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LA THÈSE A ÉTÉ
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A COMPARATIVE ANALYSIS OF THE USE OF
COMMON INITIAL INTERVIEW TECHNIQUES
BY JOSEPH WOLPE AND CARL ROGERS

GARY MICHAEL DURAK

Thesis proposal presented to the
School of Graduate Studies,
University of Ottawa as partial
fulfillment of the requirements
for the degree of Doctor of
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Gary Michael Durak, Ottawa, Canada, 1982.

Curriculum Studiorum

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Abstract

Therapists of differing theoretical orientations have been known to have various techniques in common. A comparison, however, of the specific conditions under which experienced therapists use similar techniques as well as the consequences of these techniques have never been carefully studied, especially in the context of actual therapy sessions. In the present research, five verbatim transcripts of the initial interviews of Joseph Wolpe and Carl Rogers were rated by ten judges, with the intent to identify those techniques common to both therapists and compare the antecedent and consequent conditions of their use of such techniques. Results indicated that in initial interviews, Wolpe and Rogers had one technique in common, that is, both interpreted but under different therapeutic conditions. Specifically, Wolpe interpreted following statements in which patients had their attention focused on the self either in the form of describing the self or informing about the problem. Rogers, on the other hand, interpreted following statements in which patients had their attention focused on the therapist, primarily in the form of accepting what the therapist had said. Consequent to both Wolpe's and Rogers' interpretations, results indicated a "soft" tendency for patients to respond in a similar manner, namely, by accepting what the therapist had said and describing the self. Results were discussed and implications of these findings for practitioners and researchers were explored.

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Introduction To Problem

Psychotherapy research has concerned itself with various comparisons of the different schools of psychotherapy (e.g. Bergin & Strupp, 1972; Bergin & Garfield, 1971; Bergin & Suinn, 1975; Garfield & Bergin, 1978; Gomes-Schwartz, Hadley & Strupp, 1978). In this research, one avenue consists of the comparison of the technical operations of therapists of differing therapeutic approaches. Summarizing a number of such investigations on this issue, Sundland (1977), found that therapists of different theoretical orientations may well use similar techniques. He concluded:

In some respects therapists behave similarly....even though the rationale that they give....may be dissimilar; in other respects therapists behave dissimilarly in ways that are consonant with the theoretical orientation that they hold (p.208).

Likewise, Goldfried (1978) observes similar overlap and recommends study of actual therapist operations with therapists of differing approaches:

It is precisely within the domain of what actually goes on within the counselling or clinical situation that we may find invaluable points of overlap among various therapeutic orientations....I would suggest that we examine different approaches with regard to the intervention strategies used by different therapists, which exist at a level of abstraction somewhere between theory and technique (p.29).

Previous psychotherapy research has compared therapists from a variety of approaches, but rarely has there been comparison between therapists of

client-centered and behavioral orientations. In spite of theoretical differences between the client-centered and behavioral schools, and differences between what they seek to accomplish within an interview, it is at the level of actual therapist techniques that specific differences have yet to be studied. The question is: In what specific ways do client-centered and behavioral therapists compare and contrast with each other in the techniques used in initial therapeutic interviews? Joseph Wolpe and Carl Rogers are taken as leading exponents of these two therapeutic approaches.

Several questions are central to this investigation:

1. What techniques are used by Wolpe and Rogers in their initial interviews, and what are the relative frequencies with which these techniques are used?

For both Wolpe and Rogers, the clinical and research literature will be examined in order to compare what may be expected from the literature with what may be found by studying actual transcripts.

Data answering this first question will permit investigation of the second question which is the major question of the study.

2. For those initial interview techniques used by both Wolpe and Rogers, what are the similarities and differences in the ways in which these common techniques are used? The present study will examine the conditions under which Wolpe and Rogers employ common techniques, and also the consequences or effects of these common

techniques. Although these therapists may use similar techniques, the question is whether Wolpe and Rogers use these techniques in similar or differing ways, and whether or not the consequences or effects of their use of these common techniques are similar or different. This is the major question to which this study is addressed.

There are several reasons for examining these questions within the context of the initial interview: (a) The initial interview has been identified as an important session in its own right, and also as crucial in defining the interactional patternings of the therapist-patient relationship (i.e. Argelander, 1976; Gill, Newman & Redlick, 1954; Kruger, 1976; Love, 1971; Perez, 1968; Wolk, 1967). (b) The techniques used by Wolpe and Rogers in the initial interview have been discussed in the clinical literature, although, as will be indicated, there is little research study of the use of these techniques in the initial interview. (c) From a practical standpoint, verbatim initial interviews of these two therapists are available, especially as compared with the relative unavailability of subsequent interviews.

)

Chapter I

REVIEW OF THE LITERATURE

This chapter reviews the literature with regard to (a) the initial interview techniques of Joseph Wolpe and Carl Rogers and those techniques common to both, and (b) the manner in which each therapist uses common techniques in their first sessions, i.e. the conditions under which common techniques are used and the consequences following these techniques. The following review of the literature addresses these topics.

The Initial Interview Techniques of Wolpe and Rogers

The first intent is to describe the initial interview techniques of Wolpe and those behavior therapists who follow his approach, namely therapists considered as "Wolpean", "desensitization therapists", "reciprocal inhibition therapists", or "conditioning therapists". Second, the intent is to describe the initial interview techniques of Rogers and client-centered therapists. The overall objective is to formulate a composite picture of those techniques which both therapists have in common.

Wolpe's Initial Interview Techniques

In the following section, the initial interview techniques of Wolpe will be described using several sources: (a) the clinical writings of Wolpe; (b) clinical observations of Wolpe's initial sessions; (c) descriptions of what "Wolpean" behavior therapists do in the initial session; and (d) empirical research on Wolpe's initial interviews.

Wolpe's Clinical Writings

The aim of Wolpe's initial session is to determine an accurate "diagnosis" of the patient's complaint, and thereby develop a treatment plan for that patient. Thus, initial interviews for Wolpe are given a unique and special role distinct from other sessions, and the methods used are different from those of subsequent interviews.

The greater part of the initial interview is devoted to a chronicle of the patient's presenting problems. The therapist tries to extract as much detail as possible about precipitating events, giving closest attention to the stimuli that were then acting on the patient ... The next step is to identify factors that aggravate or ameliorate current reactions ... considerable efforts are made to elucidate the social learning contingencies that have influenced and shaped the patient's behavior (Wolpe & Lazarus, 1966, p.24).

In actual practice, the initial interview methods may span the first several sessions depending upon the patient and the nature of the complaint.

The initial interview techniques of Wolpe may be organized into four classes: gathering of information; orientation of the patient; directive procedures; and giving support to the patient. In the following paragraphs, the specific initial interview techniques or procedures which comprise or fall under these four classes will be

presented. These techniques will then be re-described, by the present author, into terms which may also be used for Rogers, that is, to enable a comparison between the initial sessions of these two therapists.

Gathering of Information: In the gathering of information, three basic procedures are followed: (1) conducting a stimulus-response analysis; (2) taking a personal history; (3) administering several questionnaires as homework assignments (Wolpe, 1973; Wolpe & Lazarus, 1966).

To conduct a stimulus-response analysis, Wolpe asks specific questions about the circumstances surrounding the onset of each of the patient's reactions and about the later contingencies of these reactions. For example, Wolpe might ask: "What is the nature of the complaint?" "When did it arise?" "What were the circumstances responsible for it?" Such questions are directed towards securing "... the greatest possible definition in relating stimuli (situations) to the responses that constitute the complaints that have brought the patient to treatment" (Wolpe, 1973, p.29).

When a personal history is taken, Wolpe asks specific questions to derive relevant facts concerning the patient's past and present life, and to explore the content and intensity of the patient's feelings (Wolpe & Lazarus, 1966). In the questioning procedure, several topical areas are covered: early family life, education, sex life, and present social life. To secure the information Wolpe may ask: "How many children were in your family?", "What kind of person was your father?", "Did he show personal interest, did he punish, and if so did it seem just or not?", "Did you enjoy school?", "How well did you do academically?", "What age

did you become aware of sexual arousal?", "When did you first begin to date?".

After the completion of the stimulus-response analysis and the personal history, Wolpe gives the patient three inventories to complete outside of the session: the Willoughby Schedule, a Fear Survey Schedule, and the Bernreuter Self-Sufficiency Scale.

Of these three procedures employed to gather information, only the first two are pertinent to what Wolpe does within the initial therapy session. Wolpe's (1973) professed aim for using these procedures is to gather information directly related to the patient's problem and gather information related to the external situational variables:

...the therapist at once proceeds to explore the patient's neurotic reactions. The circumstances surrounding the onset of each one of these reactions are meticulously examined in the hope of obtaining a coherent picture of its original determinants (p.22)

...When the patient's presenting reactions have been sufficiently explored, the therapist goes into the basic facts of his past and present life (p. 26).

Through his use of such questioning, Wolpe brings into sharper focus details related to the patient's problem and details related to external situations which in themselves may have some bearing upon the patient's problem.

One way to re-describe the two procedures and the distinction between whether the focus is on the patient or something external, is to organize them into two types of verbal techniques or classes of statements made by the therapist:

1. The therapist asks specific questions about the patient and the patient's problem. With this kind of statement, the therapist is directly attending to the patient and the kind of person the patient is; that is, her feelings, problems and complaints. The therapist's focus of attention is on the patient and her problems even if the gathering of information touches upon something external. For example, if the patient refers to headaches, the therapist may say "Tell me more about that" or "Do these occur at home?" or "When these occur what is going on?"

2. The therapist asks questions about, clarifies, illuminates and focuses the patient's attention onto some external situation. With this kind of statement, the therapist is gathering information and asking the patient to give details or facts about some external situation or scene which may have something to do with the patient's problem or the patient's self. Here, the therapist's and patient's attention is less on the patient or the patient's problem but primarily on some external scene. For example, if the patient refers to her mother, the therapist may clarify and ask "How old was she?" or "What was she like?"

Orientation of the Patient: When Wolpe orients the patient he appears to have two general aims: (1) giving information to the patient about the therapy process (Wolpe & Lazarus, 1966), and (2) giving information to the patient about the nature of the problem (Wolpe, 1973).

When giving information about the therapy process, Wolpe will teach, explain, provide examples or give short speeches about the practices of behavior therapy. He might tell the patient how behavior therapy will help, its strategy, its goal, its philosophy and theoretical underpinnings.

The behavior therapist schools the patient to realize that his unpleasant reactions are due to emotional habits that he cannot help...the overcoming of a human neurosis is within the control of the therapist through techniques quite similar to those used in the laboratory

(Wolpe & Lazarus, 1966, pp.16-17).

In giving information to the patient about his specific problem, Wolpe (1973) may assure the patient that his symptoms are reversible; he explains how the patient's reactions were learned and even provides examples of that specific learning process.

One way to re-describe what Wolpe does when providing information about the therapy process is to say that he introduces and structures therapy. This is accomplished by telling the patient about the therapy process and what can be achieved. Giving information about the nature of the problem may be re-described as the therapist telling the patient about the patient, what he is like and what his problem is like. Thus, the techniques that Wolpe uses in orienting the patient in the initial interview may be described as: (1) structuring and introducing therapy; and (2) telling the patient what the patient

and the patient's problem are like.

Directive Procedures: The procedures listed under this heading include what Wolpe (1973) calls: (1) correcting misconceptions; (2) beginning assertive training procedures; and (3) beginning systematic desensitization procedures.

Correcting misconceptions consists of Wolpe providing the patient with authoritative information about the nature of the problem. Wolpe may tell the patient that her thinking is wrong, and that she has the wrong information and ideas (Wolpe, 1958, p.199). In convincing the patient, Wolpe may provide evidence, or explain about the psychological or physiological "facts" of a specific reaction. He may suggest other causes, dispute the patient's interpretations, indicate new relationships and give advice. For example, Wolpe (1973) may say: "You are not mentally ill and there is no chance of your going insane." "All your reactions are explicable." "There is no virtue in confronting your fears" (pp.56-57). "It is not a mental illness, it is a bad emotional habit..." (Wolpe & Reyna, 1970, p.12). To convince a patient that she was not mentally abnormal..."the behavior therapist had to employ every resource of reason and demonstration and the full force of his own prestige to persuade her that she was in truth a normal person who had become disabled by neurotic conditioning..." (Wolpe & Lazarus, 1966, pp.131-132).

In correcting misconceptions, Wolpe in effect (1) directly tells the patient about the patient's self, about her feelings, her thoughts, her reality, her interpersonal relationships, her problem.) Moreover, Wolpe (2) directly tells the patient about external reality and what

external reality is like. In doing this, Wolpe is the authoritative interpreter of external reality.

Assertive training may commence in the first session: "...it is frequently introduced early in therapy, right after the conceptual aspects of the patient's complaints have been put into perspective" (Wolpe, 1973, p.80). Assertive training includes giving instructions and behavioral prescriptions for the patient to carry out. He teaches the patient what to do in certain situations and rehearses these behaviors with the patient. To find the proper situational context within which the assertive training behaviors are to take place, Wolpe collects information. He asks the patient for an example of a particular situation in which the patient had hurt feelings and inquires into the kinds of feelings and behaviors the patient encountered in a particular situation. The questions asked may be of the sort: "What do you do if this happens?", "How would you handle this kind of situation?", "Describe a scene where you felt like this?" (Wolpe, 1973).

As previously stated, this line of questioning may include focusing attention on the patient and the patient's problem, or attention may instead be focused on some external situational context. As stated earlier, this context does not necessarily have to be related to the patient's problem.

At times, the patient may be reluctant to engage in the assertive training; thus "...before assertive training can begin, the patient must accept its reasonableness" (Wolpe, 1973, p.83).

In effect, when Wolpe begins assertive training, he may be described as using three techniques: (1) Structuring and introducing the session--this is accomplished by directly telling the patient what she is to do in

the session and what her role is as a patient. He may also tell the patient about the effects of the treatment, its advantages and disadvantages. (2) Asking the patient to provide data about herself or the problem. (3) Clarifying or gathering information about some external situational context. Wolpe may accomplish this by asking the patient to provide information about some external situation or give a description of it.

In the initial session, Wolpe may also begin the procedure of systematic desensitization, especially when the root of the problem seems to be diagnosed adequately. When this occurs, two techniques are used. Wolpe might first structure the situation. He may tell the patient about or introduce the desensitization process, its advantages and rationale, and he may give instructions for relaxation. Secondly, Wolpe may ask the patient to provide relevant factual data about herself and the hierarchy of anxieties she experiences, i.e., the degree of anxiety associated with specific scenes (Wolpe & Lazarus, 1966.) This procedure requires the focusing of his attention on the patient.

Furthermore, in his directive questioning, Wolpe may focus his and the patient's attention onto some external situation not necessarily related to the patient's problem, or focus on a scene which may, to some degree, give information about the patient and the patient's problem.

In carrying out these directive procedures, the therapist may be described as using the following initial interview techniques: (1) the therapist talks to the patient about the patient and asks the patient to provide data about what the patient or her problem is like; (2) the therapist authoritatively tells the patient what the patient or her problem is like;

(3) the therapist authoritatively tells the patient what external reality is like; (4) the therapist structures the session and tells the patient what to do, he describes the process and the benefits of therapy; and (5) the therapist illuminates external situations or scenes, not necessarily related to the problem, and asks the patient to provide data about these external scenes.

Giving Support to the Patient: When providing support to the patient Wolpe seeks to develop a particular kind of therapeutic atmosphere. Although this therapeutic atmosphere is more of a non-specific factor in the overall treatment process (Bergin & Lambert, 1978; Frank, 1973; Truax & Carkhuff, 1967; Wandersman, Poppen & Ricks, 1976; Wolpe, 1976), it is considered important to construct supportive conditions through the therapist's permissiveness, approval, warmth and acceptance of the patient.

...All that the patient says is accepted without question or criticism. He is given the feeling that the therapist is unreservedly on his side...

(Wolpe, 1958, p. 106).

In developing this atmosphere, Wolpe may be described as: (1) simply giving verbal acknowledgment of the patient's statements; or (2) giving permission-approval-encouragement for the patient to continue to talk. In effect, the therapist conveys to the patient that it is acceptable to speak about what he is speaking about. (3) Wolpe may tell the patient in an accepting manner, what external reality is like. The therapist is the authority, interpreter or explainer of what that external thing or situation is really like.

For example, when the patient shamefully recounts an extramarital love affair it is sincerely pointed

out that there is no reason for shame, because factors in the circumstances make it a natural thing to happen (Wolpe, 1958, p.106).

Furthermore, Wolpe may (4) ask more questions to indicate that he approves and that it is appropriate for the patient to continue to talk about that. For Wolpe, the existence of this supportive atmosphere is an important part of therapy (Patterson, 1968). However, the techniques used in establishing this atmosphere in the initial interview, are given little attention in his writings.

Observations of Wolpe's Initial Interviews

To identify potential initial interview techniques Wolpe might also use, the present research consulted several reports which describe his therapy sessions. These reports however, did not limit their observations to his initial interviews alone.

Brown (1967) observed Wolpe at work in both initial and later sessions. He pointed out that in the initial interview, a complete history is taken with Wolpe asking many specific and direct questions. To gain further information, Wolpe often repeats the last word of a patient's sentence in a somewhat puzzled manner. He responds with "uh-huh" and "good" when he feels these are appropriate. After the history is taken, Wolpe explains the process of therapy. During the first part of the session, advice may be given, sentences paraphrased, and general comments expressed.

Klein, Dittmann, Parloff and Gill (1969) observed Wolpe, along with other behavior therapists, in interviews which occurred at various points along the duration of treatment but they did not specify if the initial interview was observed. Assuming it was, these therapists were described

as using assertive training, systematic desensitization, and education in learning principles. Suggestion was used in the orientation period of treatment: "...the therapist tells the patient at length about the power of the treatment method, pointing out that it had been successful with comparable patients and all but promising similar results for him too" (p.260). The therapists were further described as approaching the patient in an explicit, positive and authoritative manner. They provided a learning theory formulation of the problem and a rationale for the way in which the treatment would work. The therapists corrected misconceptions and clearly laid out the treatment plans and goals.

Locke (1971) examined unspecified writings and various transcript excerpts of Wolpe, and organized his methods as follows:

- (a) convincing the patient that he can be helped by (behavior) therapy;
- (b) identifying the patient's irrational beliefs, values, and fears;
- (c) providing the patient with new knowledge and/or values;
- (d) helping and persuading the patient to act on this new knowledge; and
- (e) teaching the patient how to relax in the presence of formerly frightening situations (relaxation training, imagining situations, etc.) (p.324)

Furthermore, Locke notes that Wolpe offers reassurance, encouragement and clarification.

The descriptions in these reports are in essential agreement with

what Wolpe states he does in the initial session. However, it is not clear whether these reports included data from initial interviews. With this drawback in mind, it may be concluded that Wolpe, in his initial interview, may also use two additional techniques. First, Locke (1971) and Brown (1967) point out that Wolpe paraphrases, repeats last words, and clarifies. Maneuvers like these are generally labeled as "reflections". Thus, reports suggest that Wolpe may use reflective-type statements, although this is not discussed in any length in his writings. Secondly, these reports (Brown, 1976; Locke, 1971) suggest that Wolpe may give advice, persuade the patient to act differently or consider changing his behavior in a particular manner. That is, the therapist talks to the patient and gives advice about potential behavior or personality change. To the extent that the above reports reflect Wolpe's initial interview behavior, then, these two techniques may be expected to occur in his initial sessions.

Based upon the clinical writings of Wolpe and observations of his therapy sessions, the present investigator concludes that in initial sessions, Wolpe may use the following techniques:

1. The therapist tells the patient what the patient and his problem are like. He tells the patient about the patient.
2. The therapist draws the patient's attention onto an external situational context and asks for information about that external situational context.
3. The therapist asks the patient to provide data about what the patient or problem are like.

4. The therapist structures or introduces the therapy session. The therapist tells the patient what the patient is to do, and may include a rationale of the therapy process and a description of the benefits of therapy.
5. The therapist gives approval-permission-encouragement for the patient to talk or continue talking.
6. The therapist gives simple acknowledgement of what the patient says.
7. The therapist tells the patient what external reality is like.
8. The therapist says what he believes the patient is saying, that is, he reflects what the patient says.
9. The therapist gives advice to the patient about potential personality-behavior change.

Frequency of Occurrence of Wolpe's Initial Interview Techniques

A careful description of the techniques used by therapists may include an examination of the frequency with which given techniques are used (e.g. Becker & Rosenfeld, 1976; Stoten & Goos, 1974; Strupp, 1955, 1957; Zimmer & Pepyne, 1971). Thus, in addition to investigating the kinds of techniques used by Wolpe in the initial interview, this study will be concerned with the frequency with which these techniques are used.

Wolpe does not discuss directly the frequency with which his particular techniques are employed. However, there are clear implications that a considerable amount of time, in the initial interview, is dedicated to gathering data (Wolpe & Lazarus, 1966, p.24). Wolpe may spend a large

proportion of the initial interview asking questions directly about the patient and his problem, or asking questions about some external situational context the patient refers to. Furthermore, but less clearly stated, his writings (Wolpe, 1973; Wolpe & Lazarus, 1966) suggest that he may spend a moderate amount of time in the initial interview informing the patient about the patient's problem and the patient's self as well as providing other kinds of sheer information. The extent to which all other techniques are used is not discussed. His writings provide a general outline of what to do in the initial session, but specification of the frequency of use of a particular technique is missing. Also, the writings about Wolpe do not shed light on this question, and observations of Wolpe in therapy (e.g. Locke, 1971; Brown, 1967; Klein et.al., 1969) do not provide data on the extent to which a particular technique is used in the initial session.

Accordingly, one purpose of the present study is to answer the following question: What techniques are used by Wolpe in initial interviews, and what are the relative frequencies with which these techniques are used?

Initial Interview Techniques of Wolpean Therapists

Considered at this point is the question whether there exists other initial interview techniques which Wolpe may possibly use that are typical or representative of behavior therapists adhering to his brand of therapy (e.g. Wolpe, Salter & Reyna, 1964). While Wolpe may represent only one stream of behavior therapy (e.g. systematic desensitization, conditioning, or reciprocal-inhibition), there does not seem to be any one explicitly designated school that clearly follows his methods alone throughout the

therapy process or specifically in the initial interview. Wolpe's treatment of the initial interview appears quite similar to the initial interview procedures characteristic of many behavior therapies.

In general, it is customary, in the initial interview, for many behavior therapists to gather information through a stimulus-response analysis, through careful questioning about the patient's problem and the external situational factors, and through questionnaires (Franzini, 1970; Hersen & Bellack, 1976, 1978; Kanfer & Saslow, 1969; Lazarus, 1972; Liberman, 1972; Mash & Terdal, 1976). Behavior therapists often structure the initial interview through explaining the therapy process, and by giving instructions and advice to the patient. The therapist tells the patient about the patient's problem and tells about the external situation as he explains the patient's problem to the patient. To help encourage the patient's self-reporting and reduce the patient's anxiety level within the session, the behavior therapist may reflect, give permission-approval, and give acknowledgement to what the patient says (Dangrove, 1972; Fensterheim, 1972; Klein, Dittmann, Parloff & Gill, 1969; McGlynn, 1978; Morgans, 1976; Rimm & Masters, 1974). These techniques are similar to those used by Wolpe in the initial interview.

Empirical research corroborating behavior therapist's use of these explicit techniques in the initial interview cannot be found, since most research has been on other than the initial interview. However, in the initial interview (Fisher, Paveza, Kickerts, Hubbard & Grayston, 1975) as well as other interviews (Brunink & Schroeder, 1979; Ford, 1978; Mitchell, Bozarth & Krauft, 1977; Sloane, Staples, Chistol, Yorkston & Wipple, 1975a, 1975b, 1976), behavior therapists have been found to

engage in practices commonly associated with such labels as empathy, genuineness, warmth, as well as directiveness. Yet, these data are global and neither the actual techniques nor their frequencies are clearly specified. Thus, no hard research is available which allows a direct comparison of the initial interview methods of behavior therapists in general and the initial interview methods explicitly used by Wolpe.

Wolpe's Initial Interview Techniques: Empirical Research

Empirical research on Wolpe's initial interview techniques is rare, but there is, perhaps, one indirect examination. In a dissertation, Becker (1975) used two initial interviews by Wolpe as training materials for raters for a research problem unrelated to the present study. Nevertheless, his training findings appear to offer perhaps the only available data on the actual initial interview techniques used and their relative frequencies. According to Becker, Wolpe gathered data by asking factual questions 53.25% of the time and rhetorical questions 7.35% of the time. He spent a large proportion of his time teaching and giving information to the patient about the patient's self and external reality (25.2% of the time). These three techniques accounted for 85.8% of his activities in the initial interview and further support the clinical writings of Wolpe. Thus, in the initial interview Wolpe may be expected frequently to ask for data about the problem or external situation. He can be expected, with moderate frequency, to tell the patient about the patient and tell the patient about external reality.

Wolpe's Initial Interview Techniques: Summary

Rather extensive clinical literature has discussed the techniques used by Wolpe and Wolpean therapists in the initial interview. On the

basis of this clinical literature, together with one preliminary study (Becker, 1975), it is suggested that the following techniques are used:

1. The therapist tells the patient what the patient and his problem are like. He tells the patient about the patient.
2. The therapist draws the patient's attention onto an external situational context, and asks for information about, clarifies and illuminates that external situational context.
3. The therapist asks the patient to provide data about what the patient or problem are like.
4. The therapist structures or introduces the therapy session. This includes telling the patient what the patient is to do, providing a rationale of the therapy process, and describing the benefits of therapy.
5. The therapist gives approval-permission-encouragement for the patient to continue talking.
6. The therapist gives simple acknowledgement of what the patient says.
7. The therapist tells the patient what external reality is like.
8. The therapist says, or reflects, what he believes the patient is saying.
9. The therapist gives advice to the patient about potential personality-behavior change.

Of these initial interview techniques, which are used most frequently? On this question, the extensive clinical literature and single preliminary research study (Becker, 1975) suggests that the following will be more frequently used in the initial interview:

1. The therapist asks the patient to provide data about what the patient or problem are like.
2. The therapist talks to the patient about the patient and tells the patient what the patient and his problem are like. He tells the patient about the patient.
3. The therapist draws the patient's attention onto an external situational context and asks for information about, clarifies and illuminates that external situational context.
4. The therapist tells the patient what external reality is like.

In order to compare and contrast Wolpe's and Rogers' initial interview techniques, the following section focuses on those techniques used by Rogers in the initial interview.

Rogers' Initial Interview Techniques

In the following section, the initial interview techniques of Rogers' will be described using several sources: (a) the clinical writings of Rogers; (b) descriptions of the initial sessions of client-centered therapists, and (c) empirical research on Rogers' initial sessions.

Rogers' Clinical Writings

For Rogers (1942), "...counselling treatment may begin at once, in the first contact, without a diagnostic study...this procedure is entirely justified if the counselor is alert to the crucial aspects of the picture as they are revealed during the initial interview" (p.82). Furthermore, "in a true counselling process, the individual is much more likely to reveal the genuinely dynamic forces in his experience, the patterns of his life behavior, than in a more formal history taking process" (p.83). Thus, in contrast to Wolpe's treatment of the initial interview, there is no explicit emphasis upon a formal diagnosis, case history, nor the systematic gathering of information about the patient. Additionally, there seems to be no distinction between the goals of the initial session and all other sessions. Rogers apparently conducts all his interviews in a similar fashion. Thus, all the methods he purports to use in therapy may be considered as occurring in initial interviews.

The bulk of Rogers' (1942, 1951, 1957, 1961; Rogers, Gendlin, Kiesler & Truax, 1967) techniques in the initial interview may be discussed under the three general headings of genuineness, empathy, and unconditional positive regard. Most of what Rogers does in the initial interview may be considered to represent some facet of these three conditions. For Rogers (1957) these three headings represent the necessary and sufficient therapist "facilitative conditions," "attitudes," "qualities," and "methods" which lead to personality change.

The following section presents a description of these three therapist conditions, especially emphasizing the specific initial interview techniques used by Rogers to bring these conditions about.

Genuineness: . The first condition states that the therapist is genuine, congruent, open, and transparent to the patient. In this capacity, Rogers (1957) is "...freely and deeply himself, with his actual experience accurately represented by his awareness of himself. It is the opposite of presenting a facade, either knowingly or unknowingly" (p.97). In regard to explicit techniques, Rogers states "...I would try to be aware of my own feelings and express them as my feelings without imposing them on him. I would express even negative feelings. I might tell a client: 'I'm bored by what you're saying' " (Evans, 1975, p.26). Rogers (1957) is being genuine when he resorts to the method of "...being himself even in ways which are not regarded as ideal for psychotherapy. His experience may be 'I am afraid of this client' or 'My attention is so focused on my own problems that I can scarcely listen to him'. If the therapist is not denying these feelings, but is able to be them (as well as being his other feelings), then the condition we have stated is met" (p.97).

Accordingly, when Rogers is genuine in the initial interview, he is expressing and disclosing to the patient his own feelings, thoughts, fantasies, and experiences. He is voicing them, if appropriate, and expressing them in some behavioral way (Evans, 1975, pp.19-20; Rogers, 1961, 1970, p.53). He is making a statement to the patient, but in a sense he is "owning" that statement since the content of that statement originates from within himself. Genuineness, then, is conveyed by disclosing or expressing to the Patient, information about the kind of person the therapist is. In doing this, the therapist may tell the patient about his own fantasies, thoughts, and feelings on matters of concern to the patient. He may also acknowledge his perceptions and misperceptions.

Empathy: The condition of empathy has been described as the therapist's sensing the patient's private world; recognizing and clarifying the patient's feelings; accepting and being permissive of these feelings; exploring the patient's feelings; and encouraging their free expression (Rogers, 1942, 1957).

An important procedure used to communicate the therapist's sense of the patient's world is commonly referred to as reflection of the patient's feelings and attitudes: When reflecting, Rogers expresses and communicates to the patient what the patient is trying to express; he articulates for the patient the patient's inner attitudes, unformulated feelings and bodily-felt meanings (Gendlin, 1972, p.337; Rogers, 1957, p.99). Reflections, then, include the therapist saying to the patient what he believes the patient is saying, feeling or meaning.

As Rogers (1942) assists the patient in the recognition and clarification of feelings, he may, at times, step slightly beyond a reflective-type statement and toward the realm of interpretative statements (Staines, 1969).

