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CLIENT RESPONSES TO THERAPIST STATEMENTS AS BEHAVIOURAL REQUESTS

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Dissertation presented to the School of Graduate Studies,
University of Ottawa, as partial fulfillment of
the requirements for the degree of
Doctor of Philosophy

ISBN 0-315-60074-8

UNIVERSITÉ D'OTTAWA
UNIVERSITY OF OTTAWA

ACKNOWLEDGEMENTS

I embarked upon this journey hoping to learn and to grow. Thanks to the many individuals I met along the way, I have not been disappointed. First and foremost, I would like to express my deepest gratitude to my supervisor, Dr. Alvin R. Mahrer, for providing me with this opportunity; for stimulating and challenging my mind with his innovative thinking regarding the theory, practice, and research of psychotherapy; for his invaluable guidance in the completion of this thesis.

I would like to thank the members of my thesis committee, Dr. Pierre Baron, Dr. Henry Edwards, and Dr. Sue Johnson for their valuable suggestions and assistance in the development of this project. Special thanks are expressed to Dr. Henry Edwards for giving me access to Bill Maloney's sessions. I am very grateful to the late Dr. William Barry for so generously allowing me to study his own work as a therapist. In addition, I would like to thank Bill Maloney for his enthusiastic cooperation and support. I am indebted to the many individuals who generously volunteered to serve as raters in this study: Andre Dessaulles, David Fairweather, Mary Theresa Howard, Joanna Irvine, Dr. Peggy Kleinplatz, Alison Lee, Dr. Rick Markow, Dr. Wayne Nadler, Janine Scott, Suzanne Simond, and Michelle Souliere. I would like to thank Dr. Howard Schacter and Dr. Rick Markow

for their editorial comments. Very special thanks are extended to Dr. Peggy Kleinplatz for her excellent editorial assistance, not to mention her unwavering friendship and support. I would like to express my gratitude to Dr. Kenneth B. Campbell for the extended loan of his personal computer and for giving patiently and generously of his time. I would like to thank Laura Ospina for her help in word processing and graphics. In addition, I would like to acknowledge the financial support and assistance of the Medical Research Council of Canada and the School of Graduate Studies and Research of the University of Ottawa.

In this endeavor, there were people whose contributions, while not always academic, were nonetheless significant. I have been very fortunate to have wonderful friends who helped make these years stimulating and exciting; whose support, encouragement, and understanding helped me through the hard times. I would like to thank my sister and father for their support. Lastly, there is one individual to whom I owe a debt that I could not even begin to repay. In large part, my interest in human psychology was aroused by what she experienced in her life. She was also my role model of the working woman. Even when she did not understand or share my goals, she always supported me in the pursuit of my dreams. For this and much more, I dedicate this thesis to my mother, Adela Neuman Sterner, with abiding love and profound gratitude.

ABSTRACT

Psychotherapists' statements may be conceptualized and described in different ways, depending on which aspects of the statements are highlighted. Traditionally, therapist statements have been described in terms of techniques that serve, for example, interpretative, reflective, or supportive functions. From a psycholinguistic or an interactional communications perspective, therapist statements may also be understood as inviting or instructing the client (directly or indirectly) to respond in a particular manner and to carry out given behaviours. Accordingly, the primary purposes of the present research were (1) to examine therapist statements as potentially containing requests for verbal behaviour, and (2) to test hypotheses regarding clients' responses to these antecedent behavioural requests. The data consisted of 12 sessions; two sessions from the beginning, middle, and end of two therapy cases, one Gestalt and the other psychodynamic. Raters identified therapist statements that contained requests for verbal behaviour and specified the nature of these requests. The requests were then organized into a general set of categories for each therapist. A second team of raters ascertained the goodness of fit between the therapist statements and the categories to which they had been assigned. A third team of judges rated the clients'

responses to the therapists' antecedent requests on a four-point scale of conformity. The results indicated that a large proportion of therapist statements contained requests for verbal behaviour (66.3%). While some requests were communicated explicitly as such, others were implicit in the therapists' statements. Some categories of requested verbal behaviour were common to both therapists while others appeared to be unique to a particular therapeutic approach. Both therapists invited certain categories of verbal behaviour more often than others. The findings also showed that the level of client conformity to the therapists' antecedent requests was high in general (82% of client responses in the Gestalt case, 98% in the psychodynamic case), and that this high level was relatively stable and consistent across sessions. In the Gestalt case, the degree of conformity was found to vary depending on the type of verbal behaviour requested by the therapist. Nevertheless, a high level of conformity was reflected in all the categories in one case, and most of the categories in the other case. Contrary to expectations, the findings did not show (1) a strong upsurge in client opposition corresponding to particular stages of therapy, or (2) stage differences in the extent of conformity or type of opposition. The findings of this investigation are discussed in terms of their implications for clinical practice and future research.

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INTRODUCTION

It is generally acknowledged that many factors determine progressive developments in a client's verbal behaviours across a psychotherapy session and a series of sessions (e.g., Garfield, 1978; Goldfried, 1982; Greenberg, 1983; Kiesler, 1973; Orlinsky & Howard, 1978; Rice & Greenberg, 1984b; Schlien, Hunt, Matarazzo, & Savage, 1968; Strupp, 1973). Included in this broad family of factors are those relating to the stages and phases of therapy, specific therapeutic methods and operations, the therapist's overall approach, the fluctuating and developing nature of the therapist-client relationship, the client's personality structure and typical behavioural patterns.

