The development of ideas about empathy. Journal of Counseling Psychology, 10, 61-70.
- Carson, R. C., Harden, J. A., & Shows, W. D. (1964). A-B distinction and behavior in quasi-therapeutic situations. Journal of Consulting Psychology, 28, 426-433.
- Casey, G. A. (1973). Behavior rehearsal: Principles and procedures. Psychotherapy: Theory, Research and Practice, 10, 331-333.

- Chamberlain, P., Patterson, G. R., Reid, J. B., Kavanagh, K., & Forgatch, M. S. (1984). Observation of client resistance. Behavior Therapy, 15, 144-155.
- Chambless, D. L., & Goldstein, A. J. (1979). Behavioral Psychotherapy. In R. J. Corsini (Ed.), Current psychotherapies (2nd ed.). Itasca, IL: F. E. Peacock.
- Chase, W. P. (1946). Measurement of attitudes toward counseling. Educational and Psychological Measurement, 6, 467-473.
- Chorafas, D. N. (1990). Knowledge Engineering: Knowledge Acquisition, Knowledge Representation, the Role of the Knowledge Engineer, and Domains Fertile for AI Implementation. N.Y.: Van Nostrand Reinhold.
- Colby, K. M. (1964). Psychotherapeutic processes. Annual Review of Psychology, 15, 347-370.
- Crabtree, B. F., & Miller, W. L. (1992). Doing qualitative research: Multiple strategies. Thousand Oaks, CA: Sage Publications.
- Cronbach, L. J. (1975). Beyond the two disciplines of scientific psychology. American Psychologist, 30, 116-127.
- Cutler, R. L. (1958). Countertransference effects in psychotherapy. Journal of Consulting Psychology, 22, 349-356.
- de Koning, A. J. J. (1986). Introduction. In P. D. Ashworth, A. Giorgi, & A. J. J. de Koning (Eds.) Qualitative Research in Psychology (pp. vii-xv). Pittsburgh, PA: Duquesne University Press.

- Dell, D. M. (1973). Counselor power base, influence attempt, and behavior change in counseling. Journal of Counseling Psychology, 20, 399-405.
- Denzin, N. K., & Lincoln, Y. S. (1994). Handbook of qualitative research. Thousand Oaks, CA: Sage Publications.
- DiClemente, C. C., & Prochaska, J. O. (1982). Self-change and therapy change of smoking behaviour: A comparison of processes of change in cessation and maintenance. Addictive Behaviors, 7(2) 133-142.
- Dittes, J. E. (1957). Galvanic skin response as a measure of patient's reaction to therapist's permissiveness. Journal of Abnormal and Social Psychology, 55, 295-303.
- Dittmann, A. T. (1952). The interpersonal process in psychotherapy: Development of a research method. Journal of Abnormal and Social Psychology, 47, 236-244.
- Duncan, S. Jr., Rice, L. N., & Butler, J. M. (1968). Therapists' paralinguage in peak and poor psychotherapy hours. Journal of Abnormal Psychology, 73, 566-570.
- Elliott, R. (1979). Interpersonal process recall (IPR) as a research method for studying psychological helping processes: A research manual. Unpublished manuscript. (Available from University of Toledo, Department of Psychology.)
- Elliott, R. (1983a). "That in your hands": A Comprehensive Process Analysis of a significant event in psychotherapy. Psychiatry, 46(2), 113-129.

- Elliott, R. (1983b). Fitting process research to the practicing psychotherapist. Psychotherapy: Theory, Research and Practice, 20, 47-55.
- Elliott, R. (1984). A discovery-oriented approach to significant change events in psychotherapy: Interpersonal process recall and comprehensive process analysis. In L. N. Rice and L. S. Greenberg (Eds.), Patterns of change: Intensive analysis of psychotherapy process. NY: The Guilford Press.
- Elliott, R. (In press) Interpersonal process recall (IPR) as a psychotherapy process research method. In L. Greenberg & W. Pinsof (Eds.), The psychotherapeutic process: A research handbook. New York: Guilford.
- Elliott, R., James, E., Reimschuessel, C., Cislo, D., & Sack, N. (1985). Significant events and the analysis of immediate therapeutic impacts. Psychotherapy, 22, 620-630.
- Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1993). Doing naturalistic inquiry: A guide to methods. Thousand Oaks, CA: Sage Publications.
- Exner, J. E. (1965). Therapist attendance as a variable in group psychotherapy. In G. E. Stollak, B. G. Guerney, & M. Rothberg (Eds.), Psychotherapy research: Selected readings (pp. 372-376). Chicago: Rand McNally & Co.
- Farson, R. E. (1961). Introjection in the psychotherapeutic relationship. Journal of Counseling Psychology, 8, 337-342.
- Fendrich, J. M. (1967). A study of the association among verbal attitudes, commitment, and overt behavior in different experimental situations. Social Forces, 45, 347-355.

- Fielding, N. G., & Lee, R. M. (1991). Using computers in qualitative research. Thousand Oaks, CA: Sage Publications.
- Flanders, P. A., & McNamara, J. R. (1985). Enhancing acne medication compliance: A comparison of strategies. Behaviour Research and Therapy, 23, 225-227.
- Floyd, F. J. (1989). Segmenting interactions: Coding units for assessing marital and family behaviors. Behavioral Assessment, 11, 13-29.
- Ford, D. H. (1959). Research approaches to psychotherapy. Journal of Counseling Psychology, 6, 55-60.
- Fortune, A. E. (1979). Communication in task-centered treatment. Social-Work, 24(5), 390-396.
- Frank, G. H. (1961). On the history of the objective investigation of the process of psychotherapy. Journal of Psychology, 51, 89-95.
- Frank, G. H., & Sweetland, A. (1962). A study of the process of psychotherapy: The verbal interaction. Journal of Consulting Psychology, 26, 135-138.
- Freud, S. (1959). Turnings in the world of psycho-analytic therapy. In S. Freud, Collected Papers (Vol. 2). New York: Basic Books.
- Friedlander, M. L., & Heatherington, L. (1989). Analyzing relational control in family therapy interviews. Journal of Counseling Psychology, 36, 139-148.
- Friedlander, M. L., Thibodeau, J. R., & Ward, L. G. (1985). Discriminating the "good" from the "bad" therapy hour: A study of dyadic interaction. Psychotherapy, 22, 631-642.

- Gadamer, H. G. (1981). Reason in The Age of Science. Cambridge, MA: MIT Press.
- Gannon, L. (1982). The role of power in psychotherapy. Women and Therapy, 1, 3-11.
- Gervaise, P. A. (1984). Patient laughter as a function of antecedent therapist verbal behaviour. Doctoral dissertation, University of Ottawa, Ottawa.
- Gervaise, P. A., Mahrer, A. R., & Markow, R. (1985). What therapists do to promote strong laughter in patients. Psychotherapy in Private Practice, 3, 65-74.
- Gilgun, J. F., Daly, K., Handel, G. (1992). Qualitative methods in family research. Thousand Oaks, CA: Sage Publications.
- Giorgi, A. (1970). Psychology as a Human Science. New York: Harper & Row.
- Giorgi, A. (1975). An application of phenomenological method in psychology. In A. Giorgi, C. Fisher, and E. E. Murray (Eds.), Duquesne Studies in Phenomenological Psychology, II, 82-103. Pittsburgh, Duquesne University Press.
- Giorgi, A. (1985). Sketch of a psychological phenomenological method. In A. Giorgi (Ed.), Phenomenology and Psychological Research (pp. 8-22). Pittsburgh, PA: Duquesne University Press.
- Giorgi, A. (1986). Theoretical justification for the use of description in psychological research. In P. D. Ashworth, A. Giorgi, & A. J. J. de Koning (Eds.) Qualitative Research in Psychology (pp. 3-22). Pittsburgh, PA: Duquesne University Press.