Under certain conditions, it is possible to interpret to the client some of the material which he has been revealing. When the interpretation is based entirely upon statements which the client has made, and when the interpretation is merely a clarification of what the client has already perceived for himself, this type of approach can be successful (Rogers, 1942, p.196).

Interpretations are given:

...by clarifying the new understandings at which the client has arrived...in helping the client to explore and recognize the choices, the possible courses of action which lie before him. The counsellor may, in addition, suggest relationships or patterns of reaction which seem to be evident in material which the client has freely stated (Rogers, 1942, p.204).

Accordingly, Rogers uses statements in which the therapist tells the patient what the patient is like, what the problem is, what the patient's relationship to the self is, what his perceptions of reality are, what his thoughts are, and what his external world is like. Rogers (1942) may use such phrases as "you feel pretty bitter about this," "you want to correct this fault but still you don't want to" (p.38), "you feel you should go into commerce but music is the thing you really like," "in spite of your bitterness toward your father, you do like him," "you want to come for help, yet still, at times, you feel it is too difficult" ...(p.147). Although Rogers in the initial interview may sometimes use what might be called interpretations, his writings indicate that he does not intend this to be a major way to express empathy.

Unconditional Positive Regard: This condition consists of accepting the client as a separate person without judging or evaluating her. It is an unconditional acceptance of the patient and a creation of a non-threatening atmosphere:

It is at the opposite pole from a selective

evaluating attitude... 'You are bad in these ways, good in those.' It involves as much feeling of acceptance for the client's expression of negative, 'bad', painful, fearful, defensive, abnormal feelings as for his expression of 'good', positive, mature, confident, social feelings, as much acceptance of ways in which he is inconsistent as of ways in which he is consistent. (Rogers, 1957, p.98)

What the therapist actually does to bring about this condition is generally stated in terms of what the therapist does not do. For example, the therapist does not voice statements which pass judgement, show evaluation, or express disapproval (Rogers, 1957). However, one way the therapist does express this general acceptance is by means of simple acknowledgement, approval, and recognition. These might take the form of the therapist saying "un-hum," "Mmm-Hmm," "yes," and "go on."

Acceptance and positive regard are communicated by a sensitive framing of the patient's ongoing feelings, explicit and implicit meanings. That is, inherent in proper reflections are acceptance and positive regard. In both proper reflection and in talking to the patient about the kind of person the patient is, Rogers conveys positive regard by indicating "...you can be self directing... your feelings are natural" (Rogers, 1951, p.50).

In summary, the clinical writings of Rogers indicate that he makes no distinction between his therapy behaviors whether he is conducting an initial interview or conducting subsequent interviews. Therefore, the techniques which comprise his style of therapy can be assumed to occur in

his initial session. Thus, in initial interviews, Rogers may be expected to use the following explicit techniques in establishing the facilitative conditions of genuineness, empathy and positive regard:

1. The therapist tells the patient about the kind of person the therapist is, his thoughts, his feelings, his perceptions.
2. The therapist says, or reflects, what he believes the patient is saying or meaning.
3. The therapist gives simple acknowledgement of what the patient says.
4. The therapist tells the patient what the patient's problems, feelings, thoughts, reality and relationships are like. He tells the patient about the patient.

Frequency with which Rogers uses initial interview techniques:

Rogers' writings about his own conduct of therapy do not indicate the frequency with which he may use any of these particular techniques in the initial interview. The only statement of this nature which could be found relates to "structuring" and how infrequently it is used (Rogers, 1942, p.91; Rogers, 1951, p.69). His writings imply, however, that in all his interviews, including the initial session, the technique of reflecting or restating is used to a considerably higher degree than most other techniques (Rogers, 1942, 1951). The frequency with which techniques, other than reflections, are used in the initial interview is not clear. Neither do those individuals who describe the therapy and techniques of Rogers (e.g., Hart & Tomlinson, 1970; Rogers, Gendlin, Kiesler & Truax, 1967) give clear indication of these fre-

quencies, but they do imply that reflections in general are used often. It is therefore one of the aims of the present research to provide data on this issue, specifically in relation to the initial interview.

Initial Interview Techniques of Client-Centered Therapists

To contribute to the formulation of possible techniques Rogers might use in his initial sessions, the literature regarding which techniques client-centered therapists use in their initial interviews will be consulted.

Unfortunately however, it appears that only one study exists which at a general level, looks at what client-centered therapists do in initial sessions (Fisher et al. 1977), while most other research has studied subsequent sessions (i.e. Ashby, Ford, Guerney & Guerney, 1966; Cartwright, 1966; Gomes-Schwartz & Schwartz, 1978; Rogers et al., 1967; Seeman, 1949; Snyder, 1945; Stiles, 1979; Strupp, 1955, 1958). Together, these studies indicate that similar to Rogers, client-centered therapists also express such conditions as genuineness, empathy and warmth in their therapy sessions. Although not in the initial interview, Stiles (1979) found that client-centered therapists frequently use techniques of reflection and simple acknowledgement, while self-disclosing techniques were used moderately. Techniques which may be classed as interpretative were used infrequently. Since the bulk of this research literature is not specific to initial interviews, it is not clear whether client-centered therapists, in first sessions, would perform in the manner found by Stiles. However, the literature is in essential agreement with the clinical writings of client-centered therapists; that is, writings suggesting which techniques should be used in client-centered therapy sessions (Carkhuff & Berenson, 1967; Gendlin, 1966; Rogers, Gendlin, Kiesler & Truax, 1967; Truax & Carkhuff, 1969).

As a result, it appears that client-centered therapists use similar techniques as those suggested in Rogers' clinical writings and it appears that the client-centered literature does not indicate the use of other techniques, unlike the ones already predicted.

Rogers' Initial Interview Techniques: Research Literature

There exists a small body of empirical research which has studied Rogers in various initial interviews and has identified the techniques he used as well as the frequency with which he used them. Strupp (1957), found Rogers to reflect slightly less than 70% of the time, engage in minimal activity slightly less than 10% of the time, and give opinions 15% of the time. Stiles and Sultan (1979), found Rogers to use the same three techniques, but with more variability. It was found that Rogers reflected only 13.2% of the time but acknowledged 47.1% of the time. Furthermore, Rogers was found to give information to the patient 19% of the time and self-disclose only 1.3% of the time. Hill, Thames and Rardin (1979) studying a different initial interview found results similar to Stiles and Sultan (1979). In this interview, Rogers reflected and restated 18% of the time, acknowledged 53% of the time, interpreted and gave information 14% of the time and self-disclosed only 1% of the time. Studying the same interview as Hill et.al. (1979), but with a different system of content analysis, Stoten and Goos (1974) found Rogers to interpret and give opinions to the patient 32.3% of the time.

Based on this research literature, it may be concluded that Rogers primarily uses three of the four initial interview techniques suggested in his clinical writings. In this regard, Rogers says what he believes the patient is saying, that is, he reflects and restates (Hill et.al.,

1979; Stiles & Sultan, 1979; Strupp, 1957; he acknowledges and encourages (Hill et.al., 1979; Stiles & Sultan, 1979; Strupp, 1957); and he tells the patient what the patient is like, that is, he interprets, provides information and gives opinions (Hill et.al., 1979; Stiles & Sultan, 1979; Stoten & Goos, 1974; Strupp, 1957). It appears that the extent to which Rogers self-discloses in initial sessions is minimal (Hill et.al., 1979; Stiles & Sultan, 1979).

In light of such empirical research, the intention of the present study is not necessarily to add to this literature, but rather identify the initial interview techniques used by both Wolpe and Rogers in order to compare their use of these important techniques.

Rogers' Initial Interview Techniques: Summary

Based primarily on the clinical writings of Rogers and empirical research of his initial sessions, it is expected that in the initial interview Rogers will use the following techniques:

1. The therapist says or reflects what he believes the patient is saying, feeling or meaning. This technique is expected to be used frequently in the initial interview.
2. The therapist gives simple acknowledgment of what the patient says. This technique is suggested to be used frequently in the initial interview.
3. The therapist tells the patient what the patient's problems, feelings, thoughts, reality and relationships are like. He tells the patient about the patient. This technique is purportedly used with moderate frequency in the initial interview.
4. The therapist tells the patient about the kind of person the therapist is, his thoughts, his feelings, his perceptions. This technique is held to be used, but with low frequency in the initial interview.

One of the major purposes of the present study is to examine whether there are any techniques used in the initial interview by both Rogers and Wolpe. If any techniques are used by both therapists, the second and primary purpose is to examine similarities and differences in the ways these techniques are employed, i.e., in the antecedent conditions and consequent effects of these common techniques.

Initial Interview Techniques Common to Wolpe and Rogers

It seems reasonable to suggest from the literature review thus far, that both therapists may spend considerable time providing, in some form or another, information about the patient to the patient. This technique might well be in the service of correcting misconceptions (Wolpe, 1973; Wolpe & Lazarus, 1966), giving opinions or interpreting (Hill et. al., 1979; Rogers, 1942; Stiles & Sultan, 1979; Stoten & Goos, 1974; Strupp, 1957).

The findings of Becker (1975) support such an expectation. In his research, two initial interviews of Wolpe and two of Rogers were studied using therapist categories derived from a Rational-Emotive orientation. Nevertheless, Becker found that Wolpe, 25.10% of the time and Rogers, 14.9% of the time shared a technique in which the therapist provided information and opinions to the patient, the nature of which largely included information about the kind of person the patient is and the kinds of problems the patient has.

The present investigator has described a technique of this nature as simply the therapist telling the patient what the patient is like. Specifically, this includes the therapist telling the patient about the patient's feelings, thoughts, relationships, the kinds of problems he has

as well as the kinds of reactions he may have. In essence, the therapist is the authority and explainer of reality to the patient, focusing primarily on the kind of person the patient is.

In addition to Wolpe and Rogers sharing this technique, it may be that both therapists also share the techniques of reflection and acknowledgement. While these two techniques are used by Rogers, there exists clinical descriptions of Wolpe's sessions as well as sessions of other behavior therapists which suggest that similar techniques might also be used by Wolpe (Brown, 1974; Fisher et.al., 1975; Lazarus, 1972; Sloane et.al., 1975a, 1975b; Rimm & Masters, 1974; Wolpe, 1976).

Consequently, one of the major purposes of the present research will be to compare the initial interview techniques of Wolpe and Rogers in order to identify those techniques used by both therapists and compare how each therapist uses such techniques. The literature cited above suggests that Wolpe and Rogers will have at least one technique in common, namely: telling the patient what the patient is like.

Antecedent and Consequent Conditions of Initial
Interview Techniques Common to Wolpe and Rogers

In psychotherapy research a major concern is to identify those therapy techniques that work and to study the conditions under which they work. In part, to address such an objective, an investigation might include study of the antecedent and consequent conditions of important therapy techniques, namely those shared by experienced and competent therapists (Bergin & Strupp, 1970, p.22; Goldfried, 1978; Kiesler, 1965; Lambert & Bergin, 1976; Mahrer, 1979). As such, the major purpose of this research is to compare and contrast how Wolpe and Rogers, experienced therapists of differing psychotherapeutic orientations, use similar initial interview techniques. In this pursuit two questions are central: (a) Under what conditions do Wolpe and Rogers use the same initial interview techniques, that is, what kinds of patient responses precede their use of common techniques? (b) What are the consequences or in-therapy outcomes of Wolpe's and Rogers' use of common techniques? That is, how do patients respond, or what kinds of statements do patients make subsequent to such techniques?

Since the actual common techniques in the initial interviews of Wolpe and Rogers are not yet known, the specific antecedent and consequent conditions cannot be predicted. The following sections, however, will review the literature with regard to the antecedent and consequent conditions of those techniques which the previous clinical and research literature anticipates may be common to both Wolpe's and Rogers' initial sessions, namely, telling the patient what the patient is like, reflection, and acknowledgment.

Antecedent Conditions of Common Initial Interview Techniques

Antecedents of Rogers' Common Techniques: To the present author's knowledge, neither the clinical writings of Rogers nor empirical research address the issue of specific antecedent conditions of his use of reflections, acknowledgement or telling the patient what the patient is like.

There are no data which specify the conditions under which Rogers would use these particular techniques.

Although not central to the issue in question, the following literature does provide a basis for formulating a general expectation. Rogers claims that his aim in therapy is to "recognize" the patient's ongoing feelings regardless of the manifest content of the patient's words. His claim implies that recognition techniques, such as reflection, acknowledgement and telling the patient about the patient (Rogers 1942), are not used in a manner "favoring" or "reinforcing" certain kinds of patient responses or statements.

Primarily the counselor endeavors to respond to, and verbally recognize, the feeling content, rather than the intellectual content, of the client's expression. This principal holds, no matter what the type of emotionalized attitude-negative attitudes of hostility, discouragement, and fear, positive attitudes of affection and courage and self-confidence, or ambivalent and contradictory attitudes. This approach is sound whether the client's feelings are directed toward himself, toward others, or toward the counselor and the counseling situation (p.173).

Truax (1966) however, provides data contrary to Rogers' claim. In a rare investigation of antecedent conditions, Rogers' use of empathic, accepting and directive responses were found to be differentially linked to identifiable kinds of patient statements. Specifically, Truax found that following statements in which the patient was expressing insight, expressing problems, talking about the self, or speaking in a manner similar to the therapist, Rogers tended to be empathic and understanding, but when the patient showed a lack of clarity, Rogers tended to be directive. Truax concluded that Rogers is selective and reinforces certain kinds of patient statements over others.

Truax's findings, along with Rogers' claim, set up competing expectations: (a) Rogers will be empathic and accepting on a selective basis and may reflect, acknowledge, or tell the patient about the patient following only certain kinds of patient responses and (b) Rogers' recognition of patient's feelings will be on a non-selective basis. That is, his use of such techniques as reflection, acknowledgement and telling the patient about the patient will be evenly distributed across various kinds of patient responses.

Since no data exist on the specific antecedent conditions of Rogers' common initial interview techniques, the above literature provides a basis for formulating a general expectation, namely, that Rogers will use common techniques under certain kinds of conditions and not under others; that is he may tend to favor or reinforce certain kinds of patient responses.

Antecedents of Wolpe's Common Techniques

With regard to Wolpe, no such literature addressing the specific antecedent conditions of any of the expected common techniques, nor any

literature illuminating the underlying principles of his use of common techniques could be found. There seems to be no articulated source for basing a specific expectation. In spite of this glaring lack of data, the present author makes a general prediction that: both Wolpe and Rogers, proponents of different approaches to psychotherapy, will follow different guidelines for their use of common techniques; that is, they will use common initial interview techniques differently. Each therapist will use such techniques under different conditions, favoring different kinds of antecedent patient responses over others.

Consequent Conditions of Common Initial Interview Techniques

Given that the techniques common to both Wolpe's and Rogers' initial interviews have not yet been identified, the consequences specific to those techniques can not be stated. However, in the following section, the literature will be reviewed regarding how patients tend to respond to Wolpe's and Rogers' use of reflection, acknowledgement and telling the patient what the patient is like, those techniques expected to be common to their initial sessions.

Consequences of Rogers' Common Techniques: Rogers (1951, 1958, 1975; Rogers et.al., 1967) describes two specific consequences which usually occur following the expression of empathy, namely, patient self-exploration and the patient focusing on and relating to the therapist in an accepting manner.

With regard to the first consequence, the patient self-explores; that is, she talks about and relates to her "self". In this response, the patient describes the kind of person she is, the kinds of thoughts she has, the kinds of feelings and reactions she has, and the kinds of relationships she has. In essence, the patient's attention is focused on her self and the kind of person

she is, rather than on the therapist or something external.

In the therapeutic experience, to see one's attitudes, confusions, ambivalences, feelings, and perceptions accurately expressed by another, but stripped of their complications of emotions, is to see oneself objectively ...he (the patient) then* is able to explore, for example, a vague feeling of guiltiness which he has experienced (Rogers, 1951, p. 40-41).

Although no study has looked at the specific consequences of Rogers' expression of empathy in the initial interview, a body of research exists which indicates that therapist's expressions of empathy do to some degree lead to patient self-exploration (Bergman, 1951; Bergin & Strupp, 1972; Kurtz & Grummon, 1972; Michell, Bozarth, Krauft, 1977; Truax & Carkhuff, 1965; Truax & Mitchell, 1971).

With regard to the second consequence of therapist's expression of empathy, Rogers (1975) suggests that the patient will largely focus her attention on the therapist. That is, she will become more aware of and be in full interaction with the therapist, rather than focus upon external concerns or on the kind of person she is. In essence, the patient will largely accept and welcome what the therapist says.

Though it may not be articulated clearly, the experience goes something like this. "I have been talking about hidden things, partly veiled even from myself, feelings that are strange, possibly abnormal, feelings I have never communicated to another, nor even clearly to myself,

and yet he (the therapist) has understood them even more clearly than I do. If he knows what I am talking about, what I mean, then to this degree I am not so strange, or alien, or set apart. I make sense to another human being. So I am in touch with, even in relationship with, others. I am no longer an isolate'

(Rogers, 1975, p.6).

There is however no empirical literature which specifically addresses this second consequence with regard to Rogers' expression of empathy in the initial interview. Nor, to the present author's knowledge, is there any research addressing this issue in general.

The two consequences described are largely in relation to the therapist's expression of empathy. To some extent empathy can be expressed with several techniques, most commonly reflection and acknowledgement. However, the expression of empathy may also be transmitted by the therapist telling the patient about the patient or what the patient is like, since such a technique is both close to and difficult to distinguish from a reflection (Staines, 1969; Hill et.al., 1979; Rogers, 1942). To the extent that these three techniques may be operational components of the expression of empathy, it may be expected that the use of such techniques, by Rogers in the initial interview, might all lead to similar consequences.

Although the specific common techniques of Wolpe and Rogers are not known and the specific consequences cannot therefore be stated, the above literature provides some basis for a general prediction, namely, that certain kinds of patient responses will tend to follow Rogers' use of common techniques to a greater degree than other kinds of patient responses.

Consequences of Wolpe's Common Techniques: The topic of immediate consequences, or how the patient responds to the certain initial interview techniques expected to be common for Wolpe, is given little attention in his clinical writings (Wolpe, 1958, 1973, 1976; Wolpe & Lazarus, 1966). Furthermore, neither empirical research on Wolpe or other behavior therapists, has yet addressed this important issue (i.e. identifying patients' responses to such techniques as reflection, acknowledgement or telling the patient what the patient is like). Due to this lack of clinical or research data, only a general prediction can be made for Wolpe, namely, that certain kinds of patient responses may tend to follow Wolpe's use of common techniques to a greater degree than other kinds of patient responses. This prediction rests on the notion that techniques, used by experienced therapists will elicit specific patient responses (Barnabei, Cormier & Nye, 1974; Gamsky & Farwell, 1966; Heller, 1963; Houts, MacIntosh & Moos, 1969; Krasner, 1962; Rotter, 1960; van der Veen, 1965).

Moreover, it is expected that since Wolpe and Rogers are from different therapeutic orientations, it may be expected that patients will respond to their use of common techniques differently.

Summary of Literature Review

In summary of Chapter One, the following are the questions this present research intends to answer, as well as the expectations provided by the literature regarding each of the research questions:

1. The first question is: Of the techniques used in initial interviews by Wolpe and Rogers, as proponents of different approaches to psychotherapy, are there any techniques which are used in common? The clinical and research literature confirms the difference between the,

techniques used by Wolpe and Rogers in the initial interview. However, there is some indication that both therapists will use the technique of telling the patient about the patient's problem and the patient's self. It is therefore expected that, although the two therapists will predominantly use different techniques in the initial interview, at least this one technique will be used in common.

2. The second question is: What are the similarities and differences in the conditions under which Wolpe and Rogers, as proponents of different approaches to psychotherapy, use common techniques in the initial interview? That is, are these common techniques used following similar or different kinds of antecedent patient statements?

As proponents of different therapeutic approaches, it would seem that common initial interview techniques might be used under differing therapeutic conditions, i.e. following different kinds of patient statements. With regard to Wolpe, however, the literature offers essentially no basis for specific expectations. With regard to Rogers, the literature provides scant and competing expectations that Rogers may use initial interview techniques on either a selective or a non-selective basis. Given these considerations, it is hypothesized that Wolpe and Rogers will use common initial interview techniques (a) on a selective basis (i.e. following certain kinds of antecedent patient statements), and (b) they will use these common techniques in different ways (i.e. following different kinds of antecedent patient statements).

3. The third question may be stated as follows: What are the similarities and differences in the consequent conditions following Wolpe's and Rogers' use of common techniques in the initial interview? That is,

what kinds of patient responses immediately follow these therapist's common techniques? As proponents of different therapeutic approaches, it would appear that patients would respond differently to the common techniques of Wolpe and Rogers. However, with regard to Wolpe, there is virtually no literature which directly speaks to the specific consequences of the initial interview techniques expected to be common. With respect to Rogers, the literature suggests that in response to his use of reflection, acknowledgement and telling the patient about the patient, patients may self-explore or relate to the therapist. Since however, common initial interview techniques are not explicitly known for Wolpe and Rogers, only a general prediction can be stated, namely, Wolpe's and Rogers' use of common initial interview techniques will lead to different kinds of patient responses.

Chapter II

METHODOLOGY

The purpose of Chapter II is to develop a methodology to answer those questions and hypotheses established in the preceding chapter. The various strategies researchers have used to compare techniques from different psychotherapeutic approaches will be discussed first. Following the choice of a general strategy, the various research and methodological considerations linked to that strategy will be discussed.

Comparing Techniques from Two Different Approaches

In comparing the therapy techniques from two different psychotherapeutic approaches, researchers have either compared groups of therapists representing each approach (e.g. Brunink & Schroeder, 1979; Cartwright, 1966) or they have compared highly experienced individual therapists (e.g. Hill, Thames & Rardin, 1979; Stiles & Sultan, 1979; Stoten & Goos, 1974; Strupp, 1957; Zimmer & Pepyne, 1971). The present investigator has decided, of these two options, to compare the initial interview techniques of two eminent representatives of the client-centered and behavioral schools, namely, Carl Rogers and Joseph Wolpe.

Researchers comparing techniques of individual therapists from different orientations employ various research strategies broadly categorized as indirect and direct methods (Kiesler, 1973). In the use of indirect methods, researchers study the therapist techniques and responses of the patient, but not in the context of the actual session. Rather, therapist and patient behaviors are studied after the therapy session is over or in hypothetical situations (e.g. Strupp, 1960). Such indirect

strategies commonly consist of questionnaire procedures in which therapists give their perceptions about the sessions or report what techniques they might use in particular situations. These procedures however, are designed to assess therapists' general attitudes about therapy, the therapeutic relationship, and therapist behaviors independent of actual therapy transactions.

Researchers apply direct methods to actual sessions or some representation of them. Strategies of this nature commonly consist of a number of judges applying a system of content analysis to some form of observation of actual therapy sessions. The advantage of this method over an indirect method is that the data collected closely specifies what therapists actually do in real therapy sessions, rather than what is asserted in their writings, recollections or speculations about therapy. Since the objective of the present research is to study Wolpe's and Rogers' techniques as they occur in actual therapy sessions, a direct method of content analysis will be used.

The direct approach carries with it various research considerations including the choice of: (a) a system of content analysis; (b) type of sampling (whole sessions vs. parts of sessions) and sampling location within the interview; (c) data form; (d) sample size and representativeness; (e) judges; (f) procedure for rating and (g) statistical methods. In the following sections, each of these research considerations will be discussed.

Selecting a System of Content Analysis

Within the field of psychotherapy process research, the most common means of investigating therapist and patient behaviors in actual therapy sessions is with a system of content analysis. Many content analysis systems are available and have been reviewed elsewhere (Auld & Murray, 1955; Dittes, 1959; Kiesler, 1973; Marsden, 1965, 1971; Meltzoff & Kornrieck, 1970; Russell & Stiles, 1979).

In addressing the questions and hypotheses of the present research, a system of content analysis must meet several important criteria:

(a) The system must consist of both patient and therapist categories. These categories must be designed to measure the actual therapy techniques of the therapist as well as the manner in which patients respond in therapy.

(b) The therapist categories must include at least all techniques that Wolpe and Rogers are expected to use in their initial sessions. Thus, there must be at least those ten therapist categories cited in Chapter One.

(c) The nature of these categories must not be bound to any one theoretical orientation, but be able to accommodate the therapy techniques of different psychotherapeutic schools.

(d) The categories must classify the verbal "techniques" of therapists as opposed to such verbal dimensions as linguistic behaviors or voice quality (i.e. Lennard & Bernstein, 1969; Mattarazzo, Weins, Mattarazzo & Saslow, 1968; Rice & Wagstaff, 1967). Furthermore, the general definition of a "technique" must be defined as: all the therapist says between two patient statements. This, for example, is in contrast to classifying a technique as only part of the therapist's verbalizations or all that the therapist says within a five minute segment (i.e. Lennard & Bernstein, 1969; Truax & Carkhuff, 1967).

(e) The patient categories must be able to accommodate those verbal responses which are expected to occur in the sessions of Wolpe and Rogers, and responses which are the logical consequences of several of their techniques. Specifically, it is expected that in response to

Rogers' reflecting, giving acknowledgment or telling the patient what the patient is like, patients are likely to self-explore and relate to the therapist in an accepting manner. Therefore appropriate categories must be present to handle such responses. Moreover, Wolpe is expected to ask the patient questions about the problem and the external situational context. Questions of this nature will likely lead the patient to provide the requested information (Beier, 1966; Frank & Sweetland, 1962; Labov & Fanshel, 1977) and there must be appropriate categories to classify these responses, for example, the patient giving factual information about the problem or himself, and the patient giving information about the external situational context.

(f) There must be a sufficient number of patient categories to classify responses patients commonly make in therapy sessions. The nature of these categories must be that none are bound to any one theoretical orientation, but can classify patient responses no matter what the orientation of the therapist.

(g) Since the aim of this research is to identify patient antecedent and consequent responses of therapist techniques, patient responses must be defined as: those statements between two therapist techniques.

The above criteria provides a basis from which to evaluate existing category systems and come to a decision whether any of the available systems are appropriate for the purposes of the present project. In the literature, there exist several systems of content analysis which are designed to classify both therapist techniques and patient responses. However, none of these systems fully meet each of the criteria just described. In the following section the particular drawbacks rendering each of these systems

unsuitable for the present investigation will be described.

The Bales' (1970) system focuses on the interactional aspects of small group problem-solving activity. As Kiesler (1973) points out "...the Bales' system was inappropriate for precise analysis of psychotherapy interviews. As new systems designed for therapy appeared, the Bales procedure and its modifications were gradually abandoned" (p.70). In this system, the manner in which the therapist and patient categories are described is not able to classify appropriately several of the techniques Wolpe and Rogers are expected to use in their initial interviews (i.e. self-discloses, asks for information about the problem, asks for information about the external situation). Nor does this system distinguish between patients giving information about the problem, from patients giving information about the external situation. Thus, this system does not have enough categories to classify all the techniques of Wolpe and Rogers, and several of the patient responses expected to occur in first sessions.



The system of Dollard and Auld (1959), Murray (1956) and Leary and Gill (1959) were derived from concepts rooted in psychoanalytic theory, and both patient and therapist categories reflect this heritage. The major goal of the first two systems is less on assessing the techniques of the therapist, but rather to assess the conscious and unconscious motivation of patients and their underlying emotional processes. The system of Leary and Gill assesses both the psychological functioning of the patient and the emotional-intellectual interactions between the patient and therapist. Based upon the particular objectives of each of these three systems, their categories are theoretically bound to psychoanalytic thinking. As a result, these systems are unable to categorize all the techniques Wolpe and Rogers might use in their sessions and the kinds of patient statements expected to occur.

The system of Snyder (1945) is based upon the principles of non-directive therapy and was designed to contrast non-directive with directive procedures. Although some of the therapist categories are similar to those initial interview techniques of Wolpe and Rogers, several would be lost to the more encompassing categories. For example, in this system the category "Giving Information Or Explanation" would embody such techniques as: the therapist tells the patient what external reality is like, and the therapist tells the patient what kind of person the therapist is. Additionally, the category "Directive Questions" would envelop two separate techniques of Wolpe; namely, the therapist

asks for information about the patient and the problem and the therapist asks for information about an external situational context. Furthermore, there is no room to categorize those patient responses expected to occur in the initial sessions of Wolpe and Rogers, namely, statements relating to: the patient self-explores or describes the "self", the patient provides factual information about the problem, and the patient describes or provides information about an external situational context.

The system of Stiles (1979) also falls short of categorizing all the therapist and patient verbalizations which are expected to occur in Wolpe's and Rogers' initial sessions. For example, Wolpe's asking questions about the nature of the problem might be classified in the same category as his asking about the external situational context, and his telling the patient about external reality might be classed in the same category as his telling the patient what the patient is like. Likewise, patients describing the self or self-exploring would not necessarily be categorized differently from patients telling about external reality, or patients giving factual information about the problem.

Thus, of the few systems containing both therapist technique and patient response categories, each system does not have enough categories to classify all of Wolpe's and Rogers' techniques or the expected patient responses. Likewise, of those systems which classify only patient responses or therapist techniques, no one system has enough categories to classify all patient responses or therapist techniques which might occur in the initial interviews of Wolpe and Rogers.

For example, several systems designed to measure patient in-therapy

responses, 'confine themselves to only a few kinds of categories which are conceptually linked to psychoanalytic theory. These systems, for example, measure a patient's level of anxiety, degree of hostility, drives in conflict, level of schizophrenic thinking, and ability to free associate (Borden, 1966; Gottschalk & Gleser, 1969; White, Fichtenbaum & Dollard, 1966a, 1966b). The systems of Klein, Mathieu, Gendlin and Kiesler (1970); and Truax and Carkhuff (1967), although derived from client-centered theory, measure a patient's level of experiencing and self-awareness. These systems do not contain categories which reflect those patient responses expected to occur in the initial interviews of Wolpe and Rogers.

Similarly, of those systems designed only to measure therapist techniques (Bandura, Lipsher, & Miller, 1960; Goodman & Dooley, 1967; Harway, Dittman, Raush, Bordin & Rigler, 1955; Hill, 1978; Howe & Pope, 1961; Siegman & Pope, 1962; Strupp, 1957), none have enough categories to classify all techniques expected to occur in the initial sessions of Wolpe and Rogers.

Thus, since no one system of content analysis fully meets the criteria set forth earlier, the present research will "borrow" the appropriate categories. That is, therapist techniques and patient responses categories will be drawn from established systems of content analysis to develop a measure which will be comprised of therapist and patient categories suitable to the needs of this project. The final product is essentially that used in the psychotherapy research project at the University of Ottawa.

Therapist Categories

The following therapist technique categories were borrowed or selected from other major systems of content analysis (The complete description of each therapist category is found in Appendix A).

1. The therapist structures the therapy session: The therapist clarifies the role of the patient as patient, tells the patient

how therapy works, its benefits, its rationale, its advantages and disadvantages.

This category is similar to those of Structuring (Strupp, 1957), Structuring and Giving Information or Explanation (Snyder, 1945). It is also similar to the categories of Information (Hill, 1978) and Directions (Murray, 1956) although less broadly defined.

2. The therapist tells the patient what the patient is like:

In effect, the therapist names, labels, describes, tells about the kind of person the patient is. He tells the patient about the patient. This may include telling the patient about the kind of problem(s) he has, the kinds of thoughts he has, and the kinds of feelings he has. The therapist speaks from his own perspective, and, generally as an authority, tells the patient how the patient functions, what his interpersonal relationships are like, what kind of world the patient lives in and creates for himself, and what the patient's relationship to the self is like.

This category is taken from the category known as Interpretation in the systems of Dollard and Auld (1959), Goodman and Dooley (1976), Hill (1978), Siegman and Pope (1962), Snyder (1945), Stiles (1979) and Strupp (1957). It is also similar to what Bandura, Lipsher and Miller (1960), and Murray (1956) refer to as Labeling. The Confrontation category of Hill (1978) and the Confirmation category of Stiles (1979).

also contain elements which approximate the above category.

3. The therapist asks the patient to provide data about what the patient or problem is like: The therapist is seeking to obtain more or less factual data about the problem or about the patient as related to the problem. The therapist's attention, to a large extent, is focused on the patient or the patient's problem. The therapist may gather information about the patient or problem by: (a) Inviting the patient to tell more about the problem in general, asking the patient for clarification, or indicating a desire to hear more about that aspect of the problem. (b) Asking direct fact-related questions about the problem, its history, and nature. (c) Asking about the patient as related to that specific problem, including the patient's history and the background of the problem in the patient's current and past life. (d) Asking about the patient's reactions, thoughts, feelings about the problem or his self. The therapist may also ask for the patient's causal explanations about the problem.

4. The therapist gathers data about and clarifies the external situational context: The therapist draws the patient's attention to, or clarifies and illuminates, some external situational context. This may be with respect to an object, figure, or situation. The therapist attends to, and asks for more information or impres-

sions about that external target which engages the patient's attention. The therapist's and patient's center of attention is predominantly on that external scene rather than focused on other areas, such as the patient and the kind of person the patient is.

Therapist technique categories three and four, just described, are of the kind in which the therapist is asking questions to gather information. In this general sense, these two categories are similar to therapist categories in other systems such as: Asks For Information, Asks For Opinion (Bales, 1970); Exploration (Bandura, Lipsher & Miller, 1960); Question (Goodman & Dooley, 1976; Stiles, 1979); Open Question, Closed Question (Hill, 1978); Mild Probe (Murray, 1956); Directive Questions, Nondirective Leads (Snyder, 1945); Asks For Specific Factual Information (Siegman & Pope, 1962); and Exploratory Operations (Strupp, 1957). However, in category three, the therapist is asking specifically about the patient and the problem but in category four, the therapist is asking about the external situational context. This distinction is not made in other category systems and therefore categories three and four provide further ways of categorizing patient responses.

5. The therapist discloses and tells about the kind of person the therapist is: The therapist tells about the kind of person the therapist is, his thoughts, his feelings, his perceptions. This kind of statement resembles what is generally termed self-

disclosure. Statements of this nature may include revelations about the therapist's own personal life, involvement with the patient's problem or symptoms, the way the therapist copes with this type of problem or symptom, his fantasies, images, associations, bodily-phenomena, his mistakes and errors, and what he seeks to do in the immediate therapy situation.

This category is similar to Self-Disclosure categories in other systems (Goodman & Dooley, 1976; Hill, 1978, Stiles, 1979). Moreover, this category is also similar to the major therapy technique of Self-Disclosure as described by Sidney Jourard (1971a, 1971b, 1978) and others (Bundza & Simonson, 1973; Epting et.al., 1977; Kempler, 1969; Simonson & Bahr, 1974; Weiner, 1972).

6. The therapist tells the patient what external reality is like:

The therapist interprets external reality by serving as the authority or the one who explains what the external situation, or state of events are really like. The therapist describes the relationship between the facts and the external event, he tells how events take place and what consequences will follow. The therapist provides an explanation of the situation, how and why it came about.

The above category, although confined to external reality, is commonly embodied within broadly defined categories such as Interpretation, Giving

Information Or Explanation (Snyder, 1945) and Interpretative Operations-Reality Model (Strupp, 1957).

7. The therapist says what he believes the patient is saying: This category is comparable to what is generally known as reflection and restatement. The therapist reflects, restates or clarifies what the patient says, feels or means. He summarizes what the patient is saying, expressing the patient's inner feelings, attitudes, thoughts, and wishes. The therapist may simply repeat what the patient says or put it in a clearer, more recognizable form.

This category is similar to what is referred to in other systems as Reflection or Restatement (Bandura, Lipsher & Miller, 1960; Goodman & Dooley, 1976; Hill, 1978; Stiles, 1979), Restatement of Content or Problem, Clarification Or Recognition Of Feeling (Snyder, 1945) and Clarification (Strupp, 1957).

8. The therapist gives simple acknowledgment to what the patient says: The therapist indicates he hears the patient and is paying attention to the patient. The therapist may communicate this by simply saying "Yes", "Uh-huh", "Mm-Mm".

This category is similar to the categories: "M" (Dollard & Auld, 1959), Mm and Mild approvals (Murray, 1956), Simple Acceptance (Snyder, 1945), Single Word (Siegman & Pope, 1962), Facilitating Communication-Passive Acceptance (Strupp, 1957) and Acknowledgment (Stiles, 1979). Hill's (1978) Minimal Encourager category is similar to the above category although more broadly defined.

9. The therapist gives permission-approval-encouragement to the patient to continue to talk: The therapist encourages the patient to continue to speak. He may say, "go on", "that's fine to talk about that", "go ahead and say it".

This category is like the categories: Approval (Bandura, Lipscher & Miller, 1960), Approval-Reassurance (Hill, 1978), Strong Approval (Murray, 1956), Brief Remark To Encourage The Patient To Proceed (Siegman & Pope, 1962), Approval-Encouragement (Snyder, 1945), Facilitating Communication-General Invitation To Talk (Strupp, 1957).

10. The therapist gives advice to the patient about potential personality-behavior change: The therapist talks to the patient about his readiness or willingness regarding some personality-behavior change. He provides advice to the patient about what the patient should do next, either out of or within the therapy session.

This category is similar to such categories as: Advisement (Goodman & Dooley, 1976; Stiles, 1979), Direct Guidance (Hill, 1979; Strupp, 1957) and Proposing Client Activity (Snyder, 1945).

11. Other: When a statement cannot be classified in any of the above categories, it can be placed into this category only if statements are of the type in which the therapist laughs; inquires what the patient said; or answers the patient's question.

This category is not an open ended "All Other" category. It is specific in content and unlike the categories in other systems commonly labeled as: Other (Hill, 1978), Irrelevant (Murray, 1956), Unclassifiable (Snyder, 1945), and Unscoreable (Stiles, 1979).

Patient Categories

The present author acknowledges that the criteria set forth concerning patient categories provides wide latitude in their selection. The following is one approach to the selection of patient categories from other major systems that the present investigator finds most practical and sensible.

The work of Raimy (1948) and Seeman (1949) provides a three-part framework from which to organize patient responses in therapy. This framework organizes statements into those predominantly directed toward the self, those directed toward some external referent, and those directed toward the therapist. These three domains provide a broad and common sense outline to select specific patient categories, and constitute the three-fold patient category system used in the psychotherapy research project at the University of Ottawa.

The following patient categories were selected or "borrowed" from other major systems of content analysis. (A complete description of each patient category can be found in Appendix B).

When the patient is judged as attending and relating predominantly with and towards the therapist, patient statements are placed in the following categories:

1. The patient opposes the therapist: The patient engages in an oppositional relationship with the therapist. This includes the patient's being oppositional by standing up to, arguing with, disagreeing with, resisting, pulling away from, objecting to, rejecting, or confronting the therapist, or confronting and disagreeing with what the therapist says.

This category is generally similar to those in other systems such as: Negation, Resistance (Dollard & Auld, 1959), Disagreement With Therapist Remarks (Murray, 1956), Disagrees (Bales, 1970) and, Rejection Of A Clarification Or Interpretation (Snyder, 1945).

2. The patient accepts the therapist: The patient engages in an accepting relationship with the therapist. The patient is positive, welcoming, and seems to be pleased with and feel good about the therapist and what the therapist says. This includes corroborating, acknowledging, refining, rephrasing and restating in a positive manner what the therapist says.

This category is similar to such categories as: Agrees (Bales, 1970), Confirmation (Dollard & Auld, 1959), Agreement with Therapist Remarks (Murray, 1956), and Simple Acceptance (Snyder, 1945).

When the patient is judged as attending and relating predominantly to his own self, patient statements are placed in the following categories:

3. The patient describes his self: The patient tells about the kind of person he is, the kinds of problems he has, the nature of his personality, how he sees himself, the kinds of interpersonal relationships he has, the ways he tends to behave, the kinds of thoughts and feelings he has. The context may be past or present. The patient in essence self-explores, and the focus of his attention is primarily on the self and the kind of person he is.

In this category, as the patient describes the kind of person he is, his attention is primarily focused upon the "self". This category is similar to Disclosure (Stiles, 1979) in that the patient is revealing something about his self, namely his feelings, thoughts, perceptions and intentions. Furthermore, the above category blends into one classification what other systems (Klein, Mathieu, Gendlin & Kiesler, 1970; Truax & Carkhuff, 1967) handle with many separate categories.

4. The patient informs of problem: The patient provides the therapist with the requested information about the problem.

The patient is attending predominantly to the problem aspect of his self as he gives relatively factual information about the problem. This includes, for example, how the problem began, what it was like, how extensive it is, and conditions that may have contributed to it, the circumstances in which it occurs, improves or worsens.

This category is similar to those categories in the systems of Klein, Mathieu, Gendlin and Kiesler (1970), and Truax and Carkhuff (1967) in which the patient is merely getting the facts or story across but not emotionally involved. In the above category however, the patient's emotional involvement is not a factor to consider. Moreover, category four is similar to Snyder's (1945) Any Statement Of The Problem Category.

When the patient is judged as attending and relating predominantly to figures, objects or situations outside the therapeutic context, patient statements are placed in the following categories:

5. The patient defines an external situation: The patient is attending to some external scene, incident or situation which occurred in reality or fantasy, recently or some time ago. His words imply or connote some scene or situational context, some locale or place. The patient is involved in the scene and talks about persons, things, objects, and events, as if he is somewhat in the scene or situation with them. He provides information and describes what happens, takes place, or he may place himself in the scene and

describe how he is or was. The patient may describe something that happened to him in such detail, and vividness that the scene almost starts to come alive.

6. The patient focuses on a defined external center: The patient's attention is focused on some defined single external object or figure. Although the person or thing is defined and seen, the situation may be virtually absent or minimal. On the other hand, there may well be some defined encompassing situation surrounding the focused person or thing. If the patient is in some scene, the patient's attention is centered on that person or thing, singularly. The patient may focus specifically upon the specific person, the way the person interacts with the patient or others, or describe something about that defined center. The patient may be practically saying the words to that other person, figure or target.

Categories five and six, just described, emphasize two features: (a) the specificity of the patient's description of something external and (b) the degree to which the patient is "involved" in that external scene. It appears that no other system of content analysis includes categories which take into account these two dimensions, but rather confounds them within other categories. For example, a statement in which the patient's attention is on something external (either a general scene or a specific target), could easily be categorized, depending on the content of the statement, into three categories in the Snyder (1945) system (i.e. Any Statement Of The Problem, Understanding Or Insight, Discussion Of Plans). In other words, these categories in the Snyder

system do not differentiate between where the patient's center of attention lies, nor the specificity of the patient focus. This issue is common to most other category systems although the Stiles system (1979) has one category (Edification) which classifies statements which are focused on some external concern. Stiles' system is probably the only one with such a category.

It appears, that categories five and six, as described in the present study, provide a further way to classify certain patient responses. That is, these categories take less into account the content of the patients words, but emphasize rather the specificity of the patient's attention as it is focused on something external.

The present research will classify the therapist and patient verbalizations in the initial interviews of Wolpe and Rogers using the therapist and patient categories just described.

Type of Sampling and Sample Location Within The Interview

In this section two concerns will be addressed; first, in what context will the techniques of Wolpe and Rogers be studied? Secondly, what "Slice" of the therapists' and patients' verbalizations will be categorized?

Type of sampling: The context or summarizing unit in which to study the antecedent and consequent conditions of common initial interview techniques may either be the complete interview or segments from many interviews (Kiesler, 1973). The latter approach has the advantage of allowing a wider level of generalization, since the segments would be from many different cases. However, with regard to the present study, there are two disadvantages of this approach: (a) Using segments from many cases does not allow for classification of all the techniques Wolpe and Rogers might use, and in this

study, the frequency with which Wolpe's and Rogers' techniques occur is crucial in determining which techniques are common to both therapists. Furthermore, a sampling procedure appears more appropriate for measuring events assumed to be continually present in various degrees, throughout the therapy session (i.e. warmth, genuineness), or for studying a wide range of therapy activities. (b) From a practical standpoint, there are simply not enough published initial interviews available from Wolpe's and Rogers' repertoire which would allow a sampling procedure.

An alternate sampling procedure is the study of complete interviews. The advantage of this procedure is that all the techniques Wolpe and Rogers use in their sessions can be identified as well as the antecedent and consequent conditions of those techniques. Mintz and Luborsky (1971) point out that this method is most appropriate for study of either the interaction between patient and therapist in the session or study of specific therapy variables. Furthermore, this sampling approach is the one most commonly used in research comparing techniques of individual therapists from different approaches (e.g. Brunink & Schroeder, 1979; Hill, Thames & Rardin, 1979; Stiles & Sultan, 1979; Stoten & Goos, 1974; Strupp, 1957; Zimmer & Pepyne, 1971).

One limitation with sampling complete interviews is that data are generally drawn from a smaller number of sessions than sampling segments. As a result, generalization of findings is usually more limited. In spite of this drawback, the present investigation will sample complete therapy sessions of Wolpe and Rogers rather than sample segments of sessions.

Sample location within the interview: A variety of scoring units within the complete interview is used in process research. These include: the clause, the sentence, the statement, the idea, the interaction exchange and time segments. Of these, the "statement" is most widely used (Kiesler, 1973, p.42-43). Kiesler (1973) defines this common scoring unit as "an uninterrupted

sequence of sentences uttered by either the patient or therapist; everything said between two therapist responses (for patient), and everything said between two patient responses (for therapist)..." (p.42).

The present research is concerned with the patient antecedents and consequent statements of therapist techniques. Thus the most appropriate scoring unit in which to study this problem is the "statement". The unit to be categorized in the present study will be each complete individual therapist statement and each complete individual patient statement.

Data Form

The medium of data presentation in process research is usually of three types; audio-visual recordings, audio recordings and most commonly, verbatim transcripts (Bergin & Garfield, 1971; Garfield & Bergin, 1978; Kiesler, 1966, 1973). Although there is substantial information lost when data is presented only in the form of printed transcripts, this limitation does not prohibit its use in the present study and therefore all three mediums are acceptable. Several of Rogers' initial interviews are available in both audio-visual and transcript forms. However, Wolpe's interviews seem only available as transcripts. This limits the choice to this form of data. Thus, verbatim transcripts of the initial interviews of Wolpe and Rogers will be studied.

Coupled with the decision to use transcripts are two issues, namely, how many transcripts should be studied per therapist and which transcripts would be representative of their initial sessions? These two concerns will be discussed below.

Number of Transcripts: The bulk of process research in which the therapy techniques of individual therapists are compared, have usually studied only one transcript per therapist (e.g. Andrews, 1980; Hill, Thames & Rardin, 1979; Stiles & Sultan, 1979; Stoten & Goos, 1974; Strupp, 1957). Furthermore, in

comparing the techniques of groups of therapists, Stiles (1979) considered that 400 - 600 therapist and patient responses per school was an adequate amount of data. The present research therefore considers that the study of at least two sessions per therapist, approximately 300 - 400 therapist and patient responses, will be adequate data for the present research. This amount of data for study of individual therapist techniques is substantially more than past research has used.

Choice of Representative Interviews: In comparing therapists representing different schools, Stiles (1979) reasoned that published or commercially available transcripts serve as teaching examples and are therefore, to some extent, representative of the therapeutic approach of a particular school or the individual therapist. The present research intends to select published or commercially available interviews that are complete.

In the present research, five separate initial interviews will be used: two initial interviews for Rogers and three initial interviews for Wolpe. The two Rogers transcripts consist of a total of 386 therapist statements and 385 patient statements while the three Wolpe transcripts consist of a total of 308 therapist statements and 307 patient statements. The following initial interviews are those that will be studied.

Rogers' Initial Interviews:

1. Mike, available from the American Association of Psychotherapists

Tape Library, volume seven (Recorded Publications Laboratories, Camden, N.J.). This interview consists of 140 therapist statements and 139 patient statements. It is a demonstration interview conducted before a number of counselling students.

The following description of this patient was derived from information available in the transcript. Mike appears to be a high school student,

seventeen years of age and living at home. He is concerned with formulating a career goal. Mike is uncertain of his future and unsure of which direction to move next. He refers to himself as a juvenile delinquent. This patient appears to be angry and in a strained relationship with his step-father. Of issue is the fact that the patient's step-father hopes Mike to be a machinist, something in which Mike has no interest. Thus there is conflict between these two individuals over career choice and various other matters.

2. Cathy, available from Psychological Films, Three Approaches to Psychotherapy II, 1976, Santa Ana, Calif. This interview consists of 246 therapist and patient interchanges. This is a demonstration session.

The following description of this patient was derived from information available in the transcript. Cathy is approximately thirty years of age and employed as a psychiatric nurse. She has been separated from her husband for four years. Recently her husband was killed. Cathy's concern is that she feels lonely and is fearful of establishing relationships with men.

Wolpe's Initial Interviews:

1. Initial interview in a hypochondriacal neurosis - Mr. P. - (Wandersman, et. al., 1976). This interview consists of 112 therapist and patient interchanges. The setting in which this interview takes place is not described.

The following description of this patient (Mr. P.) was derived from information available in the transcript. This patient is male, approximately in his middle to late forties. He is diagnosed as hypochondriacal. He is concerned with his nervousness and the pains in his arms and chest. He fears

dying of a heart attack. At the age of twenty two, he was admitted to a psychiatric hospital for several months due to similar complaints. The patient is employed by an insurance company and states he had recently been demoted in his job whereas earlier in his career he was a highly motivated and "driven" insurance salesman.

2. Initial behavioral analysis in a case of depression - Mrs. B. (Wolpe, 1976). This demonstration interview consists of 76 therapist statements and 75 patient statements.

Wolpe (1976, pp. 149-150), provides a brief sketch of this patient. According to this sketch, the patient (Mrs. B.) is female, 41 years of age, separated from her husband, and an inpatient at a university hospital. Her diagnosis is depression. According to Wolpe, this patient is feeling depressed due to guilt about activities in connection with what might be socially considered as normal sexual impulses. She is also depressed about her unsatisfactory life situation. When she was living with her husband, her depression was primarily due to restriction of her social activities because of her fear of people in groups and sometimes due to sexual frustration. Wolpe views this case as an example of a reactive depression secondary to the evocation of anxiety. However Wolpe also states that, at times, the patient was depressed due to normal physiological responses to sexual frustrations.

3. Initial behavioral analysis in an anxiety neurosis with depression and despair - Mrs. O. (Wolpe, 1976). This interview consists of 120 therapist and patient interchanges. The setting in which this interview takes place is not described.

Wolpe (1976, pp. 83-84) briefly describes this patient.

"The initial story that Mrs. O., a 34 year old divorcee, presented was that in consequence of the anesthetic for a dilatation and curettage seven months previously, ~~she~~ had had a succession of anxiety attacks characterized by a fear of not being able to breathe. Two months later these were replaced by continuous but fluctuating anxiety, with particular fears of dying and disease. There was a general undertone of depression and hopelessness. This is what would be called an existential neurosis in certain quarters.

Quite a different story was teased out by the interview. Mrs. O. had always been a rather timid person who allowed herself to be imposed upon by others. About 11 months previously, after an unsatisfactory attempt to celebrate New Year's Eve, her unexciting date had brought her home and left her. The house was empty, as her children were away. She had a feeling of isolation that was followed by a state of terror on the way upstairs to bed. She rushed off to her parents' house, where the fear gradually subsided.

Life returned to "normal" thereafter, and in April she had the dilatation and curettage. From the details provided it is quite clear that she was not adversely affected by the anesthetic. However, she was poignantly aware of her aloneness, just as she had been years pre-

viously at the birth of her first baby, when her husband was in Japan. A few days later, a dose of Valium she had taken in order to sleep produced feelings that had elements in common with her feelings of isolation, and again she had a panic attack. In the next two months similar attacks occurred whenever she imbibed alcohol. The feeling of isolation was again elicited by the disappointing termination of a brief affair in May; and a week or two later she began to be continuously anxious. This can be understood on the basis that the discrete elicitations of high anxiety had, as commonly happens, brought about a conditioning of anxiety to other stimuli that were present, many of them endogenous. Her sense of inner integrity was lost, and pleasurable feelings were no longer elicited by familiar situations. She concluded that she was breaking down mentally, the thought of which frightened her still more and sent her into a state of despair".

Judges

The majority of process research which has studied the techniques of individual therapists by rating several therapy transcripts, has generally used only two to four judges (e.g. Hill, Thames & Rardin, 1979; Stiles & Sultan, 1979; Stoten & Goos, 1974; Strupp, 1957). Furthermore, the degree of clinical expertise of these judges has varied from those of undergraduate students with no training in psychotherapy procedures to those of experienced clinicians. Since in the past the number of judges has been relatively small

and the degree of clinical sophistication rather low, the present research intends to use a larger number of judges each with some level of clinical knowledge. Therefore, two clinical psychologists and at least six graduate students will be those who have either completed their clinical internships or who are presently fulfilling those requirements. It is expected that this procedure will strengthen the ratings statistically as well as increase the validity of the ratings.

Procedure for Ratings

Generally, judges either rate all interviews in one sitting or segment the work over a period of time. The former approach has the advantage that ratings may be consistent and judges would be more likely to work independently and not discuss their ratings with colleagues. A disadvantage however, is that difficulties encountered with the categories themselves would not be discussed, moreover, judges may fatigue or tend to hurry. On the other hand, by segmenting the work into weekly assignments, several advantages may be gained: enthusiasm for the task may be maintained, effects of "set" may be minimized, competence in categorization may be acquired rapidly during the initial weeks of judging, and special problems encountered may be discussed throughout the following months of ratings. Thus, it seems that the advantages achieved through segmenting the data over time, are greater than those which might occur if the judges were to rate entire interviews in one sitting. Therefore, the rating of interviews will be segmented over a period of weeks.

In terms of the specific procedure, the judges will meet weekly as a group until the completion of ratings. The interviews will be rated in the following order: Mike and Dr. Rogers; Mr. P. and Dr. Wolpe; Cathy and Dr. Rogers; and Mrs. B., and Mrs. O. in separate sessions with Dr. Wolpe. Judges will be instructed not to view those interviews available on film prior to rating that particular transcript.

The first meeting will be to train the judges. At this meeting, the instructions and descriptions of the various categories will be discussed for approximately two hours. At the second weekly meeting, the judges will be given two pages of verbatim dialogue (approximately 30-35 interchanges) to place into the therapist and patient categories. Each judge will work independently between meetings (for detailed description of the instructions to judges, see Appendix C). Due to the small number of interchanges that judges will be rating each week, it does not appear necessary to divide segments up randomly. Therefore, the ratings of the statements will be taken in their actual sequence.

At the third and following weekly meetings, the judges will be given two pages of dialogue to rate, and the ratings of the previous week will be collected and posted, enabling all judges to compare and contrast their individual judgements with all other judges. At the end of each meeting, there will be time for further discussion of the categories and general problems in ratings but no discussion of the ratings themselves. After the completion of each transcript, those statements which did not reach criterion on the first rating attempt will be given to the judges to rate a second time. (Criteria for the classification of therapist and patient statements will be discussed in the following section).

In adopting this method of rating, it is expected that the judging of 694 therapist statements and 692 patient statements will take six months to complete.

Statistical Methods

In this section several issues will be discussed: (a) the manner in which inter-rater reliability will be calculated; (b) the criteria for therapist or patient statements to be considered classified; and (c) the manner in which the results will be statistically presented and analyzed.

Interrater Reliability

Interrater reliability will be determined by computations of Kappas (Cohen, 1960; Tinsley & Weiss, 1975). A Kappa is the proportion of agreement between two judges after chance agreement has been removed from consideration. In the present study eight judges will be chosen and randomly placed into four pairs. Kappas will be computed on two pairs of judges for all therapist statements which were classified and two pairs of judges for all classified patient statements. Thus for eight judges, four Kappas will be reported, two Kappas for therapist categories and two Kappas for patient categories.

Criteria for the Classification of Therapist and Patient Statements

The research procedure will attempt to use the same judges throughout the rating of transcripts and hold the number of judges constant. However, practical considerations such as the length of time involved, may preclude this objective. Nonetheless, at least eight judges will be used at all times for each interview and the preponderance of raters will be the same group of individuals throughout the rating period. The criteria of acceptable agreement for a therapist or patient statement to be considered categorized will be when at least five of the eight judges (62%) agree on a single category.

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If nine judges are used, then the criteria of acceptable agreement will be when at least six of the nine judges (66%) agree on a single category. If ten judges are used then the criteria of acceptable agreement will be when at least seven of the ten judges (70%) agree on a single category.

Rescoring: For those statements which after the first scoring attempt do not meet the level of acceptable criteria just described, a second scoring attempt will ensue. This will take place after the entire transcript is rated. If after a second scoring attempt a statement does not reach criteria, that statement will be considered "unscorable" and dropped from the data analysis.

The second scoring attempt seems appropriate considering the possibility that under conditions when there are many raters and many observations to be rated over a period of time, judges may lose sight of the critical guidelines of the scoring system and the categories themselves. Furthermore, it is common in psychotherapy process research to compensate for this problem by both rescoring a second time and recalibrating the raters every so often, that is, acquaint the raters with the rules of the scoring system and definitions of the categories. To some extent, this problem is reduced in the weekly meetings when judges discuss difficult categories.

Ties: For those interviews in which an even number of judges serve as raters there may be ties, that is, where half the judges place a statement in one category and the other half place it in one other category. If after the second scoring attempt tie results, that statement will be considered unscorable and dropped from the data analysis.

Criterion for Common Techniques: Stiles, (1979) compared techniques of therapists of different approaches and decided that those techniques used at least five percent of the time by therapists in each interview are predominant techniques, that is, major techniques characteristic of those therapists.

In the present research, those techniques used in each initial session at least five percent of the time by both Wolpe and Rogers will be considered common or shared techniques. The choice of such a low cut off score will increase the possibility of finding several common techniques upon which to compare Wolpe and Rogers.

Statistical Description of Data

The classification of therapist and patient statements into discrete categories constitutes nominal data. Since the present research is observing the various frequencies of these classifications, the data will be presented in descriptive form.

The descriptive presentation of data will be in terms of percentages, an approach most common in research of this nature (e.g. Hill et. al., 1979; Stiles, 1979; Stoten & Goos, 1974). Specifically, the percentage of times Wolpe and Rogers use various techniques in each interview will be reported, also the percentage of times patients use particular antecedent and consequent responses to Wolpe's and Rogers' common techniques.

The data from the interviews of Wolpe and Rogers will be described in two ways: (1) When the data from each interview are separated and (2) when the data from each interview of Wolpe and Rogers are pooled. The advantage of describing each interview separately is that the individuality and consistency of events across sessions can be viewed. Pooling, on the other hand, has the advantage of increasing the frequency of the event under study. The disadvantage however, is that the unique characteristics of each session are masked and only trends can be noted. Although this procedure is questionable, due to the influence of patient differences, it is nevertheless a common approach in research which studies more than one interview per therapist or groups of therapists

representing different approaches (e.g. Becker & Rosenfeld, 1976; Brunink & Schroeder, 1979). Since this research is primarily comparing the initial interviews of Wolpe and Rogers and looking for commonalities, the hypotheses allow for the pooling of data.

Questions and Hypotheses

The following is the list of questions and hypotheses the present investigation will address:

Of the techniques used in initial interviews by Wolpe and Rogers, as proponents of different approaches to psychotherapy, are there any techniques which are used in common?

Hypothesis 1: In the initial interview Wolpe and Rogers will share at least one technique, namely, the therapist tells the patient what the patient is like.

Hypothesis 1a: In the initial interview Wolpe and Rogers will use several different techniques. Specifically, Wolpe will primarily ask the patient about the problem; ask the patient about the external situation; tell the patient about external reality. Rogers will primarily reflect and give simple acknowledgment.

What are the similarities and differences in the conditions under which Wolpe and Rogers, as proponents of different approaches to psychotherapy, use common techniques in the initial interview?

Hypothesis 2: To the extent that Wolpe and Rogers use one or more common techniques in the initial interview, they will use such techniques under different conditions.

For the common techniques used in initial interviews by both Wolpe and Rogers, as proponents of different approaches to psychotherapy, what

are the similarities and differences in the patient's consequent or following statements?

Hypothesis 3: It is anticipated that the use of common techniques by Wolpe and Rogers will lead to different patient responses.

Chapter III

RESULTS

The purpose of this chapter is to report the data pertaining to rater agreement, and to present the findings with respect to the three questions under study.

Rater Agreement

The total number of judges varied, since several either dropped out or joined the rating team during the course of data collection. Of the five initial interviews studied, ten judges served as raters on three interviews, nine judges served as raters on one interview, and eight judges served as raters on the remaining interview. Seven of these ten judges were the same individuals throughout the rating of all five interviews. However, since the number of judges varied for several interviews, so did the criterion for rater agreement. That is, each criterion level allowed three judges to be in disagreement with the remaining judges.