- Giorgi, A. (1987). Problems in self-descriptive research as exemplified in a phenomenological analysis of imaginative experiences. In F. J. van Zuuren, F. J. Wertz, & B. Mook (Eds.), Advances in Qualitative Psychology: Themes and Variations (pp. 41-51). Berwyn, PA: Swets North America Inc.
- Glaser, B. & Strauss, A. (1967) The discovery of grounded theory: Strategies for qualitative research. Chicago: Aldine.
- Glasser, W., & Zunin, L. M. (1979). Reality Therapy. In R. J. Corsini (Ed.), Current psychotherapies (2nd ed.). Itasca, IL: F. E. Peacock.
- Goldfried, M. R. (1982). Resistance and clinical behavior therapy. In P. L. Wachtel (Ed.), Resistance: Psychodynamic and Behavioral Approaches (pp. 95-113).
- Goldfried, M. R., & Davison, G. C. (1976). Clinical Behavior Therapy. New York: Holt, Rinehart & Winston.
- Goldring, J. (1980). Quick Response Therapy. New York: Human Sciences Press.
- Gordon, J. E. (1957). Leading and following psychotherapeutic techniques with hypnotically induced repression and hostility. Journal of Abnormal and Social Psychology, 54, 405-410.
- Gott, S. P. (1988). Technical intuition in system diagnosis: or Accessing the libraries of the mind. Aviation, Space, and Environmental Medicine, 59(11, Sect 2) 59-64.
- Gottman, J. M., & Bakeman, R. (1979). The sequential analysis of observational data. In M. E. Lamb, S. J. Suomi, & G. R. Stephenson (Eds.), Social interaction analysis: Methodological issues (pp. 185-206). Madison: University of Wisconsin Press.

- Greenberg, L. S. (1984). A task analysis of intrapersonal conflict resolution. In L. N. Rice and L. S. Greenberg (Eds.), Patterns of change: Intensive analysis of psychotherapy process (pp. 67-123). NY: The Guilford Press.
- Greenberg, L. S. (1986). Change process research. Journal of Consulting and Clinical Psychology, 54, 4-9.
- Gubrium, J. F., & Sankar, A. (1993). Qualitative methods in aging research. Thousand Oaks, CA: Sage Publications.
- Gurman, A. S. (1983). Family therapy research and the "New epistemology". Journal of Marital and Family Therapy, 9, 227-234.
- Haley, J. (1984). Ordeal therapy: Unusual ways to change behavior. San Francisco: Jossey-Bass Publishers.
- Hamel, J. (1993). Case study methods. Thousand Oaks, CA: Sage Publications.
- Harcum, E. R. (1989). Commitment to collaboration as a prerequisite for existential commonality in psychotherapy. Psychotherapy, 26, 200-209.
- Harcum, E. R., Burijon, B. N., & Watson, N. (1989). Need for a theoretical justification of humanistic commitment components in behavior therapy. Psychological Record, 39, 493-500.
- Harway, N. I., Dittmann, A. T., Rausch, H. L., Bordin, E. S., & Rigler, D. (1955). The measurement of depth of interpretation. Journal of Consulting Psychology, 19, 247-253.
- Heatherington, L. (1989). Toward more meaningful clinical research: Taking context into account in coding psychotherapy interaction. Psychotherapy, 26, 436-447.

- Henry, W. P., Schacht, T. E., Strupp, H. H. (1986). Structural analysis of social behavior: Application to a study of interpersonal process in differential psychotherapeutic outcome. Journal of Consulting and Clinical Psychology, 54, 27-31.
- Hertel, R. K. (1972). Application of stochastic process analysis to the study of psychotherapeutic processes. Psychological Bulletin, 77, 421-430.
- Hill, C. E. (1978). Development of a counselor verbal response category system. Journal of Counseling Psychology, 25, 461-468.
- Hill, C. E., & O'Grady, K. E. (1985). List of therapist intentions illustrated in a case study and with therapists of varying theoretical orientations. Journal of Counseling Psychology, 32, 3-22.
- Hill, C. E., Carter, J. A., & O'Farrell, M. K. (1983). Reply to Howard and Lambert: Case study methodology. Journal of Counseling Psychology, 30, 26-30.
- Hill, C. E., Helms, J. E., Spiegel, S. B., & Tichenor, V. (1988). Development of a system for categorizing client reactions to therapist interventions. Journal of Counseling Psychology, 35, 27-36.
- Hill, M. R. (1993). Archival strategies and techniques. Thousand Oaks, CA: Sage Publications.
- Holsti, O. R. (1969). Content Analysis for the Social Sciences and Humanities. Reading, MA: Addison-Wesley Publishing Company.
- Howard, G. S. (1983). Toward methodological pluralism. Journal of Counseling Psychology, 30, 19-21.

- Hudgins, M. K., Kiesler, D. J. (1987). Individual experiential psychotherapy: An analogue validation of the intervention module of psychodramatic doubling. Psychotherapy, 24(2), 245-255.
- Hycner, R. H. (1985). Some guidelines for the phenomenological analysis of interview data. Human Studies, 8, 279-303.
- Imber, S. D., Frank, J. D., Nash, E. H., Stone, A. R., & Gliedman, L. H. (1957). Improvement and amount of therapeutic contact: An alternative to the use of no-treatment controls in psychotherapy. Journal of Consulting Psychology, 21, 309-315.
- Ishiyama, F. I. (1986). Morita therapy: Its basic features and cognitive intervention for anxiety treatment. Psychotherapy, 23, 375-381.
- Jacob, T. (1975). Family interaction in disturbed and normal families: A methodological and substantive review. Psychological Bulletin, 82, 33-65.
- James, W. (1902). Varieties of religious experience. New York: Random House.
- Jones, E. E. & Gerard, H. B. (1967). Foundations of social psychology. New York: John Wiley & Sons, Inc.
- Jones, E. E., Cumming, J. D., Horowitz, M. J. (1988). Another look at the nonspecific hypothesis of therapeutic effectiveness. Journal of Consulting and Clinical Psychology, 56, 48-55.

- Kagan, N. (1975). Interpersonal process recall: A method of influencing human interaction. Unpublished Manuscript (Available from N. Kagan, 434 Erickson Hall, College of Education, M.S.U., East Lansing, MI 48824).
- Kanfer, F. H. (1979). Self-management: Strategies and tactics. In A. P. Goldstein & F. H. Kanfer (Eds.), Maximizing treatment gains: Transfer enhancement in psychotherapy. New York: Academic Press.
- Kanfer, F. H., & Grimm, L. G. (1980). Managing clinical change: A process model of therapy. Behaviour Modification, 4, 419-444.
- Kanfer, F. H., & Karoly, P. (1972). Self-control: A behavioristic excursion into the lion's den. Behavior Therapy, 3, 398-416.
- Karasu, T. B. (1986). The specificity versus nonspecificity dilemma: Toward identifying therapeutic change agents. American Journal of Psychiatry, 143, 687-695.
- Kazdin, A. E. (1980). Research design in clinical psychology. Cambridge: Harper & Row.
- Kazdin, A. E. (1981). Drawing valid inferences from case studies. Journal of Consulting and Clinical Psychology, 49, 183-192.
- Kazdin, A. E. (1983). Treatment research: The investigation and evaluation of psychotherapy. In M. Hersen, A. E. Kazdin, & A. S. Bellack (Eds.), The clinical psychology handbook (pp 265-284). New York: Pergamon.
- Kazdin, A. E., & Krouse, R. (1983). The impact of variations in treatment rationales on expectancies for therapeutic change. Behaviour Therapy, 14, 657-671.

- Kelly, G. A. (1955). The psychology of personal constructs. New York: Norton.
- Kelman, H. (1969). Kairos: The auspicious moment. American Journal of Psychoanalysis, 29, 59-83.
- Kiesler, D. J. (1966). Some myths of psychotherapy research and the search for a paradigm. Psychological Bulletin, 65, 110-136.
- Kiesler, D. J. (1971). Experimental designs in psychotherapy research. In A. E. Bergin & S. L. Garfield (Eds.), Handbook of Psychotherapy and Behavior Change: An Empirical Analysis (pp 36-74). New York: John Wiley.
- Klein, M. H., & Gurman, A. S. (1981). Ritual and reality: Some clinical implications of experimental design. In L. Rehm (Ed.), Behavior therapy for depression. New York: Academic Press, 1981.
- Kniskern, D. P. (1985). Climbing out of the pit: Further guidelines for family therapy research. Journal of Marital and Family Therapy, 11, 159-162.
- Kothandapani, V. (1971). Validation of feeling, belief, and intention to act as three components of attitude and their contribution to prediction of contraceptive behavior. Journal of Personality and Social Psychology, 19, 321-333.
- Kushner, K., Bordin, E. S., & Ryan, E. (1979). Comparison of Strupp's and Jenkins's audiovisual psychotherapy analogues and real psychotherapy interviews. Journal of Consulting and Clinical Psychology, 47, 765-767.