For the three interviews rated by ten judges, 70% agreement was the criterion for a statement to be classified. On these interviews, 98.33%, 98.98% and 99.28% of the total number of therapist and patient statements for each interview met criterion. For the single initial interview rated by nine judges, 66% agreement was criterion. On this interview 99.76% of the total number of therapist and patient statements were classified. For the single initial interview using eight judges, the criterion was 62%. On this interview, 99.28% of the total number of therapist and patient statements met criterion.

Across five interviews, judges reached agreement on 98.99% of the

therapist statements and 98.26% of the patient statements. That is, 684 therapist statements and 680 patient statements were classified while 7 therapist and 12 patient statements were dropped. More specifically, from the two interviews of Rogers, 7 patient statements and no therapist statements were dropped. From the three interviews of Wolpe, 5 patient statements and 7 therapist statements were dropped. That is, the unclassifiable patient statements were evenly distributed across all five interviews. The unclassifiable therapist statements however, were evenly distributed only across Wolpe's three interviews.

Interrater reliability was computed using the Kappa formula (Cohen, 1960; Tinsley & Weiss, 1975). This formula gives the proportion of agreement between two judges after the effects of chance agreement have been removed. On the total number of classified therapist statements across five interviews, two separate pairs of judges obtained agreement levels of .70 and .75. For all classified patient statements, two additional pairs of judges obtained agreement levels of .64 and .73. Thus, interrater reliability was adequate for therapist and patient categories.

Questions and Hypotheses

Question One

Of the techniques used in initial interviews by Wolpe and Rogers, as proponents of different approaches to psychotherapy, are there any techniques which are used in common?

Tables 1 and 2 present the eleven therapist categories together with the distribution of responses from the three initial interviews of Wolpe and the two initial interviews of Rogers. Figures 1 and 2 illustrate the frequency with which Wolpe and Rogers used various techniques in each initial interview.

Hypothesis 1: In the initial interview, Wolpe and Rogers will share

Table 1

Distribution of Wolpe's Initial Interview Techniques:
Scoring Categories and Response Frequencies

Therapist Techniques:	Initial Interview					
	1. A case of Depression-		2. A case of Anxiety Neurosis-		3. A case of Hypochondriacal Neurosis-	
	Mrs. B.		Mrs. O.		Mr. P.	
	f*	%	f	%	f	%
1. Structures Therapy	0	0	1	.85	1	.9
2. Self-Discloses	0	0	0	0	1	.9
3. Asks about the patients problems	45	60.81	86	73.5	79	71.81
4. Asks about the external situation	2	2.7	5	4.27	9	8.18
5. Tells the patient about the patient	13	17.56	11	9.4	10	9.09
6. Tells about external reality	2	2.7	2	1.7	2	1.81
7. Reflects	0	0	5	4.27	4	3.63
8. Gives advice	10	13.51	2	1.7	0	0
9. Gives permission-approval-encouragement	1	1.35	0	0	0	0
10. Gives simple acknowledgment	1	1.35	3	2.56	3	2.72
11. Other	0	0	2	1.7	1	.9
Total:	74	99.98%	117	99.95%	110	99.94%

Note: f = raw frequency

Table 2

Distribution of Rogers' Initial Interview Techniques:

Scoring Categories and Response Frequencies

Therapist Techniques:	Initial Interview			
	1. Mike		2. Cathy	
	f*	%	f	%
1. Structures Therapy	2	1.42	1	.4
2. Self- Discloses	3	2.14	6	2.43
3. Asks about the problem	4	2.85	4	1.62
4. Asks about the external situ- ations	1	.71	0	0
5. Tells the patient about the patient	19	13.57	40	16.26
6. Tells about external reality	1	.71	0	0
7. Reflects	76	54.28	40	16.26
8. Gives advice	1	.71	2	.81
9. Gives permis- sion-approval- encouragement	1	.71	2	.81
10. Gives simple acknowledgment	24	17.14	147	59.75
11. Other	8	5.71	4	1.62
Total:	140	99.55%	246	99.96%

Note: f = raw frequency

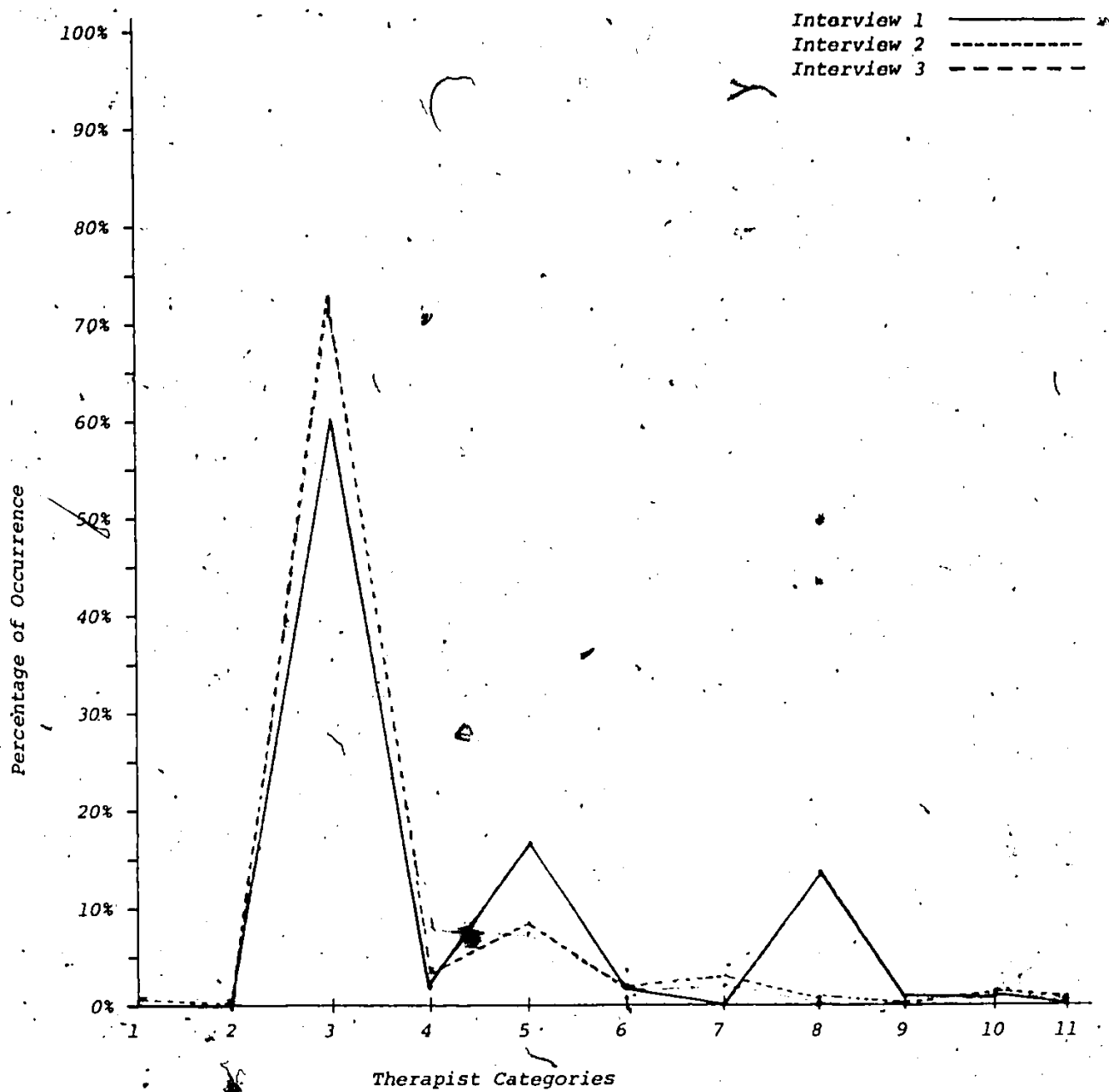


Figure 1
Response Distribution of Wolpe's Initial
Interview Techniques

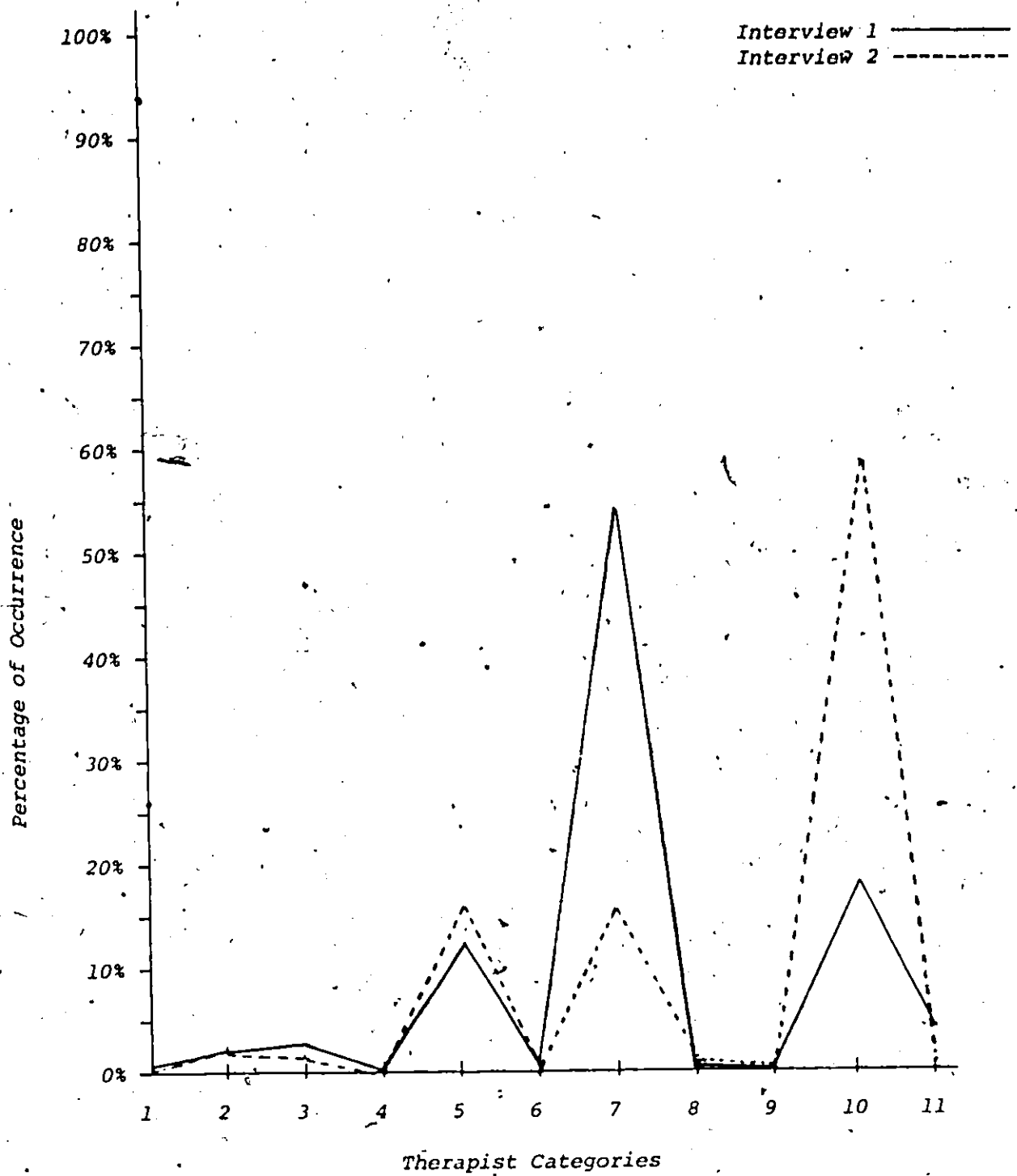


Figure 2

Response Distribution of Rogers' Initial
Interview Techniques

at least one technique, namely, the therapist tells the patient what the patient is like.

Inspection of the data (see Tables 1 and 2; Figures 1 and 2) shows that for Rogers, telling the patient about the patient comprised 13.57% of his responses in interview 1 and 16.26% in interview 2. For Wolpe, this technique comprised 17.56% of his responses in interview 1, 9.4% in interview 2, and 9.09% in interview 3. Thus, telling the patient about the patient was a common initial interview technique for Wolpe and Rogers; each therapist used it more than 5% of the time in each of their initial sessions. All other techniques shared by Wolpe and Rogers were used less than 5% of the time in each session.

Hypothesis 1a: In the initial interview, Wolpe and Rogers will use several different techniques, specifically, Wolpe will primarily ask the patient about the problem; ask the patient about the external situation; tell the patient about external reality. Rogers will primarily reflect and give simple acknowledgment.

Inspection of the data (see Tables 1 and 2; Figures 1 and 2) shows that for Wolpe, asking the patient about the patient comprised 60.81% of his responses in interview 1, 73.5% in interview 2 and 71.81% in interview 3. With the exception of the common technique, all other categories comprised less than 5% of his responses in most interviews. In all three interviews, Wolpe most frequently asked the patient about the patient's problem, while his second most frequent technique was telling the patient about the patient. Therefore, Wolpe was quite consistent in his use of all techniques across three initial sessions.

Rogers, in interview 1, reflected 54.28% of the time and gave simple acknowledgment 17.14% of the time. In interview 2, he reflected only

16.26% of the time but gave simple acknowledgment 59.75% of the time.

With the exception of the common technique, telling the patient about the patient, Rogers used most other categories less than 5% of the time in both sessions. Thus, in two interviews, Rogers most frequently either reflected or gave simple acknowledgment, although the frequency with which he used these two techniques varied considerably across sessions. His third most frequent technique was telling the patient about the patient; his use of this category was consistent across sessions. Therefore, Rogers was quite consistent in his use of all techniques across two initial interviews.

Summary of Results: Question One

The findings confirmed hypothesis 1 and partially confirmed hypothesis 1a. In initial interviews, Wolpe and Rogers shared one common technique, namely, telling the patient what the patient is like. Each also used several high-frequency techniques unlike the other. Wolpe primarily asked the patient about the problem but did not ask about the external situation nor tell the patient about external reality. Rogers primarily reflected and gave simple acknowledgment. Wolpe's and Rogers' use of all other techniques was minimal.

The data addressing questions two and three will be described both in terms of the summed interviews and the separate interviews of Wolpe and Rogers. The intention is that the description of the data from the individual interviews will complement the description of the data from pooled interviews.

Question Two

What are the similarities and differences in the conditions under which Wolpe and Rogers, as proponents of different approaches to psychotherapy, use the common technique(s) in the initial interview?

Tables 3 and 4 present the distribution of patient statements antecedent to the common initial interview technique of Wolpe and Rogers, that is, their telling the patient about the patient. Reported are both the individual and pooled data from the three Wolpe interviews and the two Rogers interviews. Figure 3 presents a graphic illustration of the pooled data while Figures 4 and 5 illustrate the individual interviews of Wolpe and Rogers.

Hypothesis 2: To the extent that Wolpe and Rogers use one or more common techniques in the initial interview, they will use such techniques under different conditions.

Comparing the percentages between the six patient categories antecedent to Wolpe's common technique, the pooled data (see Table 3 and Figure 3) shows that 38.2% were those statements in which patients described the self, while 29.4% were those in which patients provided information about the problem. No more than 14.7% comprised those antecedent statements in which patients either accepted or opposed the therapist, and no more than 5.8% comprised those statements in which patients either described an external scene or described an external target. Thus, Wolpe used the common technique differentially, following various kinds of patient statements.

Contrasting the frequencies between the six patient categories for each separate interview, Table 3 and Figure 4 shows that in interviews 1 and 2, at least 45.45% of Wolpe's use of the common technique followed statements in which patients were describing the self. However, this figure dropped to 10% in interview 3. In interview 2, he used the common technique frequently but under a different condition, that is he used it 50% of the time following

Table 3

Distribution of Patient Statements

Antecedent to Wolpe's Telling the Patient

About the Patient: Scoring Categories and Response Frequencies

Patient Antecedent Statements	Initial Interview							
	1.		2.		3.		Summed	
	f*	%	f	%	f	%	f	%
Patient relates to therapist								
1. Opposes	2	15.38	1	9.09	0	0	3	8.8
2. Accepts	1	7.69	1	9.09	3	30.0	5	14.7
Patient relates to the self								
3. Describes self	7	53.84	5	45.45	1	10.0	13	38.2
4. Informs of problem	2	15.38	3	27.27	5	50.0	10	29.4
Patient relates to external world								
5. Describes scene	1	7.69	0	0	1	10.0	2	5.8
6. Describes Target	0	0	1	9.09	0	0	1	2.9
Total:	13	99.98%	11	99.99%	10	100.0%	34	99.87%

Note: f = raw frequency

Table 4

Distribution of Patient Statements

Antecedent to Rogers' Telling the Patient

About the Patient: Scoring Categories and Response Frequencies

Patient Antecedent Statements	Initial Interview					
	1.		2.		Summed	
	f*	%	f	%	f	%
Patient relates to therapist						
1. Opposes	4	21.05	3	7.5	7	11.8
2. Accepts	6	31.57	17	42.5	23	38.9
Patients relates to the self						
3. Describes self	2	10.52	16	40.0	18	30.5
4. Informs of problem	0	0	0	0	0	0
Patient relates to external world						
5. Describes scene	2	10.52	0	0	2	3.3
6. Describes Target	5	26.31	4	10.0	9	15.2
Total:	19	99.97%	40	100.0%	59	99.7%

Note: f = raw frequency

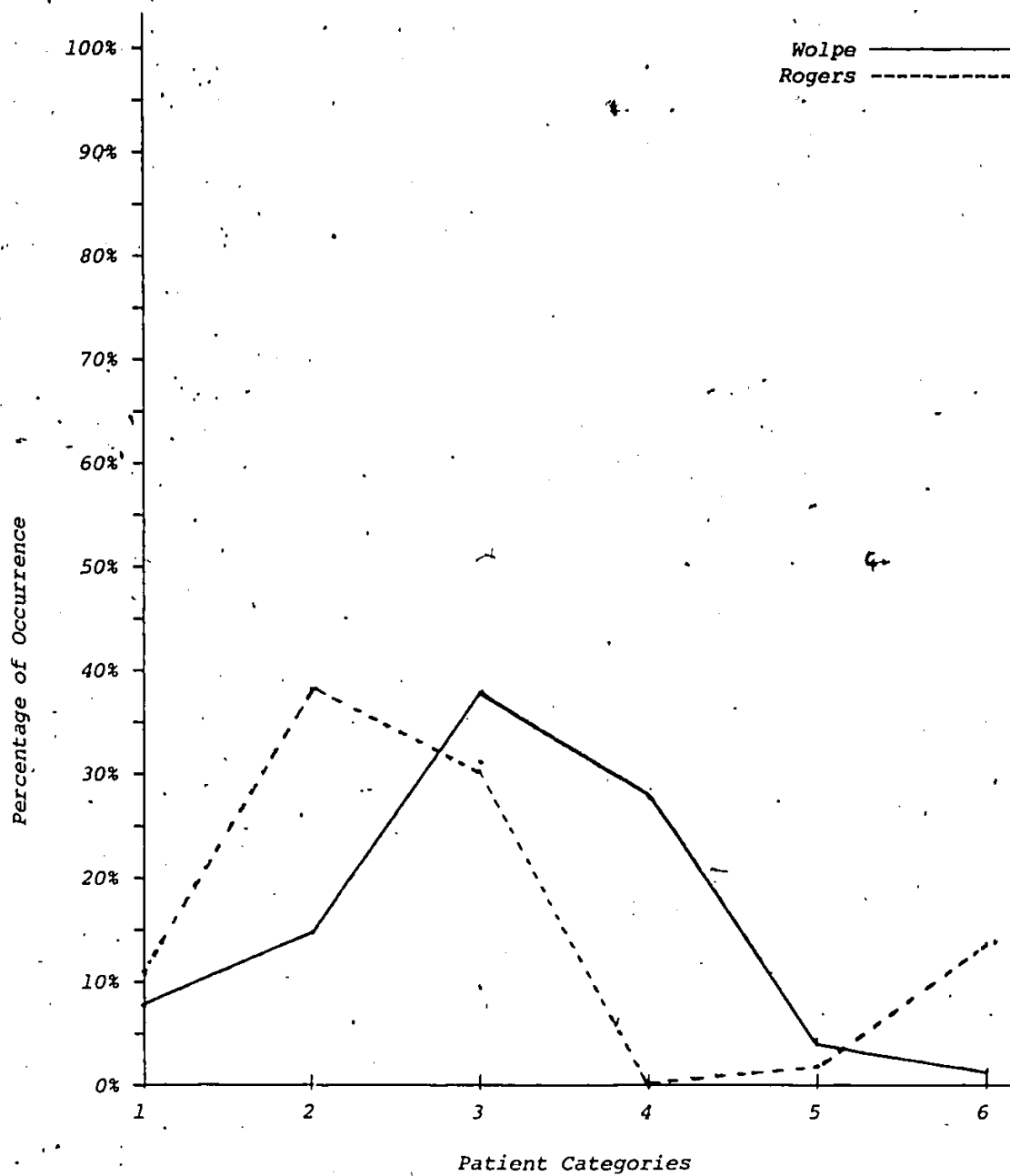


Figure 3

Comparison of the Response Distribution of Patient Statements

Antecedent to Wolpe's and Rogers' Common Techniques of

Telling the Patient About The Patient: Pooled Data

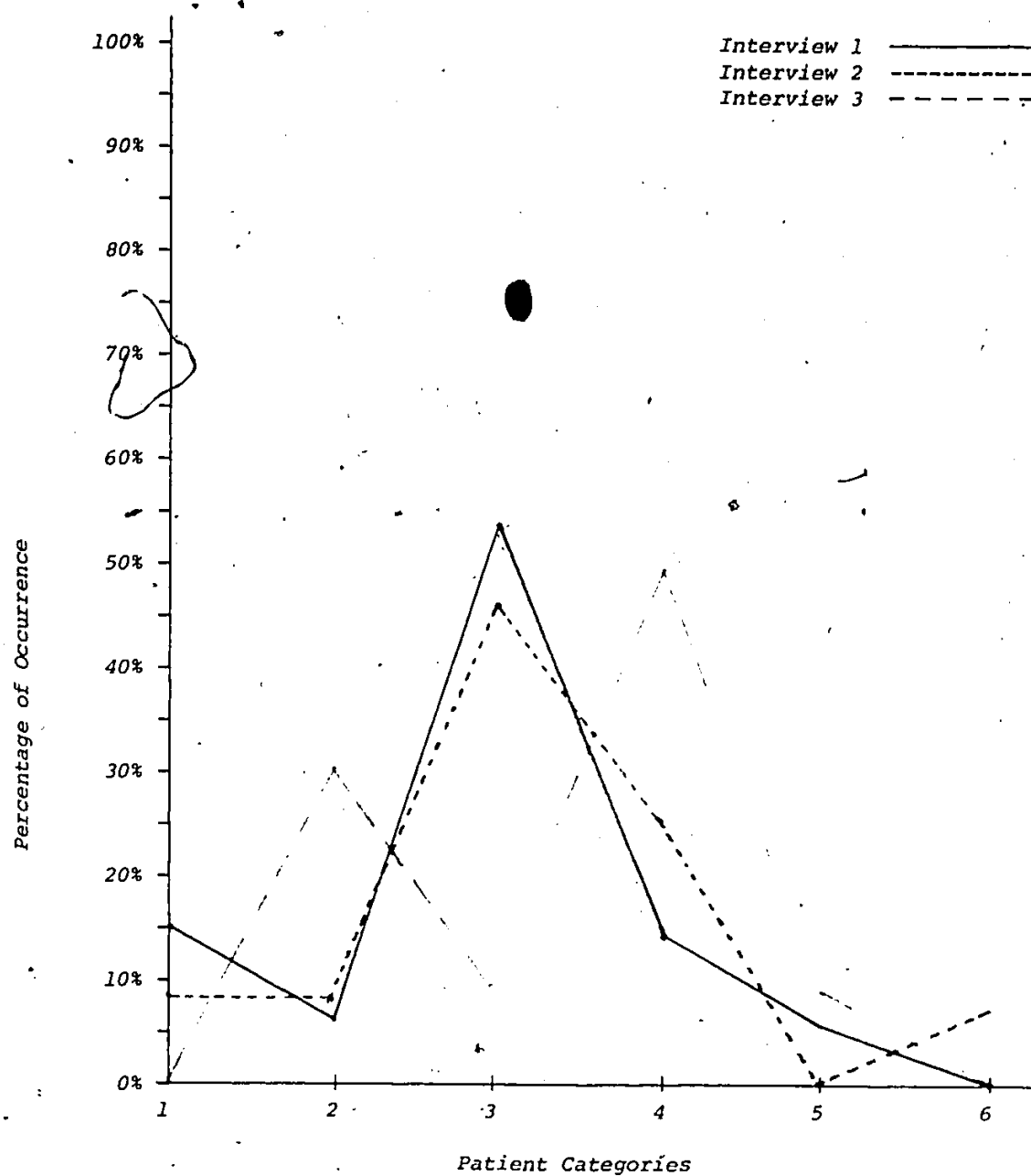


Figure 4

Comparison of the Response Distribution of Patient Statements

Antecedent to Wolpe's Common Technique of

Telling the Patient About The Patient: Separate Interviews

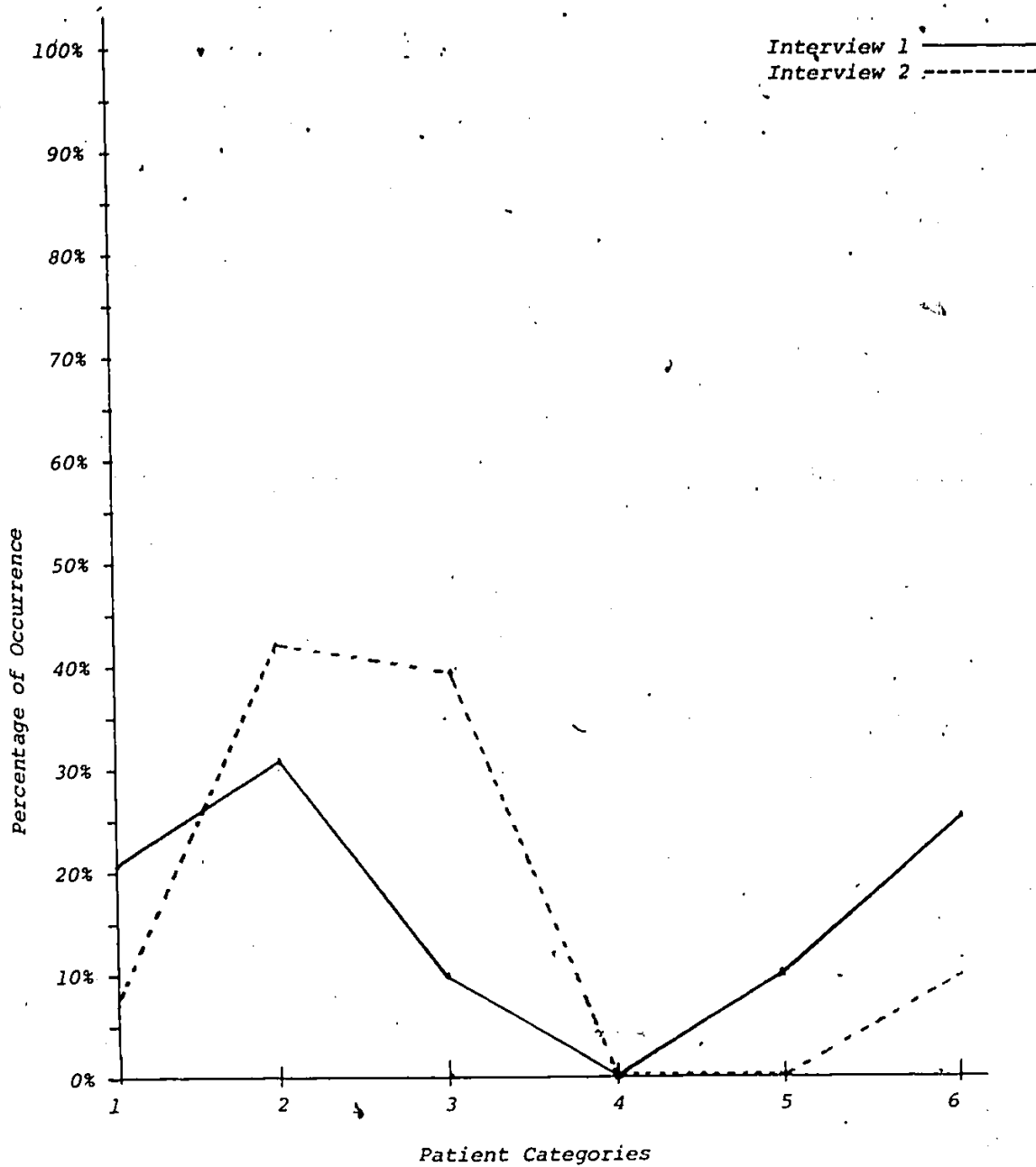


Figure 5

Comparison of the Response Distribution of Patient Statements

Antecedent to Rogers' Common Technique of

Telling the Patient About The Patient: Separate Interviews

the patient's informing about the problem. In all three interviews, not more than 15.38% of the time did Wolpe use the common technique after patients opposed the therapist, and no more than 30% of the time following patients accepting the therapist. Likewise, not more than 10% of the time in any one interview, was the common technique used after patients either described an external scene or defined a specific external target. Thus, in two interviews, Wolpe most often used the common technique (tells the patient about patient) after patients described the self, yet in one interview, he showed a moderate tendency (50% of the time) to use it after the patient informed about the problem. On the other hand, Wolpe used the common technique least often after patients accepted or opposed the therapist, as well as after patients either describe an external scene or described an external target.

The findings for Wolpe, pertaining to Hypothesis 2, suggests that Wolpe used the common technique differentially, following various antecedent patient statements in initial interviews. That is, statements in which patients related to the self by describing the self most frequently preceded Wolpe's telling the patient about the patient. Statements in which patients either related to an external world or related to the therapist rarely anteceded the common technique. Only to a moderate degree did statements, in which patients related to the self by informing about the problem, precede Wolpe's common technique.

Comparing the response frequencies between the six patient categories that were antecedent to Rogers' common technique, (see Table 4 and Figure 5) the pooled data indicate that 38.9% were statements in which patients accepted

the therapist, and 30.5% were those which described the self. No more than 15.2% comprised statements in which patients either opposed the therapist or described an external scene or target. Rogers did not use the common technique following statements in which patients provided information about the problem. Thus, Rogers used the common technique differentially, following various kinds of patient statements.

Within individual interviews, contrasting the response frequencies between six patient categories antecedent to Rogers' common technique, Table 4 and 5 indicate: in interview 1, 31.57% of Rogers' use of the common technique followed the patient's accepting the therapist and in interview 2, this figure was 42.5%. Statements in which patients described the self preceded the common technique 10.5% of the time in interview 1, but 40% in interview 2. In both initial interviews, no more than 21.5% of Rogers' use of common technique followed patients' opposing the therapist and no more than 26.31% followed patients' relating to an external target. Rogers did not use the common technique after patients informed about the problem. Thus, Rogers, in two interviews, most often used the common technique following statements in which patients accepted the therapist, however, in one interview, he showed a moderate tendency to use the common technique after the patient described the self.

The findings for Rogers, pertaining to hypothesis 2, suggest that Rogers used the common technique differentially, following certain classes of antecedent patient statements in the initial interview. That is, when patients related to the therapist by accepting the therapist, Rogers most often used the common technique. Statements in which patients either described the self or described a specific external target, anteceded the common technique

to a lesser extent, while statements in which patients either informed about the nature of their problem or described a general external scene, rarely anteceded the common technique.

Comparison of the antecedent conditions of Wolpe's and Rogers' common technique: The summed columns in Tables 3 and 4 indicated the overall tendency for Wolpe to use the common technique, most frequently, following patients' describing the self. Across three interviews, he used the common technique under this condition 38.2% of the time. Secondly, he used the common technique, 29.4% of the time following patients informing of the problem. On the other hand, Rogers, 38.9% of the time used the common technique most frequently, under the condition when patients' accepted the therapist. Not unlike Wolpe, Rogers also used the common technique under the condition when patients' described the self. Across two interviews Rogers used the common technique under this condition 30.5% of the time. Thus description of the pooled data suggests that, although there was some overlap in the conditions under which Wolpe and Rogers used the common technique, they essentially used it under different conditions.

Comparing the antecedent conditions of Wolpe's and Rogers' common techniques across individual interviews (see Tables 3 and 4), suggests that Wolpe was fairly consistent in his use of the common technique under two conditions, namely, the patient describing the self and the patient informing of the problem. In interview 1, Wolpe used the common technique following the patient's describing the self 53.84% of the time, in interview 2, 45.45% of the time and 10% of the time in interview 3. His use of the common technique following the patient's informing of the problem

was also consistent across interviews. In interview 1 he used the common technique under this condition 15.38% of the time, in interview 2, 27.27% of the time, and 50% of the time in interview 3.

On the other hand, Rogers was consistent in his use of the common technique but only under the condition of the patient accepting the therapist. In interview 1, he used the common technique under this condition 31.57% of the time, and 42.5% of the time in interview 2. His use of the common technique under the condition of the patient describing the self varied across sessions. In interview 1, he used the common technique under this condition 10.52% of the time and 40% of the time in interview 2.

In conclusion, description of both the pooled and individual interviews comprising the antecedent conditions of Wolpe's and Rogers' common techniques, suggest that Wolpe and Rogers were fundamentally different in their selection of antecedent conditions. However, some overlap does exist, and seems dependent upon the particular patients of Rogers and how he works with these patients.

Summary of Results: Question Two

The findings confirmed hypothesis 2, namely, that Wolpe and Rogers use the common technique under different conditions. Specifically, Wolpe used the common technique most often following statements in which patients described the nature of the self. Rogers, however, most often told the patient about the patient following statements in which patients accepted what the therapist said. Rarely did Wolpe use the common technique following any statements in which patients attended to something external, nor when

patients described a general external scene, provided information about the problem or opposed the therapist. To a moderate degree, Wolpe also used the common technique after patients' informed about the problem, while Rogers used it following patients' describing the nature of the self and their describing specific external concerns. Under each of these conditions, both therapists varied the consistency of their use of the common technique, however, Rogers tended to vary to a greater extent than Wolpe. Overall, some overlap existed between the antecedent of Wolpe's and Rogers' use of the common technique. This seems primarily due to the manner in which Rogers worked with different patients.

Question Three

For the common techniques used in initial interviews by both Wolpe and Rogers, as proponents of different approaches to psychotherapy, what are the similarities and differences in the patients' consequent or following statements?

Tables 5 and 6 present the distribution of patient statements consequent to the therapists' common technique in initial sessions. Figure 6 illustrates the summed data contained in Tables 5 and 6, while Figure 7 and 8 illustrate the data from the individual interviews.

Hypothesis 3: It is anticipated that the use of common techniques by Wolpe and Rogers will lead to different patient responses.

Comparing the response frequencies between the six patient categories that were consequent to Wolpe's common technique, the pooled data (see Table 5 and Figure 6) indicate that 38.23% were those statements

describing the self and 29.41% were those accepting the therapist. No more than 11.76% comprised any statements in which patients either opposed the therapist, informed about the nature of the problem, or described external concerns. Thus, certain classes of patient statements followed Wolpe's common technique to a greater degree than other classes of statements.

Inspecting the frequencies between the six categories for separate interviews, Table 5 and Figure 7 show that in interview 1, 38.46% of the patient's statements, consequent to Wolpe's common technique, were those which described the self. This figure was 36.36% in interview 2, and 40% in interview 3. Consequent statements in which patients' accepted the therapist comprised 23.07% in interview 1, 29.27% in interview 2, and 40% in interview 3. For any one interview, no more than 18.18% of patient statements comprised those in which patients opposed the therapist, no more than 9.09% comprised those in which patients informed of the problem, and no more than 10% comprised those in which patients described an external scene. Only in interview 1, did the patient, 23.07% of the time, describe an external target consequent to the common technique; yet this figure dropped to zero in interviews 2 and 3. Thus patients most frequently described the self, and secondly, accepted the therapist following Wolpe's common technique. Only to a slight extent did the other kinds of patient statements follow Wolpe's telling the patient about the patient.

Findings for Wolpe, pertaining to Hypothesis 3, suggest that patients followed the common technique with certain classes of statements to a greater degree than with other classes of statements. That is, consequent

Table 5

Distribution of Patient Statements

Consequent to Wolpe's Telling The Patient

About the Patient: Scoring Categories and Response Frequencies

Consequent Patient Statements	Initial Interviews							
	1.		2.		3.		Summed	
	f*	%	f	%	f	%	f	%
Patient Relates to Therapist								
1. Opposes	1	7.6	2	18.18	1	10.0	4	11.76
2. Accepts	3	23.07	3	27.27	4	40.0	10	29.41
Patient Relates to the Self								
3. Describes self	5	38.46	4	36.36	4	40.0	13	38.23
4. Informs of problem	1	7.6	1	9.09	0	0	2	5.88
Patient relates to external world								
5. Describes scene	0	0	1	9.09	1	10.0	2	5.88
6. Describes Target	3	23.07	0	0	0	0	3	8.82
Total:	13	99.98%	11	99.99%	10	100.0%	34	99.98%

Note: f = raw frequency

Table 6

Distribution of Patient Statements

Consequent to Rogers' Telling the Patient

About the Patient: Scoring Categories and Response Frequencies

Consequent Patient Statements	Initial Interview					
	1.		2.		Summed	
	f*	%	f	%	f	%
Patient relates to Therapist						
1. Opposes	5	26.31	2	5.0	7	11.86
2. Accepts	2	10.52	21	52.5	23	38.98
Patient relates to the self						
3. Describes self	4	21.00	14	35.0	18	30.50
4. Informs of problem	0	0	1	2.5	1	1.69
Patient relates to external world						
5. Describes scene	4	21.00	2	5.0	6	10.16
6. Describes Target	4	21.00	0	0	4	6.77
Total:	19	99.83%	40	100.0%	59	99.96%

Note: f = raw frequency

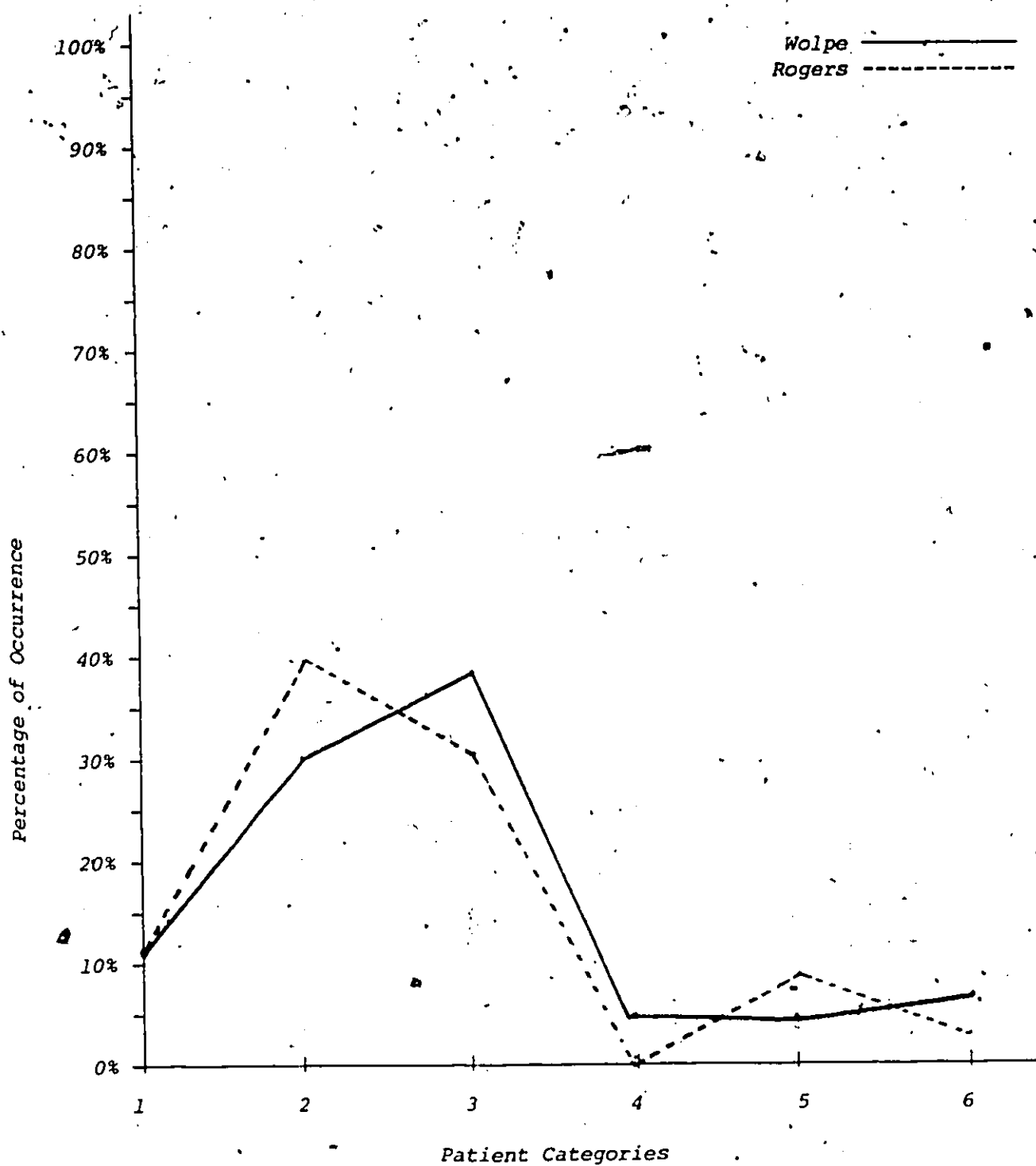


Figure 6

Comparison of the Response Distribution of Patient Statements
Consequent to Wolpe's and Rogers' Common Technique of
Telling the Patient About the Patient: Pooled Data

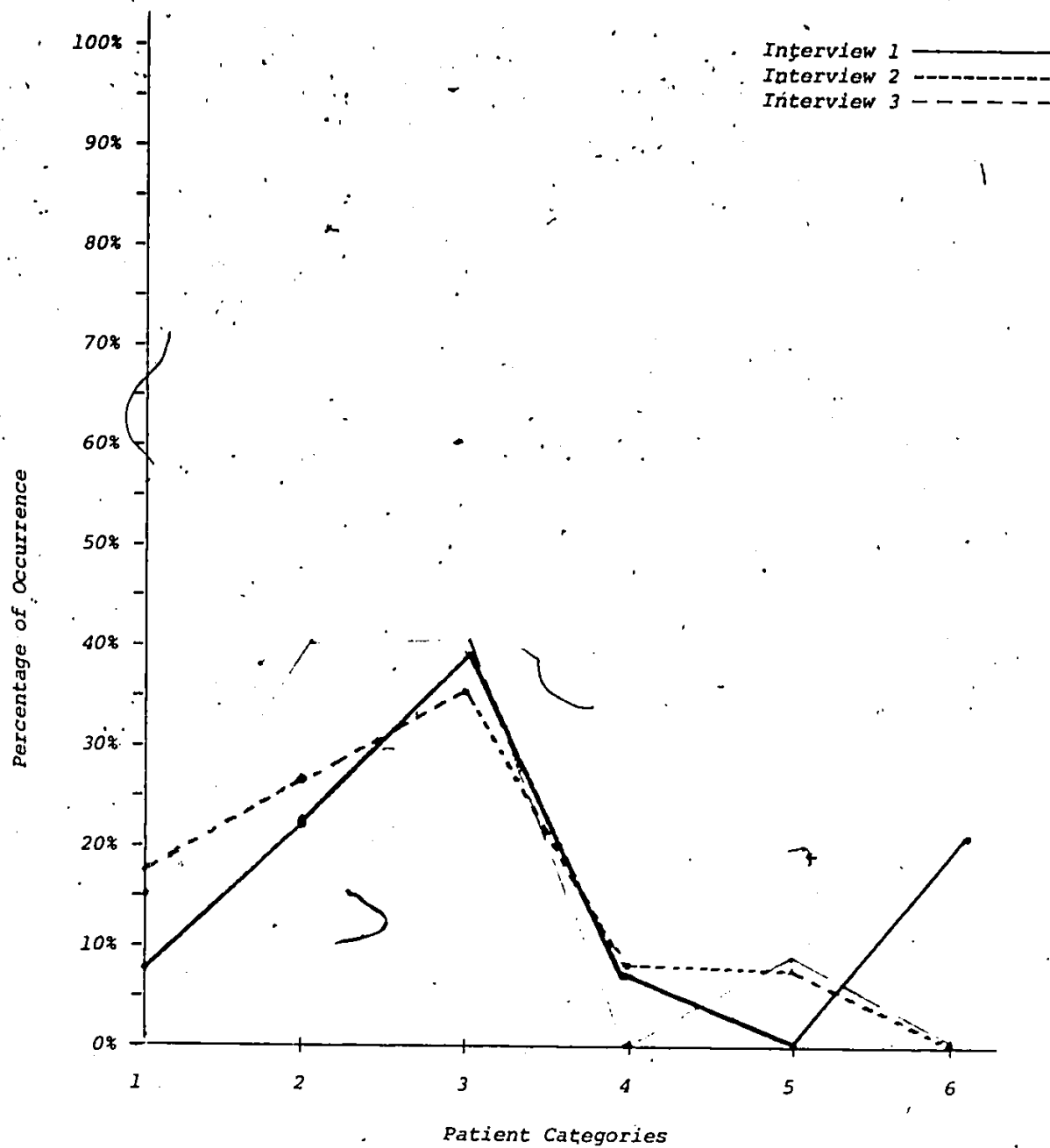


Figure 7

Comparison of the Response Distribution of Patient Statements
Consequent to Wolpe's Common Technique of
Telling the Patient About the Patient: Separate Interviews

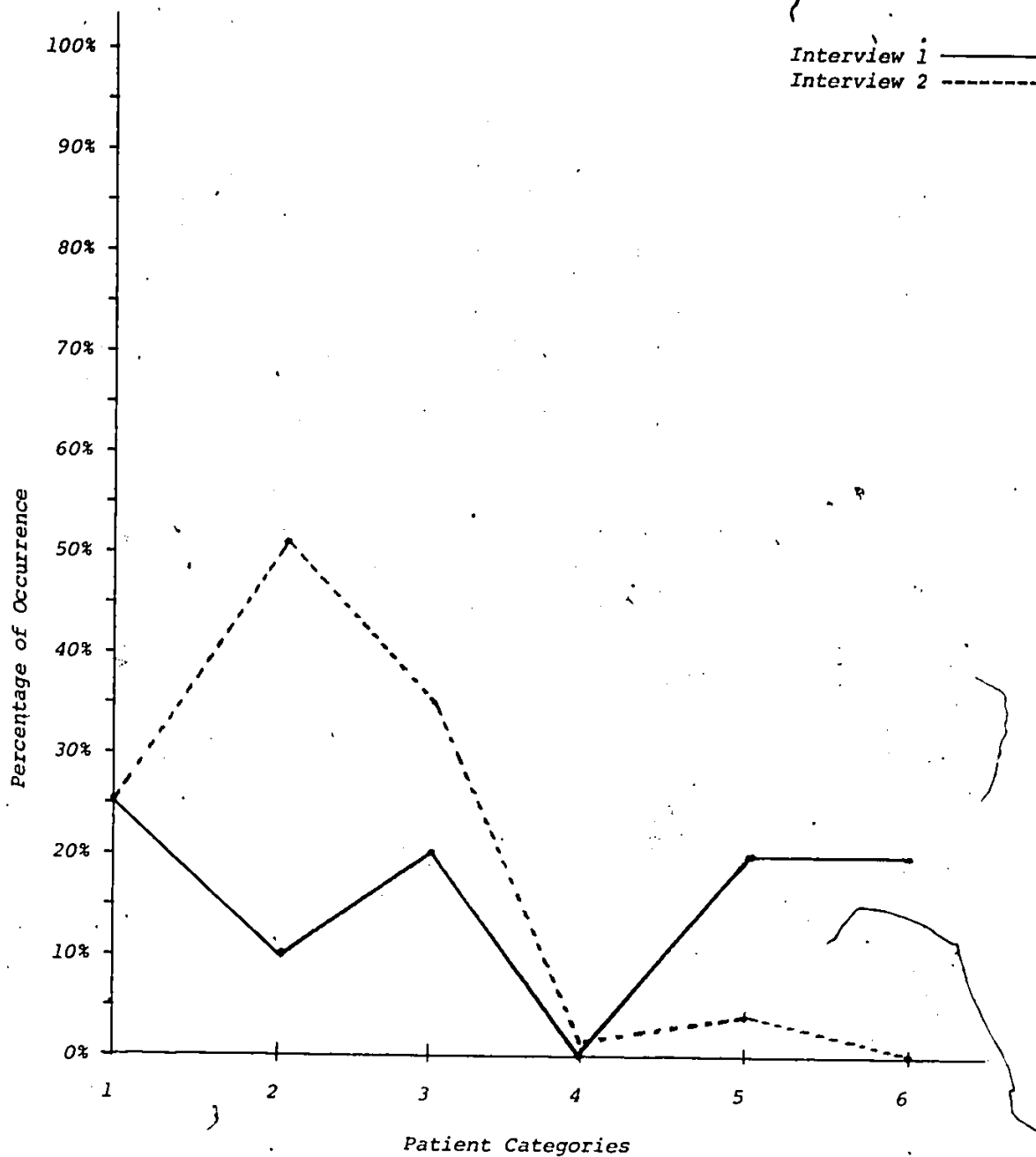


Figure 8
 Comparison of the Response Distribution of Patient Statements
 Consequent to Rogers' Common Technique of
 Telling the Patient About the Patient: Separate Interviews

to Wolpe's telling the patient about the patient, patients most frequently described the nature of the self and accepted what the therapist said. Patients did little else following the common technique in these initial interviews.

Comparing the frequencies between the six patient categories that were consequent to Rogers' common technique (see Table 6 and Figure 6), the pooled data indicate that 39.98% were statements in which patients accepted the therapist, and 30.5% were those in which patients described the self. No more than 11.86% comprised any statements in which patients either opposed the therapist, informed of the problem, described an external scene, or described an external target. Thus, consequent to Rogers' use of the common technique, patients differentially followed with certain classes of responses.

Contrasting the frequencies between the six patient categories for individual interviews, Table 6 and Figure 8, shows that in interview 1, 21% of statements consequent to the common technique, were those in which the patient described the self, while for interview 2, this figure was 35%. Statements in which patients accepted the therapist comprised 10.52% in interview 1 and 52.5% in interview 2. Any statements in which patients either opposed the therapist, described an external scene, or described an external target comprised no more than 26.31% in interview 1, and no more than 5% in interview 2. Patients informing of the problem did not occur in interview 1 and comprised only 2.5% of consequent responses in interview 2. Thus, description of separate interviews revealed that the patient's responding was actually more variable. One patient primarily opposed the therapist,

described an external scene and described an external target, while the other primarily accepted the therapist and described the self. Neither patient informed about the problem.

Thus for Rogers, the findings suggest that his use of the common technique exerted only a "soft" tendency for patients to respond in a uniform manner. Specifically, there was a "soft" tendency for patients to accept the therapist and describe the self.

Comparison of the consequent conditions of Wolpe's and Rogers' common technique: The summed columns in Tables 5 and 6 indicated the overall tendency for patients to most frequently respond to Wolpe's common technique by describing the self. Across three interviews they responded in this manner 38.23% of the time. Secondly, patients responded by accepting the therapist. Across two interviews, they responded in this manner 29.41% of the time. Likewise, patients of Rogers showed an overall tendency to most frequently respond to the common technique, by accepting the therapist. Across two interviews, patients responded in this manner 38.98% of the time. Secondly, patients responded to Rogers' common technique by describing the self. Across two interviews, patients responded in this manner 30.50% of the time. Thus, description of the pooled data suggests that although there were some differences in the consequences obtained by Wolpe and Rogers in response to their use of the common technique, patients essentially tended to respond in a similar manner.

Comparison of the consequences of Wolpe's and Rogers' common technique across individual sessions (see Tables 3 and 4), suggests that each of Wolpe's patients were consistent in their manner of responding to the common technique. Each patient responded to Wolpe's use of the common technique by describing the self 38.46% of the time in interview 1, 36.36% of the time in interview 2, and 40% of the time in interview 3. Secondly, they accepted the therapist 23.07% of the time in interview 1, 27.27% of the time in interview 2, and 40% of the time in interview 3. On the other hand, each of Rogers' patients varied considerably in their manner of responding to the common technique. In interview 1, Rogers' patient, consequent to the common technique, accepted the therapist 10.52% of the time and described the self 21% of the time. In interview 2, the patient accepted the therapist 52.5% of the time and described the self 35% of the time.

In conclusion, description of both the pooled and individual interviews, comparing the consequences of Wolpe's use of the common technique to Rogers', suggest that Wolpe and Rogers essentially obtained similar consequences. However, the degree of similarity seemed dependent upon the particular patients of Rogers.

Summary of Results: Question Three

The findings did not confirm hypothesis 3. That is, following Wolpe's and Rogers' common technique, telling the patient what the patient is like, patients generally tended to respond in a similar manner. When data was pooled, Wolpe and Rogers obtained similar consequences to their use of the common techniques. Specifically, patients most frequently tended to respond to both Wolpe's and Rogers' common technique by describing the nature of the self, and accepting what the therapist said. However, when separate interviews were described, the tendency for both of Rogers' patients to respond in this manner was less pronounced than for Wolpe's patients. That is, each patient of Rogers' tended to respond differently, while Wolpe's patients were quite consistent in their manner of responding to the common technique. However, description of the pooled data revealed that Wolpe's and Rogers' patients were generally similar in the manner in which they responded to the common technique, that is they tended to describe the self and accept the therapist. Overall, similarities existed between the manner in which patients responded to Wolpe's and Rogers' common technique however, patients also displayed some difference.

Summary of Results

The first question under study asked: which technique do Wolpe and Rogers use in initial interviews and which techniques are used, rather frequently, by both therapists? It was hypothesized that in initial sessions, Wolpe would primarily use four techniques: ask the patient for information about the problem; ask for information about external reality; tell the patient about the patient; and tell the patient about external reality. Rogers on the other hand, was expected to primarily use three techniques: reflection; simple acknowledgement; and telling the patient about the patient. It was also hypothesized that in the initial interview Wolpe and Rogers would share at least one technique, namely, telling the patient about the patient.

Both hypotheses were confirmed. The findings indicated that in initial sessions, Wolpe primarily used only two techniques, namely, asking the patient for information about the problem and, secondly, telling the patient about the patient. The extent to which Wolpe used most other techniques was minimal.

Considering which techniques Wolpe and Rogers shared, the findings indicated that each therapist was consistent across sessions in their use of one technique: telling the patient about the patient. In each initial session, both Wolpe and Rogers used this technique with moderate frequency. Thus, Wolpe and Rogers were found to share one common technique in initial sessions.

The second question under study asked: how do Wolpe and Rogers compare in the manner in which each used the common technique, that is, under what

conditions did each therapist tell the patient what the patient is like?

It was hypothesized that Wolpe and Rogers, proponents of different approaches of psychotherapy, would use the common technique under different conditions. This hypothesis was confirmed. The findings suggested that Wolpe and Rogers tell the patient about the patient under different conditions. Wolpe's use of the common technique primarily followed statements in which patients described and talked about the self, rather than when patients related to an external world or related to the therapist. However, Rogers' use of the common technique largely followed statements in which patients accepted what the therapist said, rather than when patients opposed the therapist, described the problem, or described a general external scene.

The third question under study asked: how did Wolpe and Rogers compare in terms of the manner in which patients responded to the common technique? It was hypothesized that Wolpe's and Rogers' use of the common technique would lead to different consequences. The hypothesis was not confirmed. The findings suggest that in initial interviews both Wolpe and Rogers generally obtain similar consequences to the common technique. However, consequences to Rogers' common technique seemed to vary with different patients, while the patients of Wolpe all tended to be consistent in their responding to the common technique. Specifically, in response to telling the patient what the patient is like, patients of Wolpe generally responded in two ways, namely, by describing the nature of the self and by accepting what the therapist said. These patients tended

not to respond to the common technique by informing about the problem, opposing the therapist, or by relating to external concerns. . For Rogers however, one patient responded by primarily accepting the therapist and describing the self, while the other patient showed only a "soft" tendency to respond in this manner. This latter patient, in addition, responded to the common technique by relating to external concerns and opposing the therapist.

Chapter IV

Discussion

In this chapter the following topics will be discussed: (a) the hypotheses and results in light of the clinical and research literature; (b) the methodological and procedural problems encountered during this investigation; and (c) the relevance of this study for the practitioner and for future psychotherapy research.

Results in View of the Literature

In the following paragraphs the results in view of the literature will be discussed in relation to several topics: (a) Wolpe's and Rogers' initial interview techniques, (b) the conditions under which Wolpe and Rogers used common techniques and (c) the manner in which patients responded to Wolpe's and Rogers' common techniques in initial sessions.

Wolpe's and Rogers' Initial Interview Techniques

It was hypothesized that Wolpe and Rogers, although fundamentally different in their approach to therapy, would have at least one technique in common, namely, telling the patient what the patient is like. The results confirmed this hypothesis. Relatedly, it was also hypothesized that in initial sessions Wolpe and Rogers would use several different techniques. Specifically, Wolpe would primarily ask for information about the patient and the problem, tell the patient about external reality, and ask for information about the situational context. Rogers, on the other hand, was expected to use other techniques such as reflection and acknowledgment. The results

confirmed this hypothesis although indicating that Wolpe concerned himself only with asking for information about the problem and the patient rather than the use of the other expected techniques. These findings will be further discussed below.

Wolpe's Techniques: The clinical literature (Brown, 1967; Klien et. al., 1969; Lazarus, 1972; Locke, 1971; Wolpe, 1973; Wolpe & Lazarus, 1966), indicated that, in the initial interview, Wolpe's function is to gather information about the patient's problem, provide information to the patient, and correct the patient's misconceptions about her self or her problem. The research literature (e.g. Becker, 1975) supported this expectation, showing that in initial sessions Wolpe provided a broad range of information to the patient, 26.2% of the time, and asked a broad range of questions, 60.60% of the time. As a result, Wolpe was described as active, directive and authoritative. In view of this literature, the present investigation hypothesized that in his initial interviews, Wolpe would specifically use four techniques: ask for information about what the patient or problem is like; ask for information about and clarify the external situational context; tell the patient what the patient is like; and tell the patient what external reality is like.

The first technique, asking for information about the patient, focuses both the patient's and therapist's attention upon the "self" and the nature of the problem. In contrast, asking for information about the external situational context focuses their attention upon things external to the self, such as, factual information about some other person, thing, object or situation. For example, if the patient refers to her drinking problem, the therapist, if gathering information about the problem, might say: "What

causes you to drink?" If however, the therapist asks about the external situation, he might ask: "What does your husband think about the drinking?" Although with each technique information is requested, their major difference is with respect to where the patient's and therapist's attention is focused.

Likewise, the distinction between telling the patient what the patient is like and telling the patient about external reality, is also a matter of where the patient's and therapist's focus of attention is directed. With the first technique the patient's and therapist's attention is focused upon the nature of the patient's personality, such as her feelings and thoughts. With the second technique, their attention is focused on events or things external to the patient's personality. For example, if the patient refers to her problem getting along with her second husband and his children, the therapist, telling the patient what the patient is like, might say: "Maybe you're confused if it's something about you that's causing the problem." If however, the therapist is explaining external reality, he might say: "Kids sometimes try to split their parents apart, in order to bond more closely with one parent."

The results of the present study indicated that only two techniques characterized Wolpe's first sessions. More specifically, Wolpe did little else other than ask for information about the patient, and tell the patient what the patient is like. As expected, Wolpe was found to be quite active in initial sessions, but the direction in which he focused his and the patient's attention was rather specific and limited to the patient's problem and what the patient is like. In this sense, Wolpe's approach could be considered "patient-centered"; using techniques which primarily focused

his and the patient's attention on the "self" and the problem, rather than on the therapist or things external to the personality of the patient.

In general, findings show that Wolpe does what he claims to do in initial sessions but is more limited in focus. Across three initial sessions, Wolpe orchestrated his techniques in a consistent manner and it therefore appears that he is quite predictable with regard to the techniques he uses in first therapy sessions.

Rogers' Initial Interview Techniques: The clinical literature (Rogers, 1942, 1957, 1961) provided expectation that Rogers' initial interviews would be characterized by the expression of the facilitative conditions, namely, empathy, warmth and genuineness. The empirical literature (Hill, Thames & Rardin, 1979; Stiles & Sultan, 1979; Stoten & Goos, 1974; Strupp, 1957) found that Rogers, in initial sessions, primarily used three basic techniques: reflection, simple acknowledgment and one in which he provided information or opinions about the patient to the patient. For clarity, the present research labeled this latter technique as telling the patient what the patient is like. It was hypothesized that in the initial interview, Rogers would primarily use these three techniques.