- Kvale, S. (1987). Interpretation of the qualitative research interview. In F. J. van Zuuren, F. J. Wertz, & B. Mook (Eds.), Advances in Qualitative Psychology: Themes and Variations (pp. 25-40). Berwyn, PA: Swets North America Inc.
- L'Abate, L., & Colondier, G. (1987). The emperor has no clothes! Long live the emperor! A critique of family systems thinking and a reductionistic proposal. The American Journal of Family Therapy, 15, 19-33.
- Labov, W., & Fanshel, D. (1977). Therapeutic discourse: Psychotherapy as conversation. New York: Academic Press.
- Lazarus, A. A. (1971). Behavior therapy and beyond. New York: McGraw-Hill.
- Lazarus, A. A., & Fay, A. (1982). Resistance or rationalization? In P. L. Wachtel (Ed.), Resistance: Psychodynamic and Behavioral Approaches (pp. 115-132). New York: Plenum Press.
- Leitenberg, H. (1972). Positive reinforcement and extinction procedures. In W. S. Agras (Ed.), Behavior modification: Principles and clinical applications. Boston: Little, Brown & Co.
- Levy, R. L. (1977). Relationship of an overt commitment to task compliance in behavior therapy. Journal of Behavior Therapy and Experimental Psychiatry, 8, 25-29.
- Levy, R. L., & Clark, H. (1980). The use of an overt commitment to enhance compliance: A cautionary note. Journal of Behavior Therapy and Experimental Psychiatry, 11, 105-107.

- Levy, R. L., & Shelton, J. L. (1990). Tasks in brief therapy. In R. A. Wells & V. J. Giannetti (Eds.), Handbook of the Brief Psychotherapies (pp 145-163). New York: Plenum Press.
- Lichtenberg, J. W., & Heck, E. J. (1979). Interactional structure of interviews conducted by counselors of differing levels of cognitive complexity. Journal of Counseling Psychology, 26, 15-22.
- Lichtenberg, J. W., & Hummel, T. J. (1976). Counseling as a stochastic process: Fitting a Markov chain model to initial counseling interviews. Journal of Counseling Psychology, 23, 310-315.
- Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Thousand Oaks, CA: Sage Publications.
- Linehan, M. M. (1993). Cognitive-Behavioral Treatment of Borderline Personality Disorder. New York, NY: Guilford Press.
- London, P. (1964). The Modes and Morals of Psychotherapy. New York: Rinehart & Winston.
- Luborsky, L., & Auerbach, A. H. (1969). The symptom-context method: Quantitative studies of symptom formation in psychotherapy. Journal of the American Psychoanalytic Association, 17, 68-99.
- Luborsky, L., Singer, B., Hartke, J., Crits-Christoph, P., & Cohen, M. (1984). Shifts in depressive state during psychotherapy: which concepts of depression fit the context of Mr. Q's shifts? In L. N. Rice & L. S. Greenberg (Eds.) Patterns of Change: Intensive Analysis of Psychotherapy Process (pp. 157-193). New York: The Guilford Press.

- MacKinnon, D. W. (1953). Fact and fancy in personality research. American Psychologist, 8, 138-146.
- Mahrer, A. R. (1985). Psychotherapeutic change: An alternative approach to meaning and measurement. New York: Norton.
- Mahrer, A. R. (1988a). Discovery-oriented psychotherapy research. American Psychologist, 43, 694-702.
- Mahrer, A. R. (1988b). Research and clinical applications of "good moments" in psychotherapy. Journal of Integrative and Eclectic Psychotherapy 1, 81-93.
- Mahrer, A. R. (1989). How to do experiential psychotherapy: A manual for practitioners. Ottawa: University of Ottawa Press.
- Mahrer, A. R., & Gagnon, R. (1991). The care and feeding of a psychotherapy research team. Journal of Psychiatry and Neuroscience, 16, 188-192.
- Mahrer, A. R., Dessaulles, A., Nadler, W. P., Gervaise, P. A., & Sterner, I. (1987). Good and very good moments in psychotherapy: Content, distribution, and facilitation. Psychotherapy, 24, 7-14.
- Mahrer, A. R., Murphy, L., Gagnon, R., & Gingras, N. (In Press). The counsellor as the cause and cure of client resistance. Canadian Counsellor (Special Issue).
- Mahrer, A. R., Nadler, W. P. (1986). Good moments in psychotherapy: A preliminary review, a list, and some promising research avenues. Journal of Consulting and Clinical Psychology, 54, 10-15.

- Mahrer, A. R., Nadler, W. P., Gervaise, P. A., & Markow, R. (1986). Discovering how one therapist obtains some very good moments in psychotherapy. Voices, 22(2), 72-83.
- Mahrer, A. R., Nadler, W. P., Gervaise, P. A., Sterner, I., & Talitman, E. A. (1988). Good moments in rational-emotive therapy: Some unique features of this approach. Journal of Rational-Emotive and Cognitive-Behavior Therapy, 6, 146-161.
- Mahrer, A. R., Nadler, W. P., Sterner, I., & White, M. V. (1989). Patterns of organization and sequencing of "good moments" in psychotherapy sessions. Journal of Integrative and Eclectic Psychotherapy, 8, 125-139.
- Mahrer, A. R., Nifakis, D. J., Abhukara, L., & Sterner, I. (1984). Microstrategies in psychotherapy: The patterning of sequential therapist statements. Psychotherapy, 21, 465-472.
- Mahrer, A. R., Paterson, W. E., Thériault, A. T., Roessler, C., & Quenneville, A. (1986). How and why to use a large number of clinically sophisticated judges in psychotherapy research. Voices, 22, 57-66.
- Mahrer, A. R., White, M. V., Howard, M. T., Gagnon, R., & MacPhee, D. (1992). How to bring about some very good moments in psychotherapy sessions. Psychotherapy Research, 2(4), 252-265.
- Mahrer, A. R., White, M. V., Souliere, M. D., Macphee, D. C., & Boulet, D. B. (1991). Intensive process analysis of significant in-session client change events and antecedent therapist methods. Journal of Integrative and Eclectic Psychotherapy, 10(1), 38-55.

- Marmar, C. R., Wilner, N., & Horowitz, M. J. (1984). Recurrent client states in psychotherapy: Segmentation and quantification. In L. N. Rice and L. S. Greenberg (Eds.), Patterns of change: Intensive analysis of psychotherapy process (pp 194-212). NY: The Guilford Press.
- Marshall, C., & Rossman, G. B. (1989). Designing qualitative research. Thousand Oaks, CA: Sage Publications.
- Martin, J., Martin, W., & Slemon, A. G. (1987). Cognitive mediation in person-centered and rational-emotive therapy. Journal of Counseling Psychology, 34, 251-260.
- Marzano, R. J., & Marzano, J. S. (1988). Toward a cognitive theory of commitment and its implications for therapy. Psychotherapy in Private Practice, 6, 69-81.
- Matarazzo, J. D. (1965). Psychotherapeutic processes. Annual Review of Psychology, 16, 181-224.
- Mathieu-Coughlan, P., & Klein, M. H. (1984). Experiential psychotherapy: Key events in client-therapist interaction. In L. N. Rice & L. S. Greenberg (Eds.) Patterns of Change: Intensive Analysis of Psychotherapy Process, (pp. 213-248). New York: The Guilford Press.
- McCutcheon, A. L. (1987). Latent Class Analysis. Newbury Park, CA: Sage Publications.
- McElroen, L. J., Faltico, G. J. (1977). Reality therapy and Alcoholics Anonymous: A comparison of two approaches to behavior change. Corrective and Social Psychiatry and Journal of Behavior Technology, Methods and Therapy, 23, 79-82.

- McLeod, J. (1988-89). Computer-guided educational diagnosis. Journal of Reading, Writing, and Learning Disabilities International, 4(3) 171-185.
- McNair, D. M., Callahan, D. M., & Lorr, M. (1962). Therapist "type" and patient response to psychotherapy. Journal of Consulting Psychology, 26, 425-429.
- Mendel, W. M. (1972). Comparative psychotherapy. International Journal of Psychoanalytic Psychotherapy, 1, 117-126.
- Miles, M. B., & Huberman, M. (1994). Qualitative data analysis (2nd Ed.). Thousand Oaks, CA: Sage Publications.
- Montgomery, A. G., & Montgomery, D. J. (1975). Contractual psychotherapy: Guidelines and strategies for change. Psychotherapy: Theory, Research and Practice, 12, 348-352.
- Mook, B., Wertz, F., & van Zuuren, F. (1987). Introduction. In F. J. van Zuuren, F. J. Wertz, & B. Mook (Eds.), Advances in Qualitative Psychology: Themes and Variations (pp. ix-xii). Berwyn, PA: Swets North America Inc.
- Morse, J. M. (1993). Critical issues in qualitative research methods. Thousand Oaks, CA: Sage Publications.
- Northrup, F. S. C. (1947). The logic of the sciences and the humanities. New York: Macmillan.
- Omer, H. (1985). Fulfillment of therapeutic tasks as a precondition for acceptance in therapy. American Journal of Psychotherapy, 39, 175-186.
- Oremland, J. D. (1972). Transference cure and flight into health. International Journal of Psychoanalytic Psychotherapy, 1, 61-75.

- Papajohn, J. C. (1982). Intensive behavior therapy. New York: Pergamon.
- Parloff, M. B. (1986). Placebo controls in psychotherapy research: A sine qua non or a placebo for research problems? Journal of Consulting and Clinical Psychology, 54, 79-87.
- Parloff, M. B., London, P., & Wolfe, B. (1986). Individual psychotherapy and behaviour change. Annual Review of Psychology, 37, 321-349.
- Patterson, G. R. (1984). Treatment process: A problem at three levels. (NIMH proposal MH 38730). Eugene, OR: Oregon Social Learning Centre.
- Patterson, G. R., & Forgatch, M. S. (1985). Therapist behavior as a determinant for client noncompliance: A paradox for the behavior modifier. Journal of Consulting and Clinical Psychology, 53, 846-851.
- Patton, M. J. (1989). Problems with and alternatives to the use of coding schemes in research on counseling. The Counseling Psychologist, 17, 490-506.
- Paul, G. L. (1967). Strategy of outcome research in psychotherapy. Journal of Consulting Psychology, 31, 109-119.
- Pearce, W. B., & Cronen, V. E. (1980). Communication, action, and meaning. New York: Praeger.
- Polkinghorne, D. (1983). Methodology for the Human Sciences: Systems of Inquiry. Albany, NY: State University of New York Press.
- Polyani, M. (1966). Tacit knowledge. Chicago: University of Chicago Press.

- Prochaska, J. (1979). Systems of psychotherapy: A transtheoretical analysis. Homewood, IL: Dorsey Press.
- Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. Psychotherapy: Theory, Research and Practice, 19, 276-288.
- Reid, W. J., & Epstein, L. (1972). Task-centered casework. New York: Columbia University Press.
- Rennie, D. L., Phillips, J. R., & Quartaro, G. K. (1988). Grounded theory: A promising approach to conceptualization in psychology? Canadian Psychology, 29, 139-150.
- Rice, L. N., & Greenberg, L. S. (1984a). Preface. In L. N. Rice & L. S. Greenberg (Eds.), Patterns of Change: Intensive Analysis of Psychotherapy Process (pp. vi-viii). New York: The Guilford Press.
- Rice, L. N., & Greenberg, L. S. (Eds.) (1984b). Patterns of Change: Intensive Analysis of Psychotherapy Process. New York: The Guilford Press.
- Rice, L. N., & Saperia, E. P. (1984). Task analysis of the resolution of problematic reactions. In L. N. Rice and L. S. Greenberg (Eds.), Patterns of change: Intensive analysis of psychotherapy process (pp. 29-66). NY: The Guilford Press.
- Riessman, C. K. (1993a). Qualitative studies in social work research. Thousand Oaks, CA: Sage Publications.
- Riessman, C. K. (1993b). Narrative analysis. Thousand Oaks, CA: Sage Publications.

- Rosenberg, S. D., Schnurr, P. P., & Oxman, T. E. (1990). Content analysis: A comparison of manual and computerized systems. Journal of Personality Assessment, 54(1&2), 298-310.
- Rosenfarb, I., & Hayes, S. C. (1984). Social standard setting: The Achilles heel of informational accounts of therapeutic change. Behaviour Therapy, 15, 515-528.
- Russell, R. L., & Trull, T. J. (1986). Sequential analyses of language variables in psychotherapy process research. Journal of Consulting and Clinical Psychology, 54, 16-21.
- Rouse, W. B., Hammer, J. M., & Lewis, C. M. (1989). On capturing human skills and knowledge: Algorithmic approaches to model identification. IEEE Transactions on Systems, Man, and Cybernetics, 19, 558-573.
- Safran, J. D., Greenberg, L. S., & Rice, L. N. (1988). Integrating psychotherapy research and practice: Modeling the change process. Psychotherapy, 25, 1-17.
- Schiff, A. & Schiff, J. (1971). Passivity. Transactional Analysis Journal, 1, 71-78.
- Schöfer, G., Balck, F., & Koch, U. (1979). Possible applications of the Gottschalk-Gleser content analysis of speech in psychotherapy research. In L. A. Gottschalk (Ed.), The Content Analysis of Verbal Behavior (pp. 857-870). New York: SP Medical and Scientific Books.
- Seeman, J. (1949). A study of the process of nondirective therapy. Journal of Consulting Psychology, 13, 157-168.

- Shelly, N. (1985). Transference: A universal phenomena, a clinical entity. Current Issues in Psychoanalytic Practice, 2, 19-28.
- Shelton, J. L., & Levy, R. L. (1981a). A survey of the reported use of assigned homework activities in contemporary behavior therapy literature. The Behavior Therapist, 4(4), 13-14.
- Shelton, J. L., & Levy, R. L. (1981b). Behavioral assignments and treatment compliance: A handbook of clinical strategies. Champaign, IL: Research Press.
- Shemberg, K., Keeley, S. M., & Blum, M. (1989). Attitudes toward traditional and non-traditional dissertation research: Survey of directors of clinical training. Professional Psychology: Research and Practice, 20, 190-192.
- Silverman, D. (1993). Interpreting qualitative data. Thousand Oaks, CA: Sage Publications.
- Small, J. J., & Manthei, R. J. (1986). The language of therapy. Psychotherapy, 23, 295-404.
- Snyder, W. U. (1945). An investigation of the nature of non-directive psychotherapy. The Journal of General Psychology, 33, 193-223.
- Speisman, J. C. (1959). Depth of interpretation and verbal resistance in psychotherapy. Journal of Consulting Psychology, 23, 93-99.
- Straus, E. (1980). Phenomenological Psychology. New York: Garland.
- Strauss, A., & Corbin, J. (1990). Basics of qualitative research. Thousand Oaks, CA: Sage Publications.