When Rogers (1957) provides acknowledgment he indicates he is sensitively listening and closely following what the patient is saying. Most commonly, this technique is expressed by the therapist saying "Uh-uh" or "Mmm-hmm" following various kinds of patient statements. When Rogers (1942, 1951) recognizes, reflects or re-frames the patient's immediate experiencings, he is largely expressing empathy. Although various levels of reflection and empathy have been defined (i.e. Truax & Carkhuff, 1967),

this research identified a reflection at the level where the therapist says what he believes the patient is saying or meaning. With the attention of the therapist primarily on the context of what the patient is saying, the therapist restates, clarifies or ~~mirrors~~ what the patient is saying. In effect the therapist says "You seem to be feeling this way...am I right?" ... "This is what you seem to be saying?"

Likewise, when Rogers tells the patient about the patient, he may be expressing empathy and in rare instances giving a sheer interpretation (Staines, 1969; Rogers, 1942, 1951). In contrast to a reflection, the therapist, based largely upon his own perceptions, theory, or ideas about the patient, tells or explains to the patient what he thinks the patient is like. With this technique the attention of the therapist is upon the kind of person the patient is, rather than on what the patient is trying to say. The therapist in effect might say to the patient: "You are this way"; "Here is what you are feeling"; "Here is how you are now"; "Here is what your relationships are like", or "This is what your reactions are about". When telling the patient about the patient, the therapist's words go significantly beyond the content of what the patient is saying and seem to express more than what the patient means. The therapist in one sense, expresses his view of the patient but that is rather implicit. When using this technique, the therapist is authoritative, telling rather than clarifying what the patient is like. Staines (1969) considers such a technique to be similar to an interpretation or a "deep" reflection. Hill, Thames and Rardin (1979) also find that such a technique is similar to an interpretation, indicating that judges had difficulty discriminating between a simple reflection

and the therapist interpreting.

The results indicated that in first interviews, Rogers does little else other than use three techniques, namely, saying what he believes the patient is saying; simple acknowledgment and telling the patient what the patient is like. As a result, Rogers primarily is non-directive in his therapy approach but authoritative gestures are present. Although it is not clear if these techniques are indeed the vehicles for the expression of empathy, warmth and genuineness, the findings further support previous empirical literature, confirming that Rogers does use the same set of techniques in first interviews.

Stiles (1979) studied the initial interviews of client-centered therapists and found that in addition to reflecting and giving acknowledgment, they self-disclosed rather often but rarely provided information about the patient, or expressed opinions to the patient. In contrast, the present study found that Rogers rarely self-disclosed but frequently gave information about the patient to the patient. It appears, that in initial sessions, client-centered therapists are more conservative than Rogers in the extent to which they are authoritative and tell the patient about the patient, yet express their personal feelings and experiences to the patient more often than Rogers in his initial sessions. Since Rogers (Evans, 1975) suggests that self-disclosure of the therapist's personal feelings, thoughts and experiences is one way of expressing genuineness, the question is raised concerning how else might genuineness be expressed in Rogers' first sessions or how much genuineness is necessary to convey?

Variability of Rogers' Techniques: This research found that the extent.

to which Rogers reflected and gave acknowledgment tended to vary across interviews, yet he was consistent in his telling the patient about the patient. The empirical literature (Hill et.al., 1979; Stiles & Sultan, 1979; Strupp, 1957) also suggests similar variability with regard to his use of reflection and acknowledgment, but each study looked only at one initial session and each used different sets of therapist categories classifying Rogers' techniques. The results of the present study are based upon a methodology which used one set of therapist categories but studied the initial sessions of two different patients. As a result, comparison of the data from the present study with past research raises questions concerning: (a) whether Rogers' variability is due to his individualized approach to therapy (Shapiro 1977; Rogers, 1951) and whether the varying use of these techniques is connected to varying degrees of the facilitative conditions and patient differences, or (b) whether his variability is due to the use of different sets of therapist categories.

Comparing Wolpe's and Rogers' Initial Interview Techniques: Wolpe and Rogers differed in that each used a different set of "favored" techniques, characteristic of their respective theoretical orientations. Wolpe was openly directive and active, continually asking for information about the patient and the problem. His manner of asking questions primarily focused the patient's attention on the patient and the problem rather than on things external to the patient. In contrast, Rogers seemed less directive, instead he reflected and gave acknowledgment. Perhaps with this technique Rogers conveyed to the patient that he is actively listening and that the patient is the one leading and directing the session.

Patient differences seemed to have little effect on Wolpe's therapy style, he was relatively consistent across sessions in the use of his major techniques, and seemed to be the same regardless of which patient he was working with. Rogers however, tended to vary the extent to which he used his two major techniques with different patients and as a result seemed more flexible in his approach. It appears that patient differences did influence his therapy style.

Wolpe and Rogers were similar in that both shared a common technique, namely, telling the patient about the patient. For Wolpe, this authoritative technique is compatible with his openly directive, active and authoritative style (Klein et.al., 1969; Wolpe, 1973), yet for Rogers (1942), it seems less compatible with his "non-directive" approach. However, since telling the patient about the patient is difficult to distinguish from a reflection, Rogers' use of such a technique might be more subtle in nature than Wolpe's. As a result, it is possible that patients are not actually aware that Rogers is conveying his own opinion to the patient rather than simply clarifying or restating what they are trying to say.

Both therapists, in their use of this common technique, were consistent across sessions and each used it with the same relative frequency as the other. Therefore, for Wolpe and Rogers, this technique seems important, one not overly relied upon yet one not easily overlooked. Also, it appears that in first sessions, the techniques, roles or styles of Wolpe and Rogers to some extent overlap.

Wolpe's and Rogers' Common Initial Interview Technique

The research literature (Becker, 1975) found that in initial interviews, Rogers and Wolpe had one technique in common, that is, one used at

least five percent of the time by each therapist. Becker found that both therapists provided the patient with information about the patient. In two initial sessions, Wolpe used such a technique 25.2% of the time, while Rogers used it 14.9% of the time. In the present research, such a technique was labeled as the therapist tells the patient what the patient is like. Relatedly, the clinical literature (Brown, 1967; Fisher, et.al., 1973; Rogers, 1942, 1961; Wolpe, 1973; Wolpe & Lazarus, 1966) indicated that in the initial interview, other techniques such as reflecting and simple acknowledgment might also be shared. It was therefore hypothesized that at least one technique, namely, telling the patient about the patient, would be used by both therapists in initial sessions.

Results confirmed this hypothesis, and showed that a single technique was common, that is, both Wolpe and Rogers spent considerable time telling the patient what the patient is like. For Wolpe, this was his second most frequent technique, his first was asking about the problem; while for Rogers, it was his third most frequent technique, the other techniques being reflection and acknowledgment. The extent to which Wolpe and Rogers used this common technique was similar to that found by Becker, although in his research the definition of such a technique was broader. It appears that the extent to which these therapists used this common technique suggests that it has a definite place in their initial interview repertoire.

Telling The Patient What The Patient Is Like: An Interpretation?

In the present research the technique of telling the patient what the patient is like was defined as: the therapist names, describes, labels, tells about the kind of person the patient is. This may include telling

the patient about the kinds of problems she has, the kinds of thoughts she has and the kinds of feelings she has. The therapist speaks from his own perspective, and as an authority, tells the patient how the patient functions, what her interpersonal relationships are like, what her relationship to the self is like, and what kind of world the patient lives in and creates for herself. In effect, the therapist is saying "Here is the way I see you... here is the way you are...you seem like a person who wants to do this or do that...here is the kind of problem you have...here is how I see your problem". Thus, the therapist in effect, is the authority and interpreter in telling the patient what the patient is like.

In several major systems of content analysis, such a technique has also been described, but labeled as an "interpretation". Dollard and Auld (1959), categorize an interpretation when the therapist labels, names, connects motives and ideas not previously connected, or draws discriminating meanings falsely believed to be connected. Snyder (1945) categorizes an interpretation when the therapist explains why the patient feels or does something, or makes a statement implying causation. In effect the therapist says "You do this because..." or the therapist may tell the patient how the patient is, saying in effect: "You are revealing feelings of inferiority"; "When people feel frustrated they often act the way you do"; "Here is your problem". Strupp (1957) also categorizes an interpretation when the therapist establishes connections, states definitions of the patient's problem, or analyzes the patient's defenses. Hill (1978), in her category system, describes an interpretation when the therapist goes beyond what the patient has recognized, establishing connections between events, defenses and feelings.

Such connections include pointing out of themes, patterns, and causal relationships related to the patient's behavior or personality. The therapist may give new meanings to old issues or behaviors. Stiles (1979), in his category system, describes an interpretation as the therapist speaking from his own view of the other's experience. A formal theory may serve as the speaker's frame of reference and the therapist may make connections for the patient, explain, label or draw conclusions about the patient to the patient. Thus, statements in which Wolpe and Rogers tell the patient about the patient could be considered as interpretations. It therefore appears that in initial interviews, a prominent behavior therapist and a prominent client-centered therapist use, with considerable frequency, a technique commonly referred to as an interpretation.

Brunink and Schroeder (1979) consider that such a technique is one that many therapists use regardless of their theoretical orientations. For Wolpe (1958, 1973) this technique is used in the service of correcting misconceptions, while for Rogers (1942, 1951) it is largely for clarifying and re-framing the patients' immediate experiencings and feelings. Although the writings of Wolpe and Rogers make reference to their use of such a technique neither therapist claim it to be a major technique for their initial sessions.

Nonetheless, it appears that a major initial interview technique of Wolpe and Rogers is one in which they convey their views of the patient to the patient. This is surprising for Rogers, since theoretically his role in therapy is to recognize, understand and accept the patient's phenomenological world rather than to alter it in any way. In contrast, Wolpe's use of this technique is quite understandable since the literature clearly

illustrates his authoritative and directive role in therapy. Noteworthy is that both therapists find it appropriate to convey their views of the patient in the first interview, although the critical question becomes: when do they do this and under what kinds of conditions? The following is a discussion of this issue.

Under What Conditions do Wolpe and Rogers Interpret?

No clinical or research literature stated the specific conditions under which Wolpe or Rogers would interpret. The manner in which these therapists use this technique has never been explicitly addressed, that is, virtually no data exists on such an important issue. It was therefore hypothesized that Wolpe and Rogers, as proponents of different therapy approaches, would interpret under different conditions. The results confirmed the hypothesis and delineated several conditions under which Wolpe and Rogers tended to interpret in the initial session. These conditions will be described below.

Conditions for Wolpe's Interpretations: Wolpe was found to interpret primarily under two conditions: (a) when patients described the self and (b) when patients informed about the problem. Specifically, as patients described the self, they tended to describe and talk about the kind of person they are, the sort of problems they have, how they tend to behave, the nature of their personality, and the kinds of relationships they have. The focus of their attention is predominantly on something within their own personality. In essence, patients may say: "This is the way I am...this is the way I've been...here are the kinds of feelings, thoughts, body sensations I have...these are the kinds of reactions I have to myself". In general.

patients build and construct a world in relation to the "self", something within their own personality. When Wolpe interprets, it is most frequently following patient statements of this nature.

Wolpe also tended to interpret following statements in which patients informed about the problem, that is, provided factual information about the problem or the self. For example, patients may tell how the problem began, what it was like or how extensive it is. They may provide general demographic data about themselves, such as their age, how long they have been married and what kind of work they do. With this kind of statement, patients are largely attending to information that is factual in nature and rather specific and differentiated from the "self" and the kind of person each is.

Interestingly enough, both antecedent conditions are of the variety in which each patient's attention is primarily focused on the "self", something within or about their personality, and not on the therapist or something external. Wolpe rarely interpreted when patients focused their attention on something external (i.e. "My boyfriend and the way he is"), moreover, he rarely interpreted when patients focused their attention on the therapist (i.e. the kind of person the therapist is or whether the therapist's statements are accurate or not).

It seems, therefore, that there are special conditions when Wolpe tells the patient what the patient is like. That is, he tended to seize the opportunity to interpret when patients were, already attending to and focused upon the self, the problem or something within the personality. Perhaps Wolpe finds that the best time to authoritatively tell the patient about the patient, is when their attention is already on the self. In other

words, it may be that when interpreting, it is unwise to shift the patient's attentional center from another domain (i.e. the therapist or something external) onto the self.

Conditions for Rogers' Interpretations: Several conditions were found under which Rogers would tend to interpret in initial sessions. Specifically, Rogers most frequently interpreted when patients accepted the therapist, that is, when they conveyed being pleased with and feeling good about the therapist and what he said. In essence, they might say: "Yes it does seem that way... yes you are right...yes I agree with you...you do understand me". Patients are in full interaction with the therapist and the world being constructed is in direct relationship to the therapist.

Rogers also interpreted, but with less frequency, under conditions when patients: (a) described the self, (b) described a specific external scene (i.e. the awful expression on mother's face), and (c) opposed or disagreed with what the therapist said. Rarely did Rogers interpret when patients provided factual information about the problem or when patients described general external scenes (i.e. "those nosey people at work"). It appears that Rogers interprets under a variety of conditions, favoring however, the conditions when patients are accepting of the therapist and what the therapist says. Although less dramatic, the finding that Rogers is somewhat selective with regard to the conditions under which he interprets is in agreement with the conclusion of Truax (1966), namely that Rogers is selective in the manner in which he uses various techniques.

Of interest is the fact that Rogers chooses to authoritatively present his view of patients largely at times when patients are already accepting

and receptive of what he is saying. Perhaps this opportunity is critical in that it allows for his statements to have the strongest impact.

Comparing Wolpe's and Rogers' use of Interpretation: The findings for both Wolpe and Rogers confirmed the hypothesis that Wolpe and Rogers interpreted largely under different conditions. It seems that for Rogers, the critical time is when the patients are focusing on the therapist, accepting what is said; yet for Wolpe, it seems it is when patients are either describing the self or giving factual information about the self. Wolpe tended to "listen" in this manner in three different initial interviews but Rogers, in two initial interviews, seemed more variable in his manner of listening to patients. Perhaps Rogers' variability is due to (a) the possibility that he tends not to subscribe to antecedent conditions for his interpretations, that is, the results may be due more to chance factors; (b) Rogers listens at a "level" not identified by the particular patient categories used in this study; or (c) the interviews might have been conducted many years apart.

In any event, Wolpe's and Rogers' reasons for interpreting under these particular conditions are not clear. The identification of these antecedent conditions however, provide some clues to how they listen and the particular guidelines they tend to follow in first sessions. Relatedly, the earlier work of Fiedler (1950, 1951) suggested that experienced therapists of differing orientations use similar techniques. However, the finding that Wolpe and Rogers use similar techniques, but under different conditions, extends Fiedler's notion and further suggests that it is in the conditions under which similar techniques are used that critical differences emerge between therapists of differing orientations.

Wolpe and Rogers have been found to interpret under different therapeutic

conditions, a related question becomes how do patients respond to Wolpe's and Rogers' use of this technique? This issue will be discussed below.

Consequences of Wolpe's and Rogers' Interpretations

Neither the clinical writings nor empirical research has stated how patients would respond to Wolpe's and Rogers' telling the patient what the patient is like. Nevertheless, the hypothesis was formulated that the consequences, following Wolpe's and Rogers' interpretations in the initial interview, would be different. The results did not confirm this hypothesis. Following Wolpe's and Rogers' interpretations in the initial interview, patients responded in a similar manner. The manner in which patients tended to respond will be discussed.

Patient Responses to Wolpe's Interpretations: The results identified several types of responses Wolpe's patients tended to make following his telling the patient what the patient is like: (a) accept, agree and welcome what the therapist had said and (b) describe the self and the kind of person they are. With respect to the first response, it is not clear if patients were simply acquiescing to Wolpe's authority or incorporating his view of them. However, Wolpe (1973) does to some extent value an acquiescing attitude on the part of the patient and perhaps his telling the patient what the patient is like has, in part, this goal in mind.

The complaint is that the behavior therapist assumes a kind of omnipotence by demanding the patient's complete acquiescence in his methods, which, it is felt, denudes the patient of human dignity. The truth is that the grade of acquiescence required is the same as in any other branch of medicine. Patients with

pneumonia are ready to do what the medical man prescribes, because he is the expert. Why should the expectation be different when psychotherapy is the treatment? (p. 13).

With regard to the second type of response patients made, its very nature is that of "self-exploration"; that is, patients focused their attention primarily on the self and the kind of person they are. They described the kinds of problems they have, their feelings, thoughts, reactions, behaviors, the kind of personality they have and the kinds of relationships they have. Although Wolpe's writings do not indicate that self-exploration is one of his major aims in the initial session, it may perhaps be a desired behavior for his patients to display.

Patient Responses to Rogers' Interpretations: The results identified several kinds of responses Rogers' patients tended to favor following his telling the patient what the patient is like: (a) accept, agree and welcome what the therapist had said and (b) describe the self and the kind of person they are. Both these consequences are not surprising since they are both valued by Rogers (1951, 1957, 1975) and have been found to be common responses to therapist's reflections and expressions of empathy (Bergin & Strupp, 1972; Bergman, 1951; Mitchell, et.al., 1977). That is, since the technique of telling the patient what the patient is like both resembles a reflection and to some extent expresses empathy (Hill et.al., 1979; Staines, 1969; Rogers, 1942), it is understandable that similar patient responses might also follow this technique.

When both of Rogers' initial interviews were analyzed separately however, the tendency for Rogers' interpretations to exert these particular consequences

from each patient was not as powerful. In one interview, the patient did accept what the therapist said and described the kind of person she is, but the second patient responded to Rogers' interpretations in a variety of other ways. Specifically, this patient's responses involved describing both specific and general external scenes as well as opposing the therapist. As a result, the analysis of separate interviews leads the present author to conclude that Rogers' interpretations exerted only a "soft" tendency on patients to self-explore and accept what the therapist says.

This finding raises serious questions concerning the predictability of patient responses with respect to Rogers' use of this technique. Perhaps one of these patients may have been a particularly "difficult" patient to work with and did not respond in the manner desired by Rogers. On the other hand, it is also possible that the responses given were those that Rogers aimed for with these particular patients. In any event, it is unclear what actually lead to the variability of responses between different patients.

Comparing Patients' Responses to Wolpe's and Rogers' Interpretations:

It was predicted that since Wolpe and Rogers are therapists of differing therapeutic orientations, their use of mutual technique would lead to different kinds of patient responses. However, results hint that patients, of both therapists, tended to respond in a similar manner.

It was found that consequent to Wolpe's and Rogers' interpretations, patients tended to accept the therapist and describe the self. However, subsequent to the analysis of the separate interviews of Rogers, it seemed that such responses were not consistent across both sessions, whereas for Wolpe, all his patients tended to respond in a comparable manner. Thus, Wolpe's use of

the common technique exerted more pronounced and stable consequences than Rogers, although the overall manner in which patients of both therapists tended to respond, was similar in nature.

It is not completely clear if these findings suggest that techniques used by therapists of differing theoretical orientations tend to lead to predictable consequences or whether consequences are primarily linked to a particular therapist's use of that particular technique. Perhaps the study of consequences of various therapy techniques will lead to variable findings if other factors are not taken into account. That is, patients' responses may be contingent on more than the immediate antecedent therapist technique. Such variables as the therapist's voice tone, mannerisms, personality, the nature of the patient's problem or their "learning" the proper responses over time must be taken into consideration (Garfield, 1978).

One possibility which may account for the diversity of patient responses to the same technique is that patients' responses may be linked to the various conditions under which the therapist uses his techniques (Mahrer, 1979). For example, if Rogers interprets when the patient accepts the therapist, consequence A may result. However, if Rogers interprets when the patient opposes the therapist, consequence B may result. Such a model would have been easily studied in the present investigation but due to the low frequency of occurrence of the common technique in each of Wolpe's and Rogers' interviews, such a relationship between these therapy events could not be meaningfully looked at. Nevertheless, it is clear that more data needs to be taken into account when studying consequences of therapy techniques.

In summary, the results of the study denominate the following conclusion: Wolpe and Rogers are essentially different in the manner in which they conduct their initial psychotherapy sessions. Specifically, in first sessions, each therapist "favors" a different set of major techniques having, however, one technique in common. This common technique, only occurred to a moderate degree in each of their sessions, but appeared to be used under different conditions by Wolpe and Rogers. Their use of this technique, however, led to similar consequences; that is, there was a "soft" tendency for patients of both therapists to respond to the common technique in a similar manner.

Methodological and Procedural Shortcomings

In this section the methodological and procedural shortcomings of the present investigation will be discussed. The objective is to temper the results and conclusions in light of the methodological drawbacks, and forecast to researchers various problems which may be encountered in similar research.

In this investigation, the major difficulty encountered was the classification of certain kinds of therapist statements which might fall into two categories, or statements in which it was unclear what the therapist was doing. For example, the following therapist statement was difficult to categorize: "you seem to be feeling a bit confused, and perhaps afraid of that part of you which gets angry at your mother." In this type of statement the therapist could simply be reflecting, saying what he believes the patient is saying or perhaps the therapist could be telling the patient what the patient is like. With ambiguous statements of this nature, raters lacked systematic criteria upon which to base their judgements and usually resorted to their own personal and varying criteria.

Stiles (1979) notes that at least two dimensions are important to consider when categorizing therapist and patient statements, namely, the form of the statement as well as the inferred intent of the statement. Thus, one way around the categorization problem encountered in the present research would have been to instruct judges to rate therapist statements using either the form or intent dimension suggested by Stiles. Conceivably, this would have given at least a common perspective from which all judges would be basing their decisions and perhaps have led to data of a different nature.

A second drawback is with regard to the fact that a total of only five initial interviews were examined. This fact tempers the conclusions drawn

and greatly limits the generalization of results. That is, results are safely generalizable to these particular patients in these particular interviews. The findings of this research are therefore more along the lines of hypotheses rather than hard conclusions worthy of bold generalizations.

Implications of Results

The clinical issues investigated in this study as well as the results have practical implications for the practitioner-researcher and for future psychotherapy research. These implications will be discussed below.

Implications for the Practitioner-Researcher

One broad contribution of this research is that it provides the practitioner-researcher a model for systematic self-study. First, through the use of any set of therapist and patient categories, practitioners can identify the techniques they use as well as make sense of antecedent and consequent patient responses. In this regard, practitioners can begin to answer such important questions as: "How do I listen to patients and what kinds of data are important?" "What techniques do I use and when do I use them?" "What effects do my techniques have, under what conditions and with what kinds of patients?" "Which techniques work and which do not?" (Bergin & Strupp, 1972; Hyden, 1975; Kiesler, 1966; Lambert & Bergin, 1976; Luborsky, Chandler, Auerback, Cohen & Bachrack, 1971; Mahrer, 1979; Mukulas, 1972; Strupp, 1973).

A second, more specific, contribution of this research is that the results provide a basis from which therapists can compare their therapy behaviors in first sessions to the behaviors of two experienced and competent therapists. Such questions could be examined as: "How do my initial sessions compare to Wolpe's and Rogers'?" "How similar or different is Wolpe's and Rogers' use of interpretations to mine?" "If carrying out similar initial interview objectives as Wolpe and Rogers, which techniques do I use?". Correspondingly, the results from this study also provide a basis for teaching students how to do initial sessions as a master behavior therapist and master client-centered therapists do. Relatedly, results might also serve as a criterion for selecting client-centered or behavioral interviews for investigation purposes (Stiles, 1979).

Implications for Future Research

The present study suggests that, in the investigation of psychotherapy process, therapist activities should be considered in conjunction with patient activities. That is, future research should direct its attention towards uncovering the relationship of therapist techniques as linked to various patient in-therapy events. For example, focusing on in-therapy, process-outcome, the present investigation studied the "patient-therapist" and "Therapist-patient" interchanges. Future research however, might dilate this "window" in a variety of ways (i.e. the "patient-therapist-patient" exchanges), seeking to illuminate which factors lead to various outcomes within the session.

Secondly, this study offers several specific suggestions for follow up investigations, namely: (a) Wolpe's and Rogers' use of interpretation in non-initial sessions, ((b) the initial sessions of other experienced client-centered and behavioral therapists, especially their use of common techniques, and (c) common techniques of experienced therapists from theoretical orientations other than those studied in the present investigation. The overall goal of such studies would be to compare other therapists; cataloging those techniques used by most therapists and document the various ways they are used. That is, a careful study of conditions - operations - consequences, will tell a therapist what to do (Mahrer 1979).

References

- Andrews, J. Personal Change And Intervention Style. Journal of Humanistic Psychology, Vol. 17, No. 3, Summer 1977, pp. 41-63.
- Argelander, H. The Initial Interview in Psychotherapy. Human Sciences Press: Behavioral Publications Inc., 1976.
- Ashby, J.D., Ford, D.H. Guerney, B.G. & Guerney, L.F. Effects on Clients of a Reflective and a Leading Type of Psychotherapy In G.E. Stollack, B.G. Guerney, Jr., & M. Rothberg (eds.) Psychotherapy Research: Selected Readings (Chicago: Rand McNally, 1966) pp. 546-585.
- Auerbach, A.H. An Application of Strupp's Method of Content Analysis of Psychotherapy. Psychiatry, 26, 1963, pp. 137-148.
- Auld, F. Jr. & Murray, E.J., Content Analysis Studies of Psychotherapy, Psychological Bulletin. 1955, 52, pp. 377-395.
- Bales, R.F. Personality and Interpersonal Behavior (New York: Holt, Rinehart & Winston, 1970).
- Bandura, A., Lipsher, D.H. & Miller, P.E. Psychotherapists' Approach-Avoidance Reactions to Patients' Expression of Hostility. Journal of Consulting Psychology, 24, 1960, pp. 1-8.

Barnabei, F., Cormier, W.H. & Nye, L.S. Determining the Effects of Three Counselor Verbal Responses on Client Verbal Behavior. Journal of Counseling Psychology, 22, 1974, pp. 355-359.

Becker, I.M. Rational Emotive Therapy: A Study of Initial Therapy Sessions of Albert Ellis. Dissertation Abstracts International, 36, (6-B), December 1975, pp. 3018-3019.

Becker, I.M. & Rosenfeld, J.G. Rational Emotive Therapy: A Study of Initial Therapy Sessions of Albert Ellis. Journal of Clinical Psychology, 32 (4), October 1976, pp. 872-876.

Bergin, A.E. & Garfield, S.L. Handbook of Psychotherapy and Behavior Change: An Empirical Analysis (New York: Wiley, 1971).

Bergin, A.E. & Lambert, M.J. The Evaluation of Therapeutic Outcomes. In S.L. Garfield & A.E. Bergin (eds.) Handbook of Psychotherapy and Behavior Change (2nd ed.) (New York: Wiley, 1978).

Bergin, A.E. & Strupp, H.H. New Directions in Psychotherapy Research. Journal of Abnormal Psychology, 1970, 76, pp. 13-26.

Bergin, A.E. & Strupp, H.H. Changing Frontiers in the Science of Psychotherapy. (New York: Aldine Atherton, 1972).

Bergin, A.E. & Suinn, R.M. Individual Psychotherapy and Behavior Therapy. Annual Review of Psychology, 26, 1975, pp. 509-556.

Bergman, D.V. Counselling Method and Client Response. Journal of Consulting Psychology, 15, 1951, pp. 216-224.

Brown, B.M. Cognitive Aspects of Wolpe's Behavior Therapy. American Journal of Psychiatry, 124, 1967, pp. 854-859.

Brunink, S.A. & Schroeder, H.E. Verbal Therapeutic Behavior of Expert Psychoanalytically Oriented, Gestalt, and Behavior Therapists. Journal of Consulting and Clinical Psychology, 47 (3), 1979, pp. 567-574.

Bundza, K. & Simonson, M. Therapist Self-Disclosure: Its effect on impressions of Therapist willingness to disclose. Psychotherapy: Theory, Research and Practice, 1973, IV, pp. 215-217.

Carkhuff, R.R. & Berenson, B.G. Beyond Counselling and therapy
New York: Holt, Rinehart, Winston, 1967.

Cartwright, R.D. A comparison of the Response to Psychoanalytic and Client-Centered Psychotherapy. In L.A. Gottschalk & A.H. Auerbach (eds.) Methods of Research in Psychotherapy (New York: Appleton-Century-Crofts, 1966).

Cohen, Jacob. A Coefficient of Agreement for Nominal Scales. Educational and Psychological Measurement, Vol. 20, No.1, 1960, pp. 37-46.

Dengrove, E. Practical Behavioral Diagnosis. In A.A. Lazarus (ed.)

Clinical Behavior Therapy, (New York: Brunner/Mazel, 1972) pp. 73-86.

Dittes, J.E. Previous Studies Bearing on Content Analysis of Psycho-

therapy. In J. Dollard & F. Auld Jr., Scoring Human Motives: A

Manual, (New Haven, Conn.: Yale University Press, 1959).

Dollard, J. & Auld, F. Jr. Scoring Human Motives: A Manual, (New Haven,

Conn.: Yale University Press, 1959).

Epting, F., Suchman, D., & Barker, E.N. Some Aspects of Revealingness .

and Disclosure. In D.D. Nevill (ed.) Humanistic Psychology: New

Frontiers, (New York: Gardner Press, 1977) pp. 177-201.

Evans, R.I. Carl Rogers: The Man and His Ideas. (New York: E.P.

Dutton & Co. Inc., 1975).

Fensterheim, H. The Initial Interview. In A.A. Lazarus (ed.) Clinical

Behavior Therapy, (New York: Brunner/Mazel, 1972) pp. 22-40.

Ferguson, George A. Statistical Analysis in Psychology and Education. (McGraw-Hill: New York, 1959).

Fiedler, F.E. A Comparison of Therapeutic Relationship in Psychoanalytic, Non-Directive and Adlerian Therapy. Journal of Consulting Psychology, 14, 1950, pp. 435-436.

Fiedler, F.E. Factor Analysis of Psychoanalytic, Non-Directive and Adlerian Therapeutic Relationships. Journal of Consulting Psychology, 15, 1951, pp. 32-38.

Fisher, J., Paveza, G., Kickertz, N., Hubbard, L. & Grayston, S. The Relationship Between Theoretical Orientations and Therapeutic Empathy, Warmth and Genuineness. Journal of Counseling Psychology, 22 (5), 1975, pp. 399-403.

Ford, J.D. Therapeutic Relationship in Behavior Therapy: An Empirical Analysis. Journal of Consulting and Clinical Psychology, 1978, Vol. 46, No. 6, pp. 1302-1314.