- Svensson, L. (1986). Three approaches to descriptive research. In P. D. Ashworth, A. Giorgi, & A. J. J. de Koning (Eds.) Qualitative Research in Psychology (pp. 23-46). Pittsburgh, PA: Duquesne University Press.
- Talmon, M. (1990). Single-Session Therapy: Maximizing the Effect of the First (and Often Only) Therapeutic Encounter. San Francisco, CA: Jossey-Bass.
- Tanner, B. A. (1990). Composite descriptions associated with rare MMPI two-point code types: Codes that involve scale 5. Journal of Clinical Psychology, 46, 425-431.
- Taylor, S. J., & Bogdan, R. (1984). Introduction to Qualitative Research Methods: The Search for Meanings. New York: John Wiley and Sons.
- Thoresen, C. E., & Anton, J. L. (1974). Intensive experimental research in counseling. Journal of Counseling Psychology, 21, 553-559.
- Todd, D. M. (1987). Microcomputer-assisted qualitative analysis: A research tool for scientist-practitioners. Professional Psychology: Research and Practice, 18, 520-525.
- Tosi, D. J., & Henderson, G. W. (1983). Rational stage-directed therapy: A cognitive experiential system using hypnosis, imagery, cognitive restructuring, and developmental staging. Journal of Rational Emotive Therapy, 1, 15-19.
- Tsoi-Hoshmand, L. L. S. (1989). Alternate research paradigms: A review and teaching proposal. The Counseling Psychologist, 17, 3-79.

- Ullmann, L. P., Krasner, L., & Collins, B. J. (1961). Modification of behavior through verbal conditioning: Effects in group therapy. Journal of Abnormal and Social Psychology, 62, 128-132.
- Von Eckartsberg, R. (1971). On experiential methodology. In A. Giorgi, W. F. Fischer, & R. Von Eckartsberg (Eds.), Duquesne Studies in Phenomenological Psychology (Vol. 1). Pittsburg, PA: Duquesne University Press.
- Wampold, B. E., Davis, B., & Good, R. H. III (1990). Hypothesis validity of clinical research. Journal of Consulting and Clinical Psychology, 58, 360-367.
- Wampold, B. E., & Kim, K. H. (1989). Sequential analysis applied to counseling process and outcome: A case study revisited. Journal of Counseling Psychology, 36, 357-364.
- Wardlaw, G. (1979). Commitment to a program of therapy: A clinical trial of a laboratory analogue. Journal of Behavior Therapy and Experimental Psychiatry, 10, 199-202.
- Wells, R. A. (1982). Planned short-term treatment. New York: The Free Press.
- Wertz, F. J. (1983). Some constituents of descriptive psychological reflection. Human Studies, 6, 35-51.
- Wertz, F. J., & van Zuuren, F. J. (1987). Qualitative research: Educational considerations. In F. J. van Zuuren, F. J. Wertz, & B. Mook (Eds.), Advances in Qualitative Psychology: Themes and Variations (pp. 3-23). Berwyn, PA: Swets North America Inc.

- Whipple, V. (1985). The use of reality therapy with battered women in domestic violence shelters. Journal of Reality Therapy, 5, 22-27.
- Wiggs, C. L. & Perez, R. S. (1988). The use of knowledge acquisition in instructional design. Computers in Human Behavior, 4(3), 257-274.
- Winder, C. L. (1957). Psychotherapy. Annual Review of Psychology, 8, 309-330.
- Wolcott, H. F. (1990). Writing up qualitative research. Thousand Oaks, CA: Sage Publications.
- Wolcott, H. F. (1994). Transforming qualitative data: Description, analysis, and interpretation. Thousand Oaks, CA: Sage Publications.
- Wolpe, J., & Lazarus, A. A. (1966). Behavior therapy techniques. New York: Pergamon.
- Wurtele, S. K., Galanos, A. N., & Roberts, M. C. (1980). Increasing return compliance in a tuberculosis detection drive. Journal of Behavioral Medicine, 3, 311-318.
- Young, H. S. (1984). Practising RET with lower-class clients. Special Issue: The work of Howard S. Young. British Journal of Cognitive Psychotherapy, 2(2), 33-59.
- Yow, V. R. (1994). Recording oral history: A practical guide for social scientists. Thousand Oaks, CA: Sage Publications.
- Zakaras, M. E., & Fine, H. J. (1979). Schizophrenic language: An empiricized case study. Psychotherapy: Theory, research and practice, 16, 441-451.

Zimmer, J. M., & Pepyne, E. W. (1971). A descriptive and comparative study of dimensions of counselor response. Journal of Counseling Psychology, 18, 441-447.

APPENDIX A

Psychotherapeutic Operations for
Catalyzing Behavioural Commitments as Found in
The Technical Psychotherapy Literature

(1) Therapist direct order.

- (a) "Authoritative order". The therapist, as authority, simply orders the patient to carry out the new behaviour.

Examples: The therapist tells the patient "For this week, I want you to..." (Wells, 1982, p. 187). The therapist may also use what Bandler, Grinder and Satir (1976) have named as the "polite command method", an example of which is, "What I would like you to do, if you would, is to..." (Wells, 1982, p. 187).

(2) Provision of a rationale. This category includes rationales, good reasons or excuses which the therapist delivers to the patient in order to convince the patient that s/he should carry out the new behaviour.

- (a) "Process excuse". The therapist tells the patient that carrying out the new behaviour is important or crucial for the process of therapy, without the implication that the new behaviour is a therapeutic goal/outcome in and of itself.

Examples: The therapist may tell the patient that it is possible to do some good work, but not from where the patient is standing now. The patient must begin from some better vantage point, which can be attained by carrying out the new behaviour (Omer, 1985). Process excuse may also be a component of commitments to paradoxical assignments (e.g., Agras, 1972), whereby the therapist may imply to the patient that the exercise of the task is important as a component of therapy. Process excuse is also involved in encouraging the patient to enter situations, outside of therapy, which correspond to imagined situations in systematic desensitization (e.g., Brady, 1972), or in encouraging agoraphobic patients to walk a preplanned course between the clinic and downtown for the stated reason that the therapist "would like to see how far (the patient) can walk by (her) self without experiencing undue tension" (Leitenberg, 1972, p. 40).

- (b) "Providing a theoretical rationale". The therapist explains to the patient the theory of psychotherapy which provides a rationale for the importance of carrying out the new behaviour (Kanfer & Grimm, 1980).
(c) "Patient's ballpark". The therapist tells the patient that the success of treatment depends upon the patient's own actions and willingness to carry out the new behaviour.

Examples: The therapist may tell the patient that she is not sure that she can be of help; that it depends on the patient's readiness to do some vital things (Omer, 1985). When the patient is complaining about her circumstances at length, the therapist may say, "I admit the situation is bad, but what are

you doing to change it?" or "How do you want to do things differently?" (Montgomery & Montgomery, 1975, p. 350). The therapist may highlight the patient's volition in carrying out new behaviours by saying "It seems to me that you can have a wonderful new world and can do all sorts of things....How do you want to be?" (Mahrer, 1989, p. 73).

(3) Generating possible new ways of being and behaving. This category includes any operation which increases the patient's awareness of potential new ways of being and behaving.

- (a) "Specifying the new behaviour". The therapist makes very clear to the patient what new behaviour is to be carried out, where, when and with whom. Alternately, the therapist asks the patient to very clearly and concretely describe what new behaviour is to be carried out, where, when and with whom.

Examples: The therapist may summarize for the patient what the therapist thinks are the most significant situations or behaviours that require change (Kanfer & Grimm, 1980). The therapist should spell out the exact nature of the assignment (Wells, 1982), being very specific about the task and criteria for fulfillment (Omer, 1985). A written description of the new behaviour should be produced, including when they should be carried out (Whipple, 1985). The therapist should make the patient's general goals specific by clarifying with the patient what it would mean if the patient were different. This can be carried out through such questions as "How would you be acting now if you were self-confident?" or "How will I know when you feel confident?" (Montgomery & Montgomery, 1975, p. 349). The therapist may ask the patient such questions as, "What is your life like? What can it be like? What do you do in your life?" (Mahrer, 1989, p. 73).

- (b) "Modeling patient's new self". The therapist demonstrates or play-acts to the patient how the patient could behave outside of therapy in carrying out the new behaviour. Alternately, the therapist describes to the patient in painstaking detail, how the patient could behave outside of therapy.

Examples: The therapist play-acts how the patient could be as a different person and describes, in fantasy, carrying out new behaviours which the patient could carry out. "The patient will be drawn little by little into being the experiencing and undergoing the new behavior" (Mahrer, 1989, p. 83).

- (c) "Addressing the patient as a new person". The therapist addresses the patient as if the patient were a new, different person.