Frank, J.D. Persuasion and Healing, (2nd ed.) (Baltimore, Md.: John Hopkins University Press, 1973).

Franzini, L.R. Neglected Variables in Behavioral Case Assessment. Behavior Therapy, 1, 1970, pp. 354-385.

Gansky, N.E. & Farwell, G.F. Counselor Verbal Behavior as a Function of Client Hostility. Journal of Counseling Psychology, 13, 1966, pp. 184-190.

Garfield, S.L. Research on Client Variables in Psychotherapy.

In S.L. Garfield and H.E. Bergin (eds.) Handbook of Psychotherapy and Behavior Change (2nd ed.) (New York: Wiley, 1978) pp. 191-232.

Garfield, S.L. & Bergin, A.E. (eds.) Handbook of Psychotherapy and Behavior Change (2nd ed.) (New York: Wiley, 1978).

Gelso, C.J. Research in Counseling Methodological and Professional Issues. The Counseling Psychologist, 8 (3), 1979, pp. 7-35.

Gendlin, E.T. Therapeutic Procedures with Schizophrenic Patients. In M. Hammer (ed.) The Theory and Practice of Psychotherapy with Specific Disorders (Springfield, Ill.: Charles C. Thomas, 1972), pp. 333-375.

Gill, M., Newman, R., Redlick, F.C. The Initial Interview in Psychiatric Practice (New York: International Universities Press, Inc., 1954).

Goldfried, M.R. On the Search for Effective Intervention Strategies. Counseling Psychologist, 7 (3), 1978, pp. 28-29.

Gomes-Schwartz, B., Hadley, S.W. & Strupp, H.H. Individual Psychotherapy and Behavior Therapy. Annual Review of Psychology, 29, 1978, pp. 435-471.

Gomes-Schwartz, B., Schwartz, J., Psychotherapy Process Variables Distinguishing the "Inherently Helpful" Person from the Professional Psychotherapist. Journal of Consulting and Clinical Psychology, 1978, Vol 46, No. 1, pp. 196-197.

Goodman, G., Dooley, D. A Framework for Help Intended Inter-personal Communications. Psychotherapy: Theory, Research and Practice, 13, 1976, pp. 106-117.

Hart, J.T. & Tomlinson, T.M. New Directions in Client-Centered Therapy (Boston: Houghton Mifflin Co., 1970).

Harway, N.I., Dittmann, A.T., Raush, H.L., Bordin, E.S. and Rigler, D. The Measurement of Depth of Interpretation. Journal of Consulting Psychology, 1955, 19, pp. 247-253.

Heller, K. Experimental Analogues of Psychotherapy: The Clinical Relevance of Laboratory Findings of Social Difference. The Journal of Nervous and Mental Disease, 137, 1963, pp. 420-426.

Hersen, M. & Ballack, A.S. (eds.) Behavioral Assessment: A Practical Handbook (New York: Pergamon Press, 1976).

Hersen, M. & Ballack, A.S. (eds.) Behavior Therapy in the Psychiatric Setting (Baltimore: Williams & Wilkins Co., 1978)..

Hill, C.E. Development of a Counselor Verbal Response Category System. Journal of Counseling Psychology, 25, 1978, pp. 461-468.

Hill, C.E., Thames, T.B. & Rardin, D.K. Comparison of Rogers, Perls and Ellis on the Hill Counselor Verbal Response Category System. Journal of Counseling Psychology, 26 (3), 1979, pp. 198-203.

Houts, P.S., MacIntosh, S. & Moos, R.H. Patient Therapist Interdependence: Cognitive and Behavioral. Journal of Consulting and Clinical Psychology, 1969, 33 (1), pp. 40-45.

Howe, E.S. and Pope, B. An Empirical Scale of Therapist Verbal Activity Level in the Initial Interview. Journal of Consulting Psychology, 25, 1961, pp. 510-520.

Hyden, B. Verbal and Therapeutic Styles of Experienced Therapists Who Differ in Peer-Rated Therapist Effectiveness. Journal of Counseling Psychology, Vol. 22, No. 5, 1975, pp. 384-389.

Jourard, S.M. Disclosing Man to Himself (Princeton, New Jersey: Van Nostrand, 1968).

Jourard, S.M. Self-disclosure: An Experimental Analysis of the Transparent Self (New York: Wiley, 1971A).

Jourard, S.M. The Transparent Self (Princeton, New Jersey: Van Nostrand 1971B).

Kanfer, F.H. & Saslow, B. Behavioral Diagnosis. In C.I. Franks (ed.) Behavior Therapy: Appraisal and Status (New York: McGraw Hill, 1969) pp. 417-444.

Kempler, W. The Therapist's Merchandise. Voices: Journal of the American Academy of Psychotherapists, 1969, 5, pp. 57-60.

Kiesler, D.J. Some Myths of Psychotherapy Research and the Research Paradigm. Psychological Bulletin, 1965, pp. 110-136.

Kiesler, D.J. Basic Methodological Issues Implicit in Psychotherapy Process Research. American Journal of Psychotherapy, 20, 1966, pp. 135-155.

- Kiesler, D.J. The Process of Psychotherapy (Chicago: Aldine Publishing Co., 1973).
- Klein, M.H., Dittmann, A.T., Parloff, M.B. & Gill, M.A. Behavior Therapy: Observation and Reflections. Journal of Consulting and Clinical Psychology, 33, 1969, pp. 259-266.
- Klein, G.H., Mathieu, P.L., Gendlin, E.T. & Kiesler, D.J. The Experiencing Scale: A Research and Training Manual (2 Vols.) Madison, Wisconsin Psychiatric Institute, Bureau of Audio Visual Instruction, 1970.
- Krasner, L. The Therapist as a Social Reinforcement Machine. In Research in Psychotherapy, II, (Washington, D.C.: American Psychological Association, 1962).
- Kruger, R. Meaning and Structure in the Initial Clinical Interview. Dissertation Abstracts International, 1977, July, Vol. 38, (1-B) pp. 365-366.
- Kurz, E.R. & Grumman, D.L. Different Approaches to the Measurement of Therapist Empathy and Their Relationship to Therapy Outcome. Journal of Consulting and Clinical Psychology, 39, 1972, pp. 106-115.
- Labov, W. & Fanshel D. Therapeutic discourse: Psychotherapy as Conversation New York: Academic Press, 1977.

Lambert, M.J., & Bergin, A.E. Psychotherapeutic Outcome Issues Related to Behavioral and Humanistic Approaches. In A. Wandersman, J. Poppen & D.F. Ricks, (eds.) Humanism and Behaviorism: Dialogue and Growth. (New York: Pergamon Press, 1976).

Lazarus, A.A. (ed.) Clinical Behavior Therapy (New York: Brunner/Mazel, 1972).

Leary, T., and Gill, M. The dimensions and a measure of the process of ~~Psycho~~therapy: A system for the analysis of the content of clinical evaluations and patient-therapist verbalizations. In E.A. Rubinstein and M.B. Parloff (eds.) Research in Psychotherapy, Vol. 1. (Washington D.C.: American Psychological Association, 1959), pp. 62-95.

Lennard, H.L., & Bernstein, A. Patterns in Human Interaction. (San Francisco: Jossey-Bass, 1969).

Liberman, P.R. A Guide to Behavioral Analysis and Therapy (New York: Pergamon Press, 1972).

Locke, E. Is "Behavior Therapy" Behavioristic? (An analysis of Wolpe's psychotherapeutic methods). Psychological Bulletin, 76 (5), 1971, pp. 318-327.

Love, J.C. Research in Psychotherapy: The initial interview as a microcosm of the total therapy sequence. Unpublished Doctoral Dissertation, Michigan State University, 1971.

Luborsky, L., Chandler, M., Auerbach, A., Cohen, J., & Bachrach, H.

Factors Influencing the Outcome of Psychotherapy: A Review of
Quantitative Research. Psychological Bulletin, 75, 1971, pp. 145-185.

Mahrer, A.R. (ed.) Goals of Psychotherapy (New York: Appleton-Century-
Crofts, 1967).

Mahrer, A.R. An Invitation to Theoreticians and Researchers from an
Applied Experiential Practitioner. Psychotherapy: Theory, Research
and Practice, Vol. 16, No. 4, 1979, pp. 409-418.

Marsden, G. Content Analysis Studies of Therapeutic Interviews: 1954 to
1964. Psychological Bulletin, 63, 1965, pp. 298-321.

Marsden, G. Content Analysis Studies of Psychotherapy: 1954 to 1968.
In A.E. Bergin & S.L. Garfield (eds.) Handbook of Psychotherapy
and Behavior Change (New York: Wiley, 1971).

Mash, E.J. & Terdal, L.G. Behavior-Therapy Assessment: Diagnosis, Design,
and Evaluation (New York: Springer Publishing Co., 1976).

Matarazzo, J.D., Wiens, A.N., Matarazzo, R.G., & Saslow, G. Speech
and silence behaviors in clinical psychotherapy and its laboratory
correlates. In J.M. Schlien, H.F. Hunt, J.D. Matarazzo, & C. Savage
(eds.) Research in Psychotherapy, Vol. 3, Washington D.C.:
American Psychological Association, 1968.

McGlynn, F.D. Adults with Anxiety-Based Disorders. In M. Hersen & A.S. Ballack (eds.) Behavior Therapy in the Psychiatric Setting (Baltimore: The Williams & Wilkins Co., 1978).

Meltzoff, J. & Kornreich M. Research in Psychotherapy (New York: Atherton Press, 1970).

Mikulas, W.L. Criticism of Behavior Therapy. The Canadian Psychologist, Vol. 13, No. 2, April, 1972, pp. 83-104.

Mintz, J. & Luborsky, L. Segments versus whole sessions: which is the better unit for Psychotherapy Process Research? Journal of Abnormal Psychology, 1971, Vol. 78 (2), pp. 180-191.

Mitchell, K.M., Bozarth, J.D., & Krauft, C.C. A reappraisal of the therapeutic effectiveness of accurate empathy, non-possessive warmth and genuineness. In A.S. Gurman & A.M. Razin (eds.), Effective Psychotherapy - A Handbook of Research. (New York: Pergamon Press, 1977) pp. 482-502.

Moos, R.H. and Clemes, S.R. Multivariate study of the patient-therapist system. Journal of Consulting Psychology, 1967, 31 (2), pp. 119-130.

Morganstern, K.P. Behavioral Interviewing: The Initial Stages of Assessment. In M. Hersen & A.S. Ballock (eds.) Behavioral Assessment: A Practical Handbook (New York: Pergamon Press, 1976) pp. 51-76.

Murray, E.J. A Content Analysis Method for Studying Psychotherapy.

Psychological Monographs, 70 (13 whole no. 420), 1956.

Patterson, C.H. Relationship Therapy and/or Behavior Therapy. Psychotherapy: Theory, Research and Practice, Vol. 5, No. 4, Dec. 1968, pp. 226-233.

Perez, J.F. The Initial Counseling Contact. (Boston: Houghton Mifflin Co., 1968).

Raimy, V.C. Self-Reference in Counseling Interviews. Journal of Consulting Psychology, 12, 1948, pp. 153-163.

Rice, L.N. Client Behavior as a function of therapist style and client resources. Journal of Counseling Psychology, Vol. 20 (4), July, 1973, pp. 306-311.

Rice, L.N. & Wagstaff, A.K. Client voice quality and expressive style as indexes of productive psychotherapy. Journal of Consulting Psychology, 1967, 31, pp. 557-563.

Rimm, D.C. & Masters, J.C. Behavior Therapy: Techniques and Empirical Findings (New York: Academic Press, 1976).

Rogers, C.R. Counseling and Psychotherapy. (Boston: Houghton, Mifflin, 1942).

Rogers, C.R. The Necessary and Sufficient Conditions of Therapeutic Personality Change. Journal of Consulting Psychology, 21, 1957, pp. 95-103.

Rogers, C.R. On Becoming A Person. (Boston: Houghton Mifflin, 1961).

Rogers, C.R. Client-Centered Therapy. (Boston: Houghton, Mifflin, 1951, (2nd ed., 1965).

Rogers, C.R. On Encounter Groups. (New York: Harper & Row, 1970).

Rogers, C.R., Gendlin, E.T., Kiesler, D.J. & Truax, C.B. The Therapeutic Relationship and its Impact: A Study of Psychotherapy with Schizophrenics (Conn.: Greenwood Press, 1967).

Rotter, J.B. Psychotherapy. In P.R. Farnsworth (ed.) Annual Review of Psychology, 11 (Palo Alto: Annual Reviews, 1960), pp. 381-414.

Russell, R.L. & Stiles, W.B. Categories for Classifying Language in Psychotherapy. Psychological Bulletin, 86 (2), 1979, pp. 404-419.

Seeman, J.A. A Study of the Process of Non-directive Therapy. Journal of Consulting Psychology, 3, 1949, pp. 157-168.

Shapiro, D.A. Asymmetry of Responsiveness in Client-Centered Therapy. Journal of Consulting and Clinical Psychology, 45, No. 5, 1977, p. 956.

Siegel, S. Nonparametric Statistics for the Behavioral Sciences. (New York: McGraw-Hill, 1956).

Siegmán, A.W. & Pope, B. An Empirical Scale for the Measurement of Therapist Specificity in the Initial Psychiatric Interview. Psychological Reports, 11, 1962, pp. 515-520.

Simonson, N.R., & Bahr, S. Self-disclosure by the Professional and Paraprofessional Therapist. Journal of Consulting and Clinical Psychology, 1974, 42, pp. 359-363.

Sloane, R.B., Staples, F.R., Cristol, A.H., Yorkston, N.J., & Whipple, K. Psychotherapy vs. Behavior Therapy. (Cambridge, Mass.: Harvard University Press, 1975A).

Sloane, R.B., Staples, F.R., Cristol, A.H., Yorkston, N.J. & Whipple, K. Short-term Analytically Oriented Psychotherapy versus Behavior Therapy. American Journal of Psychiatry, 1975B, 132, pp. 373-377.

Sloane, R.B., Staples, F.R., Cristol, A.H., Yorkston, N.J. & Whipple K. Process and Outcome in Psychotherapy and Behavior Therapy. Journal of Consulting and Clinical Psychology, 44 (3), 1976, pp. 340-350.

Snyder, W.V. An Investigation of the Nature of Non-directive Psychotherapy. Journal of General Psychology, 33, 1945, pp. 193-223.

Staines, G.L. A Comparison of Approaches to Therapeutic Communications.
Journal of Counseling Psychology, Vol. 16, No. 5, 1969, pp. 405-414.

Stiles, W.B. Verbal Response Modes and Psychotherapeutic Techniques.
Psychiatry, 42 (1), February 1979, pp. 49-62.

Stiles, W.B. & Sultan, F.E. Verbal Response Mode Used by Clients in
Psychotherapy. Journal of Consulting and Clinical Psychology, 47
(3), 1979, pp. 611-613.

Stoten, J. & Goos, W. Three Psychotherapies Examined: Ellis, Rogers,
Perls. The Alberta Journal of Educational Research, 20 (2), 1974,
pp. 103-115.

Strupp, H.H. An Objective Comparison of Rogerian and Psychoanalytic
Techniques. Journal of Consulting Psychology, 9 (1), 1955, pp. 1-7.

Strupp, H.H. A Multidimensional Comparison of Therapist Activity in
Analysis and Client-centered Therapy. Journal of Consulting
Psychology, 21, 1957, pp. 301-308.

Strupp, H.H. The Performance of Psychoanalytic and Client-centered
Therapists in an Initial Interview. Journal of Consulting Psychology,
22, 1958, pp. 265-274.

Strupp, H.H. Psychotherapists in Action. (New York: Grunne & Stratton, 1960.)

Strupp, H.H. Psychotherapy: Clinical Research and Theoretical Issues
(New York: Jason, Aronson, 1973).

Sundland, D. Theoretical Orientations of Psychotherapists. In A.S. Gurman & A.M. Razin (eds.) Effective Psychotherapy: A Handbook of Research. (Pergamon Press: New York, 1977), pp. 189-219.

Tinsley, H.E. & Weiss, D.J. Interrater Reliability and Agreement of Subjective Judgements. Journal of Counseling Psychology, 1975, 22, pp. 358-376.

Truax, C.B. Reinforcement and Non-reinforcement in Rogerian Therapy. Journal of Abnormal Psychology, 71 (1), 1966, pp. 1-9.

Truax, C.B. & Carkhuff, R.R. Experimental Manipulation of Therapeutic Conditions. Journal of Consulting Psychology, 29, 1965, pp. 119-124.

Truax, C.B. & Carkhuff, R.R. Toward Collective Counseling and Psychotherapy: Training and Practice (Chicago: Aldine, 1967).

Truax, C.B. & Mitchell, K.M. Research on certain therapist interpersonal skills in relation to process and outcome. In A.E. Bergin & S.L. Garfield, (eds.), Handbook of Psychotherapy and Behavior Change: An Empirical Analysis. (New York: Wiley, 1971, pp. 299-344.

van der Veen, F. Effects of the Therapist and the Patient on Each Other's Therapeutic Behavior. Journal of Consulting Psychology, 29 (1), 1965, pp. 19-26.

Wandersman, A., Poppen, P. & Ricks, D. Humanism and Behaviorism: Dialogue and Growth. (New York: Pergamon Press, 1976).

Weiner, M.F. Self-exposure by the therapist as a therapeutic technique. American Journal of Psychotherapy, 1972, 26, pp. 42-51.

White, A.M., Fichtenbaum, L. & Dollard, J.A. A content measure of changes attributable to psychotherapy. American Journal of Orthopsychiatry, 1966A, 36, pp. 41-49.

White, A.M., Fichtenbaum, L., & Dollard, J.A. Measuring change: A verbal and non-verbal content analysis method. Psychotherapy, 1966B, 3, pp. 107-113.

Wolberg, L.R. The Technique of Psychotherapy. (New York: Grunne & Stratton, 1977).

Wolk, R.L. The Kernal Interview. Journal of Long Island Consulting Center, 5, 1, 1967.

Wolpe, J. Psychotherapy by Reciprocal Inhibition, Stanford University Press, 1958.

Wolpe, J. The Practice of Behavior Therapy (New York: Pergamon Press Inc., 1973), (1st ed., 1969).

Wolpe, J. Theme and Variations: A Behavior Therapy Casebook

(New York: Pergamon Press Inc., 1976).

Wolpe, J. & Lazarus, A. Behavior Therapy Techniques (New York:

Pergamon Press, 1968).

Wolpe, J. & Reyna, L.J. Behavior Therapy in Psychiatric Practice.

(New York: Pergamon Press, 1970).

Wolpe, J., Salter, A., & Reyna, L.J. (eds.) The Conditioning

Therapies. (New York: Holt, Rinehart, & Winston, 1964.)

Zimmer, J.M. & Pepyne, E.W. A Descriptive and Comparative Study

of Dimensions of Counselor Response. Journal of Counseling

Psychology, 18, 1971, pp. 441-447.

APPENDIX A

Appendix A contains the complete description of the therapist categories. The descriptions and the examples comprising these categories were developed by Alvin R. Mahrer, Ph.D., University of Ottawa. In both Appendices A and B "T" represents "therapist" while "Pt." represents "patient".

THERAPIST CATEGORIES

1. The Therapist Structures the Therapy Session.

The therapist structures therapy and what the patient is to do.

The T structures about the process of therapy rather than giving instructions on what the Pt. is to do right now, e.g., "Say it again with more feeling." T says in effect, "You may stop the session whenever you want to." "Here is the kind of thing you may talk about." "Time is just about up; we have to stop soon." "Is there anything you want to ask me?"

T tells what therapy can accomplish. "These worries can be gotten rid of."

T talks about the practicalities of therapy. "I'll see what I can do, and I'll send a report to your physician."

The structuring may refer to the next step in what is to be covered or what the Pt. is to turn to, or the topic to be covered next. T: "Now let's go back to when this all might have started".

When the Therapist Relates Directly and Talks to the Patient About the Patient:

In categories 2 and 3, the T talks to the Pt. about the Pt.'s self, his personality, his problem, the kind of person the Pt. is. It is as if there are three units: the T, the Pt., and a third unit, i.e. the thing they are talking about and referring to---the Pt.'s self, his personality, his problem, the kind of person the Pt. is.

Categorize statements of this type into category 2 and 3.

2. The Therapist Tells the Patient What the Patient is Like.

Here is the way you are or were. In effect the T says: This is how you seem to be right now ... Here is the way I see you ... Here's the way you are ... Here is the way you are being ... Here is how you seem ... Here is how you are being ... Here is how you sound ... You are the kind of person who wants to do this or that ... You don't want to do this or that.

The T may do this by putting it in the form of a question: "You always thought of yourself as the favored one, the special one?" or the T may link the statement with a question: "You always thought of yourself as the favored one, the special one. Is that right?" The key is that the T is telling the Pt. about what the patient is like.

T asks the Pt. a question which says in effect, "Is this the way you are or were?" "Is this how you are?" "Maybe you are this way?" "Do you have this picture of yourself?" "Is this what the problem is?" "Are you aware of this thing about the way you are (or the way you behave, or the problem)?" "Do you think of yourself as a loser?"

T tells the Pt. about the kind of person the Pt. was. "Ever since your brother died, when you were a child, you have been scared to speak up for yourself." "You had this hearing problem until you were about 11 or 12, and then it just seemed to go away."

Here is what a part of you is (was) like. Instead of referring to the Pt. as a whole, the T talks to the Pt. about some part (component, aspect) of the Pt. "Seems like there is a caring, loving part which never really had a chance to show itself."

Here is the problem. The T tells the Pt. about 'the problem'. "This is the way it seems to be for you now." "Here is the way the problem seems to be for you." "Here is what you seem to be fearful of." "This is what the problem seems to be." "Here is how you feel about that person (and that is the problem)."

Here is what your interpersonal relations are like. The T tells the Pt. about the Pt.'s life situation, how others affect him, how he relates with others, his feelings and reactions in relation to others. "Your sister is a real burden on you and your family now." "When your father died, life just seemed to end for you." "But about this jealousy toward your sister ..." "He makes you annoyed." "She makes you defensive and anxious."

Here are your thoughts or feelings. T tells or asks the Pt. about his thoughts and feelings. "You have (do you have?) this kind of thought about all of that." "You do not say-think-feel this about everyone (or in general)." "What do you think accounted for that change?" "That scary feeling is there pretty much all the time?" "You felt upset?" "and that left you just up in the air?"

T is authority and interpreter in telling the patient what the patient is like. The T adds a lot from his role as authority and interpreter of what is true about the Pt. In this, the T is the authority in telling the Pt. about his symptoms or his diagnostic condition. "There are some neurotic features here." "No, you are not psychotic." The T gives an authoritative version of what causes (or does not cause) the Pt.'s problem. "Those are not indications of a brain tumor." "Sometimes it is caused by a lot of anger which you don't express." "Smoking does not cause those headaches."

In telling the Pt. what the Pt. is like, the T may couple the statement with disclaimer clauses: "... course it may not be so all the time." "...it's something to think about."

T builds his case on the basis of what the Pt. said earlier. "Here is what you said before." The referent for what T says may be the immediately preceding statement of the Pt. However, frequently the referent may lie in the preceding two or three or more earlier statements by the Pt.

T points out something about the Pt. to the Pt. "When you say that you always have a funny grin all over your face." "Whenever you mention her, your voice gets real slow and deep." "You seem almost affectionate and soft when you say all that about your grandfather."

T tells the Pt. about the tough questions (or problems or choices) he must face or answer.

Differentiation between category 2 and other categories.

In category 7 the T says what he believes the Pt. is saying. But in the present category 2 the T goes significantly beyond the content of the Pt.'s own words and adds a lot of the T's own interpretation or description of what is real and true about the Pt. "You just feel damned disgusted with him." "So it is really a matter of competition." "You know these asthma attacks come whenever you want to be babied by someone."

3. Therapist Asks The Patient To Provide Data About What The Patient Or Problem Is Like.

The T is talking to the Pt. and getting at more or less factual information or clarification about the problem, or about the Pt. himself, or about the Pt.'s reactions, thoughts and feelings about the problem.

By inviting the Pt. to tell more about it in general. The T states: "Tell me more about that; clarify that a bit." "I want to know more about that." T indicates his willingness to hear more about that: "If you want to talk about that ..." T accomplishes this by simply repeating, in a questioning way, a word or two or a final phrase that the Pt. says: Pt.:

It first started long ago. T: Long ago? In effect the T is saying, "Give me more information, about that problem."

The referent for what the T points toward may be something in what the Pt. is saying right now, just before the T talks. On the other hand, the referent may be something the Pt. said two or three or more statements earlier.

By asking factual information about the problem. The T asks the Pt. to tell about, clarify, name, identify (give factual information about) the problem. "What is the nature of your problem?" "When did that problem (difficulty, complaint) begin?" "Is this the way it was?" "Is that what happened?" "When did it happen after that?" "How long have you had thoughts like that?" "What was the effect of that thing (event, situation) on you?" "Do you react in the same problem way to this and to that?" "Exactly where is it in your body?"

T asks the Pt. about the effect of the previous helping situation (the medication, therapy, workshop, group therapy) on the problem. "Did it help you?"

By asking factual information about the Pt. T gets at more or less factual (often demographic) information about the Pt. "Were your parents divorced?" "Do you have any children?" "When did you move to Toronto?" "How were things then in the family (with your friends, at work)?" Although the information may be about some event or situation in the Pt.'s life, the focus is upon the Pt., and gathering more information about the Pt.

T asks the Pt. questions about what the Pt. was like in the past.

By asking about the Pt.'s reactions, thoughts, feelings in the problem situation. The T is getting at the kinds of reactions, thoughts, and feelings the Pt. has in the problem situation. The focus is the problem. "Tell me more about how it affected you." "When you were in that situation, did you feel anxious (scared, depressed)?" "What were your thoughts then?" "Is this how you felt?" "Did this make any difference in how you felt?" "Do you get tense when someone comes very close to you?" "Did it really worry you a lot?" "Did you really feel especially tense then?" "I can't quite make out how you felt about that." "You felt some sort of pain there?"

T may ask questions about the Pt.'s specific reactions and behaviors in the problem situation. "When you feel that way with such a person, can you tell him directly what you think?"

Differentiation between category 3 and other categories. In this category, the T is getting data about the problem, and it is with emphasis upon the problem that the T inquires about the Pt.'s problem-related reactions, thoughts, and feelings. If, on the other hand, the emphasis is

on the kind of person the Pt. is, what he is like, then the T's focusing upon the Pt.'s reactions, thoughts, and feelings belongs in category 2.

In the following, the T is focusing upon the problem and the history of the problem (category 3) rather than the kind of person the Pt. is (category 2): T: "so after you were first married you would have these same feelings but they wouldn't worry you?"

In this category, the T's attention is predominantly on the Pt. and the Pt.'s problem. In category 4 the T's attention is more on the external situation than the Pt. or the Pt.'s problem. The T may ask the Pt. to describe (tell about, provide data about) something external. This falls in category 3 if the T's attention is predominantly on the Pt. and the Pt.'s problem, if it tells more about the Pt. and the Pt.'s problem. In effect, the T is attending predominantly to the Pt. as the T says, "Tell me about that external thing and how it affects you and your problem."

By asking the Pt. to provide causal explanations. The T asks the Pt. to explain, give an explanation, tell why. It may be in relation to the problem: "What do you think caused it?" "What do you think made you so tense in that job?" "How do you explain that?" "Why did you feel nervous (ashamed, confused, anxious) in that situation?" The focus is on the Pt.'s causal explanations, even when he is asked to tell his causal explanation of some reaction, thought, or feeling.

4. The Therapist Gathers Data About and Clarifies the External Situational Context.

Both Pt. and T are attending to something external, and the T's statement further clarifies, amplifies or illuminates that external thing. The net effect of what the T does is to amplify or clarify the Pt.'s attention on (a) some external thing, person, object, component of an external situation, or (b) the external context encompassing that external thing, person, object, component. The T amplifies, clarifies, or gets information about (a) or (b).

• By clarifying the external thing, person, object, component. If the Pt. refers to his uncle's advice, T says, "Was your uncle's advice helpful? Did he really explain things?"

If the Pt. refers generally to some external thing (e.g., when he was a child the family had a cottage), the T begins to focus the Pt.'s attention more closely. "What was it like, there at the cottage?" If the Pt. attends to and says something about the car her family had when she was a child, T says "What color was it?" "What do you remember about the car?" The T's statements go further into; get more details about, clarify that external thing, person, object, or component.

By clarifying the encompassing situational context. The T's statements place the thing, person, object, or component within its context

(scene, situation). Or the T's statements fill in the context (scene, situation). "When did that happen?" "How old were you?" "Was that in your home or in your uncle's place?" "When did your father die; how old was he?" "Your mother retired four years ago?" "Where were you living when that happened?"

By encouraging the patient's attention. When the Pt. is attending to some external situational context, the T encourages the Pt. to stay there or go further. If the Pt. tells about an external thing or situation and then stops, T says: "And then what happened?"

By giving his impression of the external situation or the patient's relationship with it. If the Pt. is telling about the family, the T says, "It seems like the whole family is ready to fall apart." The attention remains on the family as the external thing. The T is not being an authority who tells the Pt. what external reality is like (c.f. category 6 Therapist Tells Patient About External Reality).

Differentiation between category 4 and other categories. In category 4, the T's attention is on the external thing or situation. In category 2 (Therapist Talks To The Patient About The Patient), the T attends to the Pt., to the kind of person the Pt. is, to that thing about the Pt., to the Pt.'s feelings or problem or complaint. In category 4 the Pt.'s attention is already on the external situation, and the T amplifies or clarifies that external situational context.

If the T's and Pt.'s attention is substantially on the external person, thing, or scene, the category is 4. If the T asks the Pt. to provide information about something quite outside that external person, thing, or scene, and it pertains to the Pt. or the Pt.'s problem it is category 3.

5. The Therapist Discloses and Tells About the Kind of Person the Therapist is.

In a non-defensive, non-threatened way. The T discloses something about himself. What T tells about may be quite banal: "I'm glad things went O.K." ... "I'm pleased about that." T is still telling something about himself.

T tells the Pt. about the sort of feeling the T has: "I am feeling a little anxious now" ... "I feel mixed-up about what is going on."

T tells the Pt. of his personal hopes for the Pt. "I hope that whatever direction you choose is best and satisfying for you." "I hope that things will work out well with her."

T talks about the kinds of feelings he has for the Pt. "Suppose that I really like you."

T tells (explains), in a non-defensive way, why he said what he just said.

T tells a personal fantasy of his own.

T discloses that he too has "it" (the problem, symptom, worry).

T tells what he tends to do (e.g., to cope with that problem).

T shows or tells about himself. "Look what I just did." "Here is how or why I am having trouble now ... "

In a somewhat defensive, threatened way, T, in defensive and threatened way, tells the Pt. what the T is doing, or trying to do, or intending to do. T tries to answer the Pt.'s challenge, and does not do so well. T defensively explains what he meant, or what he was not trying to say. "I am trying to help you see the difference between normal and psychotic behavior."

The therapist describes his own fantasy image of the external situational context. T describes an image he has as he listens to the Pt., a fantasy image of the external thing or situation about which the Pt. is talking. It is the T's "mental picture" of it, although the mental picture comes from what the Pt. says about that external thing or situation. T frames a metaphor or simile through the use of a concrete mental picture or fantasy image. "It's kind of a treadmill with grease all over it."

The therapist acknowledges his mistakes, errors, misperceptions. The therapist might say "Oh, sorry; I was wrong".

6. The Therapist Tells the Patient what External Reality is Like.

The therapist tells the patient about external reality.

The T is the authority, the interpreter or explainer of what that external thing or situation is really like. "The actual fact is that the department was phasing out, and only the really senior people could be retained."

T tells the Pt. what people are like or what the world is like or how things are. "When a person picks out someone to marry, often that other person complements the person, maybe is the opposite of the person."

When T and Pt. are attending to the lawyer the T is suggesting to the Pt., T says, "He will have to know all the facts about your husband's previous hospitalization; tell him everything."

Differentiation between category 6 and other categories. In category 6, the T is attending to the external thing or situation. In category 2 the T also is being the authority, the interpreter of reality, but in category 2 the T is attending to the Pt. and telling the Pt. what he really is like.

7. The Therapist Says What He Believes Patient Is Saying.

T's attention is preponderantly on what the Pt. is saying, on the content or meaning in what the Pt. is saying. T is trying to make sense of what the Pt. is saying.

The T is almost joining with the Pt. in saying what he believes the Pt. is saying. It is as if the T is trying to say the same meaning, saying it for and with the Pt.

By reflective or rephrasing statements. T reflects, rephrases, restates what the Pt. says, tries to say the gist of what the Pt. is saying or meaning. T repeats part of what the Pt. says.

T says in effect, "This is what you seem to be saying (about the problem)." "I hear you saying ..." "This is what you are saying about yourself." "Here is what you are saying ..." "Here is what you feel ..." "Here is how you feel about him ..." "Here is what you think about that." "I get the feeling you are saying ..."

T follows above statements by using "I"-words: "So you are saying I want to make sure they like me." "(You are saying) I'd be lost without it."

... coupled with T-centered questions. T reflects or rephrases what Pt. says, and couples that with questions which draw the Pt. into responding directly to T.

T repeats the gist of what the Pt. says as if to ask, "Is this what you are saying?" T inquires in effect, "Is this what you are saying?" "Do I have it right?" "Is this the way it is for you?" "Is this what you mean?"

By summary generalizations. T summarizes what Pt. is saying by framing a generalization. "So your grandmother really controlled just about everything in the family." "So everything seemed fine with you then."

T sums up what Pt. says by putting it in the form of a succinct colloquialism. "So you're all tied up in knots."

The therapist speaks from the patient, through the patient's mouth. T speaks as if it is the Pt. who is saying the words. T says "I" and "me" as if he is the Pt. saying the words. "They aren't going to push me around; I just won't stand for it." "He is so demanding that I just got use to very high standards."

Sometimes the words "I" or "me" may be strongly implied without explicitly said. T says, "got to be careful; don't make a mistake" rather than "I got to be careful; don't make a mistake." T is almost being the

Pt. in saying the words. Instead of, "I hear you saying that they aren't going to push you around; you just won't stand for it", T says, "They aren't going to push me around; I just won't stand for it."

Differentiation between category 7 and other categories. The T's attention here is on the content or meaning of what the Pt. is saying, rather than (in category 2) on the Pt.; the kind of person the Pt. is, the Pt.'s self. The T is not telling the Pt. what the Pt. is like (category 2).

When the T summarizes or generalizes what he believes the Pt. is saying, he may add some of his own interpretation, but the focal emphasis is still on what the Pt. is saying or meaning. "So you are suggesting (hinting, implying) that your headaches are caused by your daughter?" Compare this with category 2 (Therapist Tells The Patient What The Patient is Like), in which the T is being an authority in telling the Pt. the kind of person he is, what he is like.

In category 7, what the T says is contained in what the Pt. said. If the T goes substantially beyond what is contained in what the Pt. says, it is category 2.

The referent for what the T says is what the Pt. has just said. If the T is still referring to what the Pt. said two or three patient statements earlier, consider placing the T's statement in category 2 (Therapist Talks To The Patient About The Patient).

8. The Therapist Gives Simple Acknowledgment Of What the Patient Says.

T says, "Yes", "Uh-huh", "A", "Mm-hmm", "Oh?", "I see.", "O.K."

If the Pt. says, "No, that's not it," T says, "No?" Pt. indicates that he has three children, not two, and T says, "Oh, three children."

The T's attention may be on anything---on some external scene, or what the Pt. is saying, or whatever. It is category 8 if the simple phrase of acknowledgment (T: "yes?") signifies, "go on ... go ahead ..."

9. The Therapist Gives Permission - Approval - Encouragement for the Patient to Continue to Talk.

T in effect says, "Go ahead and do it." "That's fine with me."
"I'd like to hear more about that." "Yes, go on."

Pt.: "I wanted to show that I could do it just as well as he can."
T: "Well, why shouldn't you do just that?"

10. The Therapist Gives Advice to the Patient About Potential Personality-Behavior Change.

The T talks to the Pt. about his readiness or willingness regarding some personality-behavioral change. "Do you think about this possible new way of being-behaving?" "Don't you think you should behave in this particular (new) way?" "What makes you hesitant about behaving in this (potentially new) way?"

T advises and introduces a potentially new way of behaving. "Maybe you might tell him directly what you need."

T tells the Pt. what to do: "Tell your wife that you will be starting group therapy once a week, and that you would like her to attend the first few sessions with you ..."

"Let your son use the money anyway he wishes, but he must understand that is the end of the money for him." T tells the Pt. what to do, what the Pt. should say, how the Pt. is to be.

The T inquires about the Pt.'s motivation to work on this problem, or to take this next therapeutic step. "Do you want this kind of change (in your problem, symptom, personality)?"

T tells what the Pt. can be like in the future, what therapy can accomplish for the Pt., how things can be through therapy.

11. Other.

When the T's statements do not fit into any of the other categories place the statement in this category.

This category is specific to statements in which the therapist laughs; answers the patient's question; or inquires about what the patient said. Specifically, statements are placed into this category when:

T answers the Pt.'s questions. T gives a more or less direct and honest answer to the Pt.'s question. In so doing, the T does not attend or respond to the "deeper" meaning or "dynamic significance" of the Pt.'s question or questioning. "Yes, I can help you."

T tries to answer the Pt.'s direct question, and is somewhat defensive in his answer or gives a vague general answer to the Pt.'s direct question.

Therapist laughs. The T's laughing is the sole or predominant part of what the T does in this statement. If the T's laugh is an incidental part of what the T does, and there are other statements by the T, place the statements in another category depending on the content of what the T is saying.

Therapist inquires what the patient says. "What did you say?" This is more a matter of not hearing what the Pt. said, rather than not quite understanding the meaning of what the Pt. said.

APPENDIX B

Appendix B contains the complete description of patient categories. The descriptions and examples comprising each category were developed by Alvin R. Mahrer, Ph.D., University of Ottawa.

Categories of Patient Statements

A. Patient Relates Directly To The Therapist

Within the attentional center A. the patient's attention is on the T predominantly (categories 1 and 2). Whatever world the Pt. is building or constructing is in relation to the T.

The patient fully addresses the therapist, is in interactional relationship with the therapist. All or most of the patient's attention is onto the therapist. There is a conspicuous interaction between the patient and the therapist, one which typically is either positive and welcoming or negative and oppositional. Often the patient refers to the therapist. The word "you" is commonly used.

In assigning categories, use 1 or 2.

1. The Patient Opposes the Therapist

The patient engages in an oppositional relationship with the therapist.

By resisting, opposing the Therapist and what the Therapist says.

The Pt. may be indirect, but the clear message is that the pt. is critical of the T., is being aggressive toward the T.
"The reason people don't talk is not because they can't; it's cause they get no response."

Trying to stand up to, oppose the T. The pt. argues with, disagrees with, opposes the T. Pt. tells his (differing, opposing) views on the matter.

The patient does not want to do what the T suggests, or not now at least.

Instead of answering the T's questions, the pt. is resistant and oppositional by being quite vague, or by not answering, or by being curt and leaving the burden on the T. "I just don't know." However there must be clear indications that the pt. is being resistant and oppositional. Unless these are evident, do not place the statement in category one.

The pt. pulls away, stops.

The pt. indicates that this is private. He doesn't want to talk about it with the T. "This is between my wife and me (and not you)."

The pt. may object to what the T says about him, or to the kind of person the T says he is. Instead, the patient says, in effect, "I am this way, not the way you say." Or the patient may say in effect to the therapist, "Here is my reaction to what you say about me or about it." If the major component is disagreeing with the therapist, the category is 1, if the major component is describing his self to the therapist, the category is 3.

The pt. voices a negative reaction to what the T says. "No! That would really bother me."

Pt. rejects what T says. In effect, pt. says: "That was bad, unacceptable, off the mark." Pt. doubts that T says, won't accept what T says. Pt. says no, that is not the way it is, says no to T's suggestion. Pt. indicates that he does not buy what T is suggesting. "No, you don't have it right about me." "No) that is not how I feel." "I can't think that all this is psychosomatic." (in response to T's suggestion that it is psychosomatic). Pt. corrects what T says in tone of opposing him, shows T how T got it wrong. Pt. thinks the T's hopes (possibilities) for him are unrealistic, wrong, crazy.

The pt. is tight, defensive when the T is attacking challenging: T: "What do you mean by motherhood? What is motherhood?" Pt: "The responsibility of a mother for her child."

By directly confronting T, putting T on the spot. Pt. puts the T on the spot, directly confronts the T, pinpoints the T, asks the T direct questions which have an aggressive ingredient in the asking. The pt. may be challenging: "Do you think you can help in this kind of problem?" "What are your views on this topic and can you be of help here?" "How do you help someone get over this problem?" "Can you help me?"

The question may merely put the T on the spot, force the T to provide an answer. "If I have a lump here, for maybe 6 months, and it hurts, do you think maybe I have cancer?"

2. Patient Accepts Therapist

The Pt. accepts therapist and what the therapist says.

Pt. is pleased, feels good about T and what T says. Pt. accepts (corroborates) what T says about him, and does so by simple acknowledgment: "Yes, that's right." "...Yeah,.." "That's the way it is." "Uh-huh." "Seems that way." Pt. even adds a bit to what T says, all in accepting manner. "You are right, because of this or that." In accepting and being pleased with what T says, pt. may laugh, grin, chuckle.

Pt. accepts what T says by filling in the last few words or completing what T says:

T: So she seems to be loyal and with you and ...

Pt:....always on my side

Pt. Essentially rephrases what T says.

In accepting what T says, pt. refines or clarifies or gently corrects a part of what T just said, but the tone is generally one of acceptance. If T indicates an understanding that Pt. has a dog and a cat, pt. may add, "...and two canaries." Pt. may qualify what T says, but the tone is one of general acceptance.

Pt. playfully kids (teases) T.

Pt. generally accepts what T says even though there is a slight sarcastic or inquiring-hesitant manner: "Sure, why not" ... "Yeah, maybe." "Well?... Go on ..."

Pt. starts out accepting, but then is less and less sure of it, without downright rejection what T says. "Yeah, that's it. Well, I don't know. Maybe. It's hard to tell."

A special case is when T doesn't quite hear or make out what the patient said, and inquires what that word or phrase was. The pt. says, "I said, 'My aunt's looney'."

Pt. treats T as being understanding. "You can understand that my father was a cripple." Pt. treats T as important figure. After telling about his mother's serious operation, pt. adds, "so that's an important thing you ought to know about her."

Pt. is acceptant in regard to parts of the therapeutic process. If T indicates that the time is up, or inquires about the pt.'s readiness to end the session, pt. says, "Sure; o.k., I'm ready to stop." "Thank you, doctor."

Differentiating between category 2 and others.

The pt's simple "yes" or "that's right" may provide information to the T in answer to the T's request for information. Under this condition the category is 4.

B. Patient Relates Directly to His Self

Within attentional center A. (categories 1 and 2), the patient's attention is upon the therapist. Within attentional center B. the patient's attention is on his self (categories 3 and 4), something within his own personality. The world he is building and constructing is in relation to his self, something within his own personality.

Each category is to be judged and rated separately: 3 and 4.

3. The Patient Describes His Self.

Although the patient may be talking to the therapist, the patient is talking about himself. The patient is attending to that self, concerned about that self, describing that self. It is as if there is a patient, a therapist, and a third thing: the patient's self -- and the patient is talking about that self.

By telling about the kind of person he is. Pt. tells the T about the kind of person the pt. is, the sorts of problems he has, the nature of his personality, how he sees and describes himself, the kinds of relationships he has, the way he tends to behave. In effect, pt. says, "I am the kind of person who ---" "This is the way I am." "Here is the kind of person I am." "I am the sort of person who tends to be this way." "I've been more irritable lately." "Usually I do what he wants just to keep things peaceful." "I have a clear notion of what my career plans should be." "I don't like being pushy or aggressive." "I don't like being the kind of person who gets people so annoyed and uptight."

By using a past context. Pt. uses a past context in which to talk about his self. "It got so that I wouldn't trust anything I saw; I was that unsure of myself." "I was always interested in mechanical things, how things worked." "I always wanted to be the hero, the one they cheered for."

By telling about his feelings, thoughts, bodily sensations. The context can be either right now or in some past situational context. He tells what his feelings, thoughts, bodily sensations are like. "I was anxious but not really scared." "I don't know

I was depressed or just worried about my weight." "I always have this suicidal thought in my mind." "When I was in that situation, I felt dizzy and I thought my head was falling off." "After he died I had thoughts that I was going crazy." "Here are my feelings and reactions in relation to it (the thing, the problem)." "I was worrying about him, and I was concerned that I couldn't make enough money." "I worry about these lumps; maybe cancer."

"Sometimes I think that my little brother likes me and tries to be like me, and sometimes I think he resents me, though I doubt it." "I would probably think this way about that thing." "I always thought my body was weak, frail; but intellectually I know it's not really."

By standing off and discussing himself as a case. The pt. seems to be holding a case conference with the T about the pt.'s self. Pt. stands aside and talks with the T about the problem, overall picture, the problem situation. "I have an alcoholic mother and a father on welfare, so you can see the stress all that puts on me." "It seems like a pattern of fear of success, or fear of failing." "I think my back problem is psychosomatic, but emotionally I can't accept it."

Pt. describes the problem with herself. "How can I be nice and yet say what I really feel?"

Pt. explains and discusses what he just said or did. Pt: "Yes I can see that when I think about it so carefully."

By using similes and placing himself in a class-category. Pt. talks about his self by using similes and generally describing some other event or thing he is like. "I'm sort of like a scared rat that's been backed into a corner." "I'm like a car where the motor's running, but it's not in gear." "I feel I'm about as useful as a fifth wheel."

Pt. may talk about his self by describing a general class into which he places himself. "Academic people tend to be this way." "Teenagers are like this." "Only children tend to be this way." "It's a neurotic condition." "People think of salesmen as con artists."

Differentiating between category 2 and other categories. If the pt.'s attention is on the bodily-physical sensations (problem, system), it is category 2. "My throat clutches up and it sounds like this -- raspy." "I have arthritis in my right hand." "I have this pain in my back, across my upper back and shoulders, and it is tight." However, if the pt.'s attention is mainly on the factual information about the bodily-physical sensations (problem, symptom), it is category 3.

If the pt. refers to others, but the main emphasis is upon himself, the category is 2: "They considered me aggressive and pushy." "After my sister got married I realized that she was an anchoring figure for me and I always sought someone out like that." If, however, the main emphasis and the major attention is upon the other person or the defined external situation, it is categories 5 or 6.

Even if T asks for information about the problem the Pt. may respond by attending to "I" or "me" (category 3) rather than merely providing information about the problem (category 4).

4. The Patient Informs of the Problem.

The patient provides factual information about the problem.

The pt.'s attention is on the problem specifically as he gives more or less factual data about it. Pt. tells when the problem started, how it began, what it was like, how extensive it is, the circumstances in which it occurs, things that help or relieve the problem, or that may have contributed to the problem conditions in which it got better or worse or when the pt. was free of it for a while:

"It started about three years ago, after I lost my baby."
"My headaches sort of happened every few days, mostly on the weekends." "It gets worse when I am in crowds." "Then I lost my job and started drinking, and my fits really started then." "Being in the group really helped me for a few years, but then my wife left me and I started in again." "The business started going downhill; that's when I started seeing Dr. J. _____." "No, I just kept on working as usual." "Even when I touch my own stuff, I gotta wash my hands right away." "Here's how I would behave-respond to that (defined) situation." "I started medication and that relieved it." "My sex life was o.k. then." "Things were good at work; there wasn't much stress there."

The pt. provides factual data about himself. Typically, this is in answer to the T's questions, and generally the information is demographic. "I'm 32 yrs. old... I have been with this company for 3 yrs now... I've been married for about 6 yrs."

"Yes" is a means of providing simple factual data when the "yes" is in answer to the T's factual question:

T: "Were you the oldest of the children?"

Pt: "Yes"

T: "Even after you started drinking, were you still nervous?"

Pt: "Yes"

The Pt's attention is on the problem, and the information is that the Pt does not have the data: "I just don't remember whether it started then or after the baby was born."

Differentiating between category 4 and other categories.

If the pt. seems to be "in" or "there" in some scene (situation) he describes, then the statement is category 5 (Patient Constructs (Defines) External Situation). However, if he is attending mainly to the factual information about the problem, the statement is category 4.

In category 4 the pt. is talking about a problem, something rather specific and differentiated from himself and the kind of person he is. He is also giving factual information about it. In category 2, the pt. tells about himself, and the kind of person he is.

C. Patient Relates Directly to an External Situation

Within attentional center A. (categories 1 and 2), the patient's attention is on the therapist. Within attentional center B. (categories 3 and 4), the patient's attention is on his self, something within his own personality. Within attentional center C (categories 5 and 6), the patient's attention is on an external situation, either on the external situation in general, or on some focal center within some external situation.

Place patient's statements in each of the two separate categories: 5, 6.

5. The Patient Defines an External Situation

The patient constructs (defines) an external situation.

The pt. constructs (describes, defines) a situational context other than that of here with the T. The pt. is attending to, and partially "in" that other situational context. He talks about persons, things, objects, events, as if he is somewhat in the scene or situation with them. His words, (a) imply, connote some scene or situational context, some locale or place, and (b) what happens, occurs, takes place, how he is or was.

Almost always the pt. is there with the T, talking with and to the T. The question is whether the pt. is being (living, existing) in some other scene to some significant degree, say even 25% or 35%. If he were in that other scene 90% or 100%, he would be fully there in that situation, and he would not even be aware that he is here with a T. So the Pt. need not be in that other scene 90% or 100% but he must be living in it to some significant degree, say 25% or 35% or more. When he is mostly here with the T, but somewhere around 30% in that other scene, use category 5.

The scene (or incident) may have occurred recently or some time ago, or in fantasy.

The scene or situation may be only slightly defined, not fully described. Pt. may just be starting to detail the specific scene or situation. But it is enough for the pt. perhaps to see what he or she refers to and to be there in some degree: "My husband was all on edge, and he told me about this other woman." "I was worried about my son and the kinds of friends he was hanging around with." "I tell him exactly what I want, and he gets confused and changes the subject." "My father pushes Tim around and Tim starts to cry." "I had a seizure when I was sitting in a meeting at work with a group of consultants." "My uncle was 49 when he died, and I was there in the hospital room when it happened."

Pt. may describe the general situation vaguely, but he defines some part of the situation in some detail. For example, he describes the awful feeling of possibility in some detail. "When I'm in groups, or at work with people, I get panicky and my head starts to buzz, and I almost feel like they are pulling away, getting funny."

Pt. may add a little more to what he described of the situation: "...Yes, and they also had a few beers when they played cards together in the evening."

Even more vaguely, the pt. simply alludes to a scene, one which is perhaps bothersome or unpleasant. It is a dark veiled hinting toward some scene: "Something is wrong, the way they are with her." "There is always a lot of fighting in our house." "After that, something really frightening happened, but I never really thought it would affect me much."

Pt. tells about himself, his condition or state. But he places it in some scene or situation or situations. "I got bitter and angry and picked on everyone, my wife and people at work."

Pt. tells a story: this happened and then that happened and then that happened and then ... The pt.'s attention is on the sequence of events, the short story he is relating. But he does not go into much detail about any of the episodes of the story. He is telling what happened.

The scene or situation may be described in such detail, and with such vividness, that it almost starts to come alive. The pt. is almost being in that scene or incident. He frames in or describes the situation, the other person(s), the action, the relationships. The scene starts to come alive. He is almost being and doing in that scene. Pt. may say the actual words the other person says: "He says, 'Here's your hat, get out of here'."

The pt. is telling a dream, in such a way that it almost seems to come alive.

The dream is told as if it is an actual incident or actual event.

Pt. gives more detail about a part of the situational context. This is either on the pt.'s own initiative or in response to a question from the T. The pt. tells more detail about the way his previous therapist was with him, or the way his mother looked, or the kind of room he had when he was a child. The T may be the one who inquires about it ("Was it a big room?" "Did you have the room all to yourself?"), and the pt. merely says yes or no. But attention is on the situational context.

A special case is when the pt. tells "his story." Without any prompting or intrusion by the T, the pt. tells his story. The story is given in some detail, and it proceeds along a relatively defined sequence. It may be the story of his life. Or it may be the story of how "it" happened. The significant element is that the centrality of the T begins to recede. It is as if the pt. is compelled to tell that story as if to some special listener who is not the T. So it seems that the pt. is telling all of this to someone, but not necessarily to the T. The pt., then, almost seems to be in some situation other than the T's office, telling all of this to some special listener.

The pt. may be feeling bad or good in the scene (situational context).

Pt. describes the situation in which "it" (the bad thing, the problem) occurs. "When I am in a crowd and there's lots of noise, then it happens, and I get real scared."

Pt. defines the awful possibility, the scene in which the bad thing may occur. "I'd tell her about it in confidence, and she'll tell all her friends, and that'd be it; they'd ridicule me and laugh at me."

Differentiation between category 5 and others.

In category 4 the pt. talks about a problem generally by providing information about it. The key is where the pt.'s attention is. If the pt. is largely attending to some scene, (even if in response to the T's request for information about a problem,), the category is 5.

In category 3 the pt.'s attention is on the whole self. If the pt.'s attention almost exclusively is on the self (I or me) even within the context of a scene, the category is 3, but if the contextual scene is substantially present, and attention is distributed over the self and the scene, the category is 5. In instances of real indecision, category 5 supervenes, or takes precedence over category 3.

6. The Patient Focuses on a Defined External Center

The patient's attention focuses upon a defined center or target.

The pt.'s attention is focused predominantly upon some person or thing which is not the T (categories 1 and 2), nor is it some aspect of the pt.'s self (categories 3 and 4). The encompassing situation or scene may be vague, almost nonexistent. Although the person or thing is defined and seen, the situation (place, surroundings, scene) may be virtually absent. On the other hand, there may well be some defined encompassing situation surrounding the focused person or thing.

If the pt. is in some scene or situation, the pt.'s attention is centered upon the person or thing. "My sister and I were fighting over the sock. She was making funny sounds, like grunting, and she had this angry look when she told me that I could have it if I wanted it." The pt. is attending to his sister.

The person or thing may be signified very simply, with little defined detail but attention is on that person. "I have an older sister ...Louise." "My mother had the operation three years ago." "Maybe he'll have a heart attack and be paralyzed."

The key is that the pt's attention is generally directed toward that external person or thing. The attention may be diffuse or it may be focused and centered.

Attention is focused upon the person whom the pt. describes in some detail, gives a bit of the person's history, character, and the way that other person acts and behaves. "My father looked awful when he was in and out of the hospital; he was thin and weak, and he could hardly talk; he stayed that way for about a year." Attention is focused on the father.

In attending to that other person, the pt. may focus on the nature of the relationship. "I love my grandfather and he loves me, and that's the way it is with us." "They think I'm lazy and can't really be trusted." "She has her mind all made up, and I ain't ever going to give in to her no matter what." "Maybe he'd have a stroke and he won't be able to talk, and then he'll stop preaching at me."

With attention on the person or thing, the pt. tells about it, describes it, fills in something about what it is like. "He's got to keep moving all the time; can't ever sit still." "She is the kind of person who has achieved a lot in life." Pt. focuses upon what the other person did, or the other person's facial expression. "He just kept getting up and sitting down; he looked worried and completely bewildered."

A physical-bodily thing. The thing upon which the pt.'s attention is centered ~~may be~~ a physical-bodily thing. "If a person had this bump for months, wouldn't that be a sign of ...something bad?" "I was scared that maybe I was having a heart attack." Attention is focused on the heart attack.

Practically Saying The Words To That Other Person

The pt. is almost "in" the interaction with the other person, attending to that person. The pt.'s words are practically said to that other person.

If the third-person word (e.g., "him") is replaced by "you" the words are just about said to that other person. "When he tells me what to do, I feel like telling him to leave me alone and do it himself" (as if the pt. is talking to his father and just about saying, "Leave me alone; do it yourself."). "I like him; I really like him" (when the pt. is attending to and interacting with "him", and practically saying, "I like you; I really like you"). "She is loyal and dedicated. She will stay with you when you're in trouble and be with you; I admire her for that." "The lawyer was angry and not with me, and I said, 'If you can't help me with this, then forget it.'" "If someone said get the report done by Monday or I'll kill you, I'd say take me away; do it; I'm dead." "She's not going to make me get rid of the store just because she doesn't like antiques." "He'd like to say that he was responsible for my being a lawyer, but he's not; my aunt really was the one who helped me all along."

The word "you" may be used, but in a general way, when it really is directed toward the person the pt. is focused upon and in interaction with. In describing his mother and practically being there with her, pt. says, "You can't treat a child that way and expect him to love you." It is phrased as a general statement, but the words are practically spoken directly to mother.

Pt. says what the other person said, and then says what he said, etc. In effect, pt. says, "He said, then I said, then he said ..."

Differentiating between category 6 and other categories. The attention is focused on a physical-bodily center such as the bump, cancer, or heart attack, and, therefore, is not a description of the kind of person the pt. is (category 3). In category 6 the pt.'s attention is largely on the external person or thing. In category 3 the pt.'s attention is largely on some aspect of the self.

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APPENDIX C

Instructions For Rating Transcripts

The instructions for rating transcripts are taken from the "Experiential System of Content Analysis" by Alvin R. Mahrer, Ph.D. unpublished manuscript, University of Ottawa.

When categorizing patient statements:

1. Study what the therapist just said. Then try to make sense out of what the patient says in the context of what the therapist just said earlier. The unit is everything the patient says after the therapist talks and before the therapist responds to what the patient says.
2. Focus on what the patient says towards the end of the statements. Consider the end as far more important than the beginning, in assigning a category. The exception is when a prominent theme characterizes the first two-thirds or so of what the patient says, and the end is practically neutral. Otherwise, attend just to the last part of the patient's statement.

Very often, a patient will clearly be doing one thing throughout the first half or two-thirds of his statements. He may, for example, be describing the kind of person he is. Then, in the last few statements, he does something else, such as engaging in a direct opposition with the therapist. Under these circumstances, categorize what he is doing in the last few statements.

3. Classify each patient statements into one and only one category; if you feel that a second category may also apply, then decide between the two.
4. Some categories may not be used at all; some may be used frequently, some may be used rarely.
5. When you read what the patient says, first answer this question: What is the patient attending to, relating to or centered upon? If the patient is relating, or attending to (centered upon) the therapist, then it is category 1 or 2. If the patient is relating or attending to his self, then it is category 3 or 4. If the patient is attending to an external situation (or some part of an external situation), then it is category 5 or 6.

Now ask this question: In attending to that, what kind of world is the patient constructing? For example, if the patient is attending to

the therapist and, furthermore, the patient is constructing an oppositional relationship with the therapist, it is category 1. If the patient is attending to the therapist and, instead, constructing a world of accepting the therapist and what he says, then it is category 2. It is a matter of distinguishing between these three domains or worlds.

The following are the categories for statements of the patient. Place each patient statement in one category.

When the patient's attention is on:

The Therapist

1. The patient opposes the therapist.
2. The patient accepts the therapist.

The Patient's Self

3. The patient describes his self.
4. The patient informs of the problem.

An External Situation

5. The patient defines an external situation.
6. The patient focuses on a defined external target.

When categorizing therapist statements:

1. Study what the patient just said, and categorize what the therapist says in this context. If the therapist's previous statement was very short (e.g., a simple acknowledgment), study the still earlier statement of the patient.

1. Patient 1: I admire his forthrightness
1. Therapist: Um-hm
2. Patient: And yet I don't care much for him
2. Therapist: But you think he's pretty forthright

In order to categorize 2T (Therapist), you must go back to 1Pt. (Patient).

2. Look for something predominating throughout the therapist statement, paying special attention to the last third of the statement.

3. You may categorize the therapist statements into one category.

The therapist may do one thing (e.g., answer the patient's question) in the beginning of a statement, and then proceed to do another thing in the balance of the statement (e.g., say what he believes the patient is saying.) Categorize just one. Judge which one is more important. Generally, it is the latter portion of the statement which is more important.

4. You need not make use of all the possible categories.

The following are the categories of statements made by the therapist:

1. The therapist structures the therapy session.
2. The therapist tells the patient about the patient.
3. The therapist asks the patient to provide data about what the patient or problem is like.
4. The therapist gathers data about, and clarifies the external situational context.
5. The therapist discloses and tells about the kind of person the therapist is.
6. The therapist tells the patient what external reality is like.
7. The therapist says what he believes the patient is saying.
8. The therapist gives simple acknowledgment to what the patient says.
9. The therapist gives permission-approval-encouragement for the patient to continue to talk.
10. The therapist gives advice to the patient about potential personality-behavior change.
11. Other..