Examples: The therapist can address the patient as a new person, the therapist and patient agreeing to play a game in which the therapist talks to the patient as if she were the new person. For example, "I want to talk with you. You're a delightfully controlling and dominating person, and you really know what it is like to have these sexual feelings, sexually being in charge..." (Mahrer, 1989, p. 72).

- (d) "Patient specifying ideal self". The therapist asks the patient to tell the therapist how the patient would want to behave differently, how the patient would be acting if she were different, or what it is that the patient would like to change. As a variant, the therapist asks the patient to tell herself how she would want to behave differently, how the patient would be acting if she were different, or what it is that the patient would like to change.

Examples: The patient may be asked how she would be acting if she were now the kind of person that she would like to be, by asking the patient how she would like to do things differently, or by asking the patient what it is that she wants to change (Montgomery & Montgomery, 1975). Subsequent to discussing with the patient what the patient could be like if the patient were a new and different person, the therapist may ask the patient such questions as, "What is your life like? What can it be like? What do you do in your life? It seems to me that you can have a wonderful new world and can do all sorts of things to get this great feeling of sexualized strength....How do you want to be?" (Mahrer, 1989, p. 73). If the patient is enacting being a new and different person in the psychotherapy session, the therapist may tell the patient, as a "new" person, to tell the "other self, old self" or "ordinary self" how to behave differently (Mahrer, 1989).

(4) Engaging patient activity. This category includes operations which "hook" the patient's motivation to act either by a simple request from the therapist or by the therapist frustrating the patient.

- (a) "Involving the patient". The therapist involves the patient in selecting the new behaviour and how it should be carried out.

Examples: The therapist may explain to the patient which types or methods of psychotherapy are available for the patient to select from, leaving the choice up to the patient as to which methods the therapist will use. The patient may be involved in selecting the new behaviours and should be permitted, at least on occasion, to decide which treatment methods should be used (Kanfer & Grimm, 1980). The therapist may plan new behaviours with the patient (Whipple, 1985).

- (b) "The shaggy dog technique" (Haley, 1984). After having announced to the patient that she must carry out a task, the therapist builds tension by using digressions, offering several examples of other patients and generally "beating around the bush".

(5) Disinhibition, desensitization, and habituation. This category includes those operations which permit the patient to try out new ways of being and behaving in the safety of the psychotherapy session.

- (a) "The behavioural experiment". The therapist tells the patient to carry out the new behaviour as "an experiment", that it is "just to try it out", "make

believe" or "not for real". The therapist may also use this operation to catalyze the patient's practicing the new behaviour in the session (See operation 21-- "Practicing the new behaviour").

Examples: In Kelly's fixed-role therapy (Kelly, 1955), the patient is taught a role to play and is instructed to play-act the role outside of therapy until the next session. The therapist assures the patient that even though the patient is trying out new behaviour patterns outside of therapy, that the therapy is structured in such a way that "none of it is for real", that it is "make believe" or "experimental" (Goldfried & Davison, 1976, p. 151). Alternately, the therapist may also use this operation to catalyze the patient's trying out a new behaviour in the session, assuring the patient that "It is clearly a game, a pretense, a play-acting, a mock trial. It is a matter of experimenting with being and behaving...merely trying it out to see how it feels." (Mahrer, 1989, p. 76), "...a playful trying out....Clearly, she is here in the office. No one else is really here. It is fantasy, It is safe because it is not real" (Mahrer, 1989, p. 83), "Come on, pretend. It's not going to happen. Just picture it. You're safe. No one can hear and it's not going to happen" (Mahrer, 1989, p. 85). The therapist may tell the patient that she may enjoy the new behaviour but that she won't be able to ascertain this until she experiments with actually trying it out (Bass, 1984).

- (b) "Practicing the new behaviour". The therapist tells the patient to try out the new behaviour in the therapy session or to try it out in imagination during the session.

Examples: The therapist may tell the patient to "Try it out by giving it a complete dress rehearsal as if she were actually doing it" (Mahrer, 1989, p. 87). The therapist may say, "Then try it out! Go ahead! Rehearse it and see what it feels like! How do you do it? How the hell do you begin?" (Mahrer, 1989, p. 88).

- (c) "Practicing an extreme form of the new behaviour". The therapist directs the patient to fantasize enjoying carrying out an extreme, exaggerated form of the new behaviour.

Examples: In Lazarus and Wolpe's "exaggerated role taking" method, subsequent to a new behaviour having been selected, the patient is asked to think of a well-known person (preferably a film star, royalty, etc.) who possesses the desired behavioural characteristics. The patient is asked to practice this exaggerated role in the therapy session and is then instructed to behave similarly outside of therapy (Lazarus, 1971; Wolpe & Lazarus, 1966). The therapist and the patient may "Invent new behaviors that are wild, outlandish, zany, silly, risky and dangerous, impractical, impossible, and unrealistic" for the patient to rehearse in imagination (Mahrer, 1989, p. 81).

- (d) "Graduation and reassurance". The therapist as psychotherapeutic authority, tells the patient that the patient has successfully practiced or confronted carrying out the new behaviour in therapy and is now

ready to carry out the new behaviour outside of therapy.

Examples: The therapist may tell the patient that the patient now can and should enter situations that correspond to those of a systematic desensitization hierarchy which have been successfully covered in therapy, in that they no longer provoke significant anxiety (Brady, 1972). After the patient has practiced carrying out a new behaviour in fantasy during the session and feels good about it, the therapist may ask the patient what the patient could do outside of therapy now that the patient feels good about the practiced behaviour (Mahrer, 1989).

- (e) "Approaching gradually". The therapist builds the patient up to a behavioural commitment by gradually approaching the idea of carrying out a new behaviour outside of therapy. The therapist accomplishes this through such means as progressing through directing the patient to consider new behaviours, trying them out in imagination, trying them out with the therapist, fine-tuning the potential new behaviours, and ending up with a commitment to carry out the new behaviours outside of therapy.

Examples: The therapist should "overcome [the patient's] uneasiness by gradually lapsing into role playing via a discussion of a hypothetical situation, having the client give a detailed verbal description of what he would say and do in this situation, and perhaps by the therapist casually demonstrating how this response might be role-played. The therapist might say something such as: 'Perhaps instead of telling me what you would do (did) in that situation, I think I would get a better understanding if you showed me what would (did) happen'" (Goldfried & Davison, 1976, p. 141). In Lazarus and Wolpe's "exaggerated role taking" method, the patient is first instructed to practice an exaggerated role in the therapy session and is then instructed to behave similarly outside of therapy (Lazarus, 1971; Wolpe & Lazarus, 1966).

(6) Vaunting the advantages of being/behaving in the new way and the disadvantages of being/behaving the old way. This category includes operations which highlight for the patient how disadvantageous it is to be/behave the way s/he currently does and how advantageous it would be to carry out the new behaviour.

- (a) "Building despair". Prior to considering a new behaviour, the therapist reviews and highlights the gravity of the patient's plight, including enumerating past failures and the patient's present helplessness (Omer, 1985).
- (b) "Highlighting potential positive outcomes". The therapist tells the patient that carrying out the new behaviour will lead to progress, improvement or correction of a patient's problem.

Examples: The therapist may tell the patient that if the patient's taking action may have a corrective effect on the

patient's problem (Montgomery & Montgomery, 1975) or that repeated practice of a new behaviour often leads to progress (Leitenberg, 1972). The therapist may tell the patient that she might enjoy carrying out the new behaviour, but that the only way to tell is to actually try it out (Bass, 1984).

- (c) "Self-observation of positive response to the new behaviour". Subsequent to the patient having tried out the new behaviour in imagination during the therapy session, the therapist tells the patient to direct her attention to good bodily-felt feelings associated with having imagined carrying out the new behaviour. As a corollary, if the imagined new behaviour does not produce good feelings, the therapist tells the patient to modify the new behaviour and retry imagining carrying it out.

Examples: The therapist may tell the patient to pay attention to how her body feels and to see if the patient feels all right, good, merely fair, or bad. The therapist may also tell the patient how the therapist feels when practicing the new behaviour in imagination (Mahrer, 1989).

(7) Therapist provision of punishment or reinforcement. This category includes the therapist punishing or reinforcing the patient, or communicating to the patient (implicitly or explicitly) that therapist punishment or reinforcement will be contingent upon the patient's behaviour.

- (a) "The carrot and stick". The therapist tells the patient that the therapist has the power to create a positive consequence for the patient, but that the therapist will withhold the positive consequence unless the patient agrees to carry out the new behaviour.

Examples: Examples of the "carrot and stick" method include Haley's (1984) "devil's pact" method. In this method, the therapist tells the patient that the therapist has the solution to the patient's problem, but will only tell the patient what it is if the patient is ready to commit herself to doing whatever the therapist tells her to do (Omer, 1985). Along a similar vein, a method used by some behaviour therapists in overcoming resistance to homework assignments is to make a subsequent therapy session contingent upon completion of the assignment (Goldfried & Davison, 1976).

- (b) "Passivity confrontation" (Schiff & Schiff, 1971). The therapist queries the patient as to what the patient is doing right now in order to avoid changing.

Examples: The therapist asks the patient, "What are you doing now to avoid change?" or "So, what is it you want to change?" (Montgomery & Montgomery, 1975, p. 351).

- (c) "Confronting avoidance". The therapist confronts the patient with the observation that the patient is avoiding carrying out therapeutic work and tells the patient that it is necessary to carry out the new behaviour now, not later.

Examples: If the patient is "playing psychiatric history....[in order to] avoid taking immediate steps to deal with his

problem....[then] the therapist might counter with 'what you are telling me is interesting, but at the end of the hour where will we be? You will have told me everything that has happened to you between 7 and 10....but I don't understand how that is going to help you'" (Montgomery & Montgomery, 1975, p. 350). "When a client wants to spend the hour complaining about his circumstances, the therapist can say 'I admit the situation is bad, but what are you doing to change it?' Or 'How do you want to do things differently?'" (Montgomery & Montgomery, 1975, p. 350)

- (d) "Chicken". The therapist either implies or tells the patient directly that the patient is being "chicken"; that the patient is letting her bad feelings get the best of her in not being willing to try the new behaviour. The therapist may teasingly imply that the patient wouldn't ever do such a thing.

Examples: If the patient is resisting carrying out new behaviours, the therapist may tell the patient that the patient "is using his symptoms of fear, confusion, and anxiety to avoid taking decisive corrective action" (Montgomery & Montgomery, 1975, p.351). The therapist may say "Listen, are you really serious about this? You really mean it?" (Mahrer, 1989, p. 88).

- (e) "Contracting". The therapist asks the patient to demonstrate the patient's commitment to carrying out the new behaviour by signing an agreement, contract or plan (McElroen & Faltico, 1977; Whipple, 1985).

(8) Mystification. This category includes operations which mystify the patient into committing themselves to carrying out the new behaviour by piquing their curiosity with a seemingly absurd request.

- (a) "Paradoxical intention". The therapist tells the patient to deliberately try to bring on the feared consequences attached to a new behaviour instead of avoiding carrying out the new behaviour (Agras, 1972).
- (b) "Circumventing motivational deficit". When the patient states that she doesn't want to carry out the new behaviour, the therapist tells the patient to continue to not feel like carrying out the behaviour, but to carry out the behaviour anyhow. The therapist may also tell the patient that the patient can not be sure that she will not enjoy carrying out the new behaviour until she actually tries it.

Examples: "Well, Bob, in light of what you are saying I think I have a strategy that you could use to get yourself to take a shower with Doris this week. Don't want to take a shower with Doris...and take a shower with Doris....[patient reply:] 'But I wouldn't enjoy doing something I didn't want to do'....[therapist:] You may be right about that. But we'll never find out for sure unless you do the experiment. This week, continue to not want to take a shower with Doris and take a shower with her anyway." (Bass, 1984, p. 33).

APPENDIX B

Research Definition of Behavioural Commitment

A statement or series of statements on the part of a patient is/are to be identified and coded as an instance of behavioural intention/commitment if all of the following six criteria are met by the candidate patient statement(s):

(1) The patient has stated or expressed the decision, determination, resolve, intention or commitment to carry out a new behaviour outside of therapy. This includes acceptance of and/or compliance with, therapist suggestions or requests for the carrying out of a new behaviour as well as decisions apparently originating from the patient without direct requests from the therapist. This decision must be expressed by the patient in a manner which conveys a substantial measure of intention to carry out the behaviour. There must exist a reasonable likelihood that the behaviour will actually be carried out.

Excluded should be:

(a) Instances where the patient is merely exploring possibilities, such as "I could..." or "I should...".

(b) Instances where the patient expresses an inability to carry out the behaviour or doubts that s/he will be able or willing to carry out the new behaviour. An expression of inability occurring earlier in the session should be disregarded if then followed by an expressed ability to carry out the behaviour in combination with a substantial measure of intention.

(c) Instances where the patient expresses intention only feebly. Examples of feeble intention are: (a) the patient tacitly accepts a therapist's request for the carrying out of a new behaviour by virtue of making no verbal statement either refusing or accepting the request; (b) the patient merely agrees that "it is a good idea", but makes no statement expressing any determination to carry out the behaviour; and (c) the patient states that s/he will carry out the behaviour, but the statement is unconvincing, flat, unemotional, or otherwise reflecting sufficient reticence that you do not believe that s/he will carry out the behaviour. Examples of such unconvincing patient statements include mere compliance such as "Yeah" or "o.k.", when these are unaccompanied by any other patient statements which would suggest strong intention.

(2) The decision is expressed as being made within the psychotherapy session. Excluded should be patient reports of having decided, between (viz., outside of) therapy sessions, on an extratherapy behaviour change as well as patient reports of having decided on a behaviour change earlier in the session without having verbalized the decision at the time. What is crucial to the definition is that the decision, resolve, intention or commitment have been made in the therapy session; the idea for the new behaviour may have already arisen outside (prior to) therapy.

(3) The "behaviour(s)" referred to by the patient consists of observable actions, such as physical actions and verbal

interpersonal behaviour. "Behaviour", for the present purpose, does not include intentions/commitments to changing attitudes, feelings, or any other non-observable construct. Actions which involve a combination of non-observable actions and observable actions are to be included as constituting occurrences of behaviour change. For example: "P: I'm going to go tell him off, that's what I'll do, and while I'll be doing it, I won't allow myself to get anxious like I usually do."

(4) The behaviour referred to must be reasonably specific rather than so vague as to leave it unclear what is involved or what behaviour would be observable. Agreements to broad, vague, unspecified behaviour changes are excluded from the present definition. An example of a situation which would not be rated as a behavioural intention/commitment: "T: OK. I want to talk to you about changing your eating ritual so it's less logical. P: O.K., if it'll make me better, I'll do it, I'll do anything."

(5) The "behaviour" is qualitatively or quantitatively different from the patient's prior way of behaving in a personally and/or clinically relevant sense, based on the patient's own reports or by your clinical judgment (based on the context of the patient's statements in the session). Judgment that the proposed behaviour is "qualitatively or quantitatively different" is to be based on indications of the patient's actions, behavioural repertoire, or functioning at this point in her/his life, as may be determined from the patient's own reports and/or inferred from her/his statements in the therapy session. That is, "change" implies that the behaviour is new, different or unusual relative to the patient's current functioning and behavioural repertoire. It is not crucial that the general category of behaviour be new; the specific instance of the behaviour may be new. For example, reading a book is not likely a new behaviour for a patient, but reading a specific book prescribed by the therapist, is. Likewise, a patient's being assertive with her boss may be a new behaviour for her, despite the fact that she has been routinely assertive with other people in the past.

"New" behaviours are identified and coded as such irrespective of the raters' value judgments with regards to the said behaviour(s). For example, a patient's decision to have an abortion or to quit her/his job and cloister her/himself, may be viewed by a rater with either disdain or approval, but the fact that a significant behaviour change decision has taken place remains and should be rated as such.

If certain patient utterances have been made which by definition warrant exclusion of the event as a behavioural intention/commitment, but these utterances are followed by utterances indicating a change which would warrant inclusion as a behavioural intention/commitment, the earlier utterances are to be disregarded; in such a case your conclusion should be that there has indeed been an occurrence of behavioural intention/commitment. For example: "P: Oh well, maybe when I get out of school I'll look for a job. [this doesn't count so far] Of course, I've been looking for one in a couple of

places. [this still doesn't count] Oh, I'm going to get a job, by God. After all---a guy getting out of school should be working. My God, a guy almost twenty-six years old. Right now it's sort of a transitional period for me, going to school and what not, but I realize now that the vacation is over and it's time that I took myself by the scruff of the neck and got to work." [this is a behavioural intention/commitment]

APPENDIX C

Instructions to Research Team Members

INSTRUCTIONS FOR JUDGES

1. Read each patient statement to see if the patient is citing (mentioning, defining, naming, identifying) a relatively new behavior that the patient may (or could, is inclined to, might possibly, will probably) do or carry out in the extratherapy world.

Once you locate this, mark down the number of the patient statement from the transcript. If the extratherapy behavior change occurs in just some part of the patient statement, mark down where it occurs in the patient statement.

Here are some helpful suggestions to clarify your work:

- It doesn't matter whether the chances seem relatively low or relatively high that the patient will actually carry out the behavior. Include that statement even if there seems to be a very slight possibility of actually carrying out the behavior, a very slight readiness, intention, commitment. The patient may say, "I would like to give her some roses"... "I think I will give her some roses"... "I think I could give her some roses"... "It would be nice if I gave her some roses." Of course, include patient statements where you believe that there is a low, moderate, or strong degree of likelihood that the patient can or will carry out the behavior, of readiness, intention, or commitment.

- The extratherapy behavior change may be in direct response to what the therapist introduces, requests, or suggests. The therapist says, "I think it would be a good idea if you apply for that job," and the patient says, "Yes, I think I will"... "Right. I'm going to do that." Exclude patient statements where, in your best judgement, there is not even a hint of the patient's actually carrying out the behavior; there is essentially no readiness, intention, or commitment. The patient merely says, "Yeah" or "Uh-huh". You have to make a best guess when you distinguish between "Yeah" and "Yeah, I think I will." There is less need for such hard judgement when you have to distinguish between a mere "Uh-huh" and "Yes, it is a good idea, and I am going to apply for the job tomorrow." Just keep in mind that the extratherapy behavior change may be in direct response to what the therapist introduces, suggests, or requests.

- The extratherapy behavior should be relatively specific, do-able, concrete, explicit, external, observable, rather than quite loose, vague, diffuse, inner, unobservable, abstractly generalized. Exclude patient statements such as, "I am going to try to be more understanding"... "I'm going to take care of myself, be in better shape"... "I can be more tolerant of my Dad cause I guess things are lots different now that Mom's so sick"... "I think I can be more assertive." Exclude general statements such as, "I'll be more in touch with my feelings"... "I'm going to be aware of my reactions"... "I want to have a different attitude toward my brother"... "I think I can be a better parent."

- The extratherapy behavior is one that may occur, in, or the situational context is, the relatively imminent future rather than the vague distance. The time frame is closer to the next days or weeks than many months from now or in the undifferentiated future.

- The extratherapy behavior is one that is judged as relatively new. The patient may have given gifts before, but giving this gift to that particular person in that situational context is something new. As long as the behavior is relatively new, include it. The behavior need not be dramatically innovative. A little bit of newness will do.

- Include patient statements that refer back to the extratherapy behavior change mentioned earlier, and that illuminate some aspect. Fore example, in one statement the patient says, "I'm going to call my Dad and ask him if we can have lunch together; I've never done that." Then, one or two statements later, the patient says, "That would be fun to do... I'd do it just to see what that would be like." Include the later statement because it refers directly to the extratherapy behavior change, and illuminates the readiness, intention, commitment to carrying it out. suppose the patient says, later, "I'll take him to Jack's place cause they have great sandwiches he'll love." Include that statement too. It illuminates and further specifies the extratherapy behavior change mentioned earlier.

- Almost any extratherapy behavior change is one that some therapists might not condone or like or think is good for the patient. Your task is to identify patient statements in which the patient cites a relatively new behavior that the patient may carry out in the extratherapy world. Include the statement quite aside from whether the extratherapy behavior change meets with your full approval as therapeutically desirable for this patient at this time. At the other extreme, there might be a particular extratherapy behavior change that arouses your disapproval or active opposition. In this first step, you are to include these extratherapy behavior changes.

- The extratherapy behavior change may be named in just a few words, or it may be fully described. Include both. The patient says, "I could write my sister, haven't written her in years"... "I could write my sister and explain what's happened to me and Sid over the past 10 years. We're divorced and I remarried. That'll startle her. She'll probably call right away."... "I know. I'll get a wig."... "I know. I'll get a wig. One of those wild things. I know just where to get one, and then I'll wear it to the family reunion. My mother will have a heart attack. A purple wig!"

2. The research team has identified that particular patient statement(s) or part of statements(s) as containing an extratherapy behavior change, with some degree of readiness, intention, commitment, likelihood, resolve, decision, determination to carry it out. You are to identify and to describe what you believe the therapist and the patient did to help bring about that particular patient statement(s) or part of statement(s).

Start with the patient statement or part of statement that was identified as containing the extratherapy behavior change. Go back as far as you believe is necessary, whether you go back just a few statements or much earlier.

You are looking for what the therapist said and did that seemed to be instrumental in helping to bring about that particular patient statement or part of statement. These are therapist operations, methods, techniques, things the therapist said and did.

You are also looking for what the patient said and did that seemed to help. Concentrate especially on what the patient was saying or doing or being like so that, when the therapist did this or that, the particular patient statement or part of statement then occurred. You are looking for the patient condition or state or way of being when the therapist then did this or that.

Usually, you will find that the patient "condition" and therapist "operation" are rather simple. When the patient is in this condition or state or being this way, then the therapist did this or that, and the consequence seemed to be the occurrence of the target, particular patient statement or part of statement. However, it may be more complicated, e.g., when the patient is in this condition or state, and the therapist does this, and when the patient then is in this condition or state and the therapist then does that, then the consequence seemed to be the occurrence of the target, particular patient statement or part of statement.

Type your description. If you would please type your description on a computer, leave a copy of your file, under your name, on one of the diskettes that Robin provided with the transcript in room 608. Please use either WordPerfect 4.2 or 5.0 or if you use another word processor, ASCII Text. In any case, make sure that you hand in your written description for the next meeting of the research team.

Your written description is to indicate-identify which therapist and patient statements, or parts of statements, were instrumental in constituting the patient "conditions" and therapist "operations"

Identify and describe what you believe were the patient conditions and therapist operations. Your description should end with this kind of framework: when the patient is in this condition, in this state, being this way, doing this or that, and when the therapist then does this or that, the consequence seemed to be the occurrence of that particular patient statement or part of statement.

Your written description should be of use to practitioners. Your written description should tell the practitioner that when the patient is being like this, doing this, in this condition, then if you do this or that, it looks like maybe the consequence is this particular kind of extratherapy behavior change, with either slight or substantial likelihood of intention, readiness, commitment, resolve, decision, or determination.

Your written description should be in the practitioner-useful middle ground between loose and general theory and a slavish repetition of what patient and therapist said. Your written description should also be in terms that are relatively free of the jargon or the technical terms of any particular therapeutic approach.

Keep in mind that every patient "condition" is itself a function of something that happened earlier. For example, you may say that the patient condition was when the patient was on the verge of tears. When the patient was being that way, that is when the therapist did this or that, and then the good extratherapy behavior change occurred. The chances are pretty good that something happened earlier that resulted in the patient's being on the verge of tears. Do you start with when the patient is on the verge of tears? Or do you go back earlier? The answer depends on the target extratherapy behavior change. Given that particular extratherapy behavior change, use your best judgement in deciding how far back to go.

Your written description will probably say that here is my description of what the patient and therapist did that helped to culminate in the extratherapy behavior change intention-resolve-commitment-etc. And you will end by saying that the overall principle here is that when the patient is in this condition, being this way, and the therapist does this or that, then that accounts for the extratherapy behavior change possibility-intention-commitment-etc.