It is reasonable to assume that the therapist's words and statements within a session are one factor that will influence what the client says and does in therapy. There are many possible ways of describing therapist statements and the ways in which they influence the client. Traditionally, therapist statements have been described in terms of their clinical intent or praxis. For example, they have been viewed as serving interpretative, reflective, supportive, empathic, confrontative, and similar functions. In addition to their role as reflections, interpretations, closed or open questions, and so forth, therapist statements can also be seen as having communicative

significance as behavioural requests that are aimed at the client. From this perspective on therapist statements, the therapist's words may be viewed as inviting the client, directly or indirectly, implicitly or explicitly, to respond in a particular manner. The client is requested, invited, instructed, or directed to carry out given behaviours. Accordingly, the subsequent client verbal behaviours may then be examined as reactions or responses to these behavioural requests.

This view of therapist statements as containing behavioural requests is directly rooted in linguistic theory (e.g., Searle, 1976) and analyses of psycholinguistic aspects of therapist statements (e.g., Labov & Fanshel, 1977). It is also derived from literature that focuses on the communicative interaction that takes place between therapist and client (e.g., Strong & Claiborn, 1982; Watzlawick, 1978; Watzlawick, Beavin & Jackson, 1967). This perspective of therapist statements is also related, albeit indirectly, to recent research on therapist intentions (e.g., Elliott, 1985; Hill & O'Grady, 1985).

The purpose of this research is to examine therapist statements as potentially containing behavioural requests and to examine consequent client statements in light of these antecedent requests. Specifically, the present research will investigate (1) the general pattern of client statements over the course of sessions as direct and

immediate responses to the requests for verbal behaviour contained in the antecedent therapist statements; (2) the quality of client responses to antecedent requests as scaled in degrees of conformity and acquiescence; (3) the level of client conformity to the therapist's requests in different stages and phases of therapy; and (4) the different kinds of requests for verbal behaviour that therapists make over a series of sessions, and the extent to which the level of conformity differs, depending on the type of verbal behaviour that is requested.

The following questions are pertinent to this investigation. What proportion of the therapist's statements contains requests for verbal behaviour? What is the pattern of client responses to the therapist's requests for verbal behaviour over the course of therapy? Does the client's level of conformity to the therapist's requests correspond to particular stages of therapy? Are there qualitative differences in the client's responses, i.e., in the degree of conformity and type of opposition to the therapist's requests which correspond to particular stages of therapy? To what extent does the level of client conformity to the therapist's requests change, depending on the kinds of verbal behaviour that the therapist is inviting?

At present, the literature contains only a preliminary investigation of therapist statements as containing

behavioural requests (Mahrer, Clark, Comeau & Brunette, in press). Therefore, predictions regarding the outcome of the present investigation are derived largely from literature that is indirectly related to this study. Sources include clinical theory and process research on the role of influence in psychotherapy and on complementarity and symmetry in therapy (e.g., Cashdan, 1973; Frank, 1975; Friedlander & Phillips, 1984; Tracey & Ray, 1984). The general expectation is that over a series of sessions there will be an increasing occurrence of the requested verbal behaviours; that is, the client will increasingly manifest, display, and express the verbal behaviours that the antecedent therapist statements invite or request. It is also predicted that there will be phases of conformity and acquiescence over a series of sessions, and that these phases will be characterized by qualitative differences in clients' verbal responses.

This study attempts to contribute to the literature by investigating potentially meaningful aspects of therapist statements. The behavioural requests in the therapist's statements may be one way in which therapist statements guide, channel, shape, and influence the client's behaviour in therapy. Accordingly, the findings may highlight the need for research that explores linguistic and psycholinguistic aspects of therapist statements and how these aspects can mediate the communicative interchange

between therapist and client. The findings may open the way for further study of the actual wording of therapist statements in terms of the behavioural requests that the therapist's words contain. Another implication for future research may be examination of the relationship between therapists' intentions, traditional descriptions of therapist statements (e.g., as reflections, interpretations, etc.), and therapist statements as behavioural requests. This study attempts to contribute to the understanding of progressive modifications and developments in clients' verbal behaviours over a series of sessions. In this regard, the findings have implications for future investigation of the ways in which the client's behaviour develops as a function of the behavioural requests in therapist statements, and as a function of the stages and phases of therapy. The findings may indicate that it is important to examine the quality of the client's responses to the therapist's interventions, for example, the form of client opposition and degree of conformity to the therapist's requests, at various points in therapy. The findings also have implications for future examination of the relationship between client conformity to the therapist's requests and the kinds of behaviour requested by the therapist.

CHAPTER I

REVIEW OF THE LITERATURE

The purpose of this chapter is to review the literature pertinent to an examination of therapist statements as behavioural requests and of client statements as responses to these requests. The chapter is divided into four sections. The first section defines the meaning of therapist statements as behavioural requests and presents the literature that is related to this conceptualization of therapist statements. The second section presents the pertinent research on client statements as responses to the therapist's antecedent requests. Based on the preceding review of the research literature, the third section outlines the research hypotheses and questions. The fourth section examines the potential significance of this investigation.

Therapist Statements as Behavioural Requests

What concepts are used to describe what therapists are doing when they are talking to their clients? Traditionally, therapists' statements have been described in terms of therapeutic vessels, conveying such things as information, empathic understanding, encouragement, approval, reassurance, acknowledgement, and so forth. Therapists' statements are framed as reflections,

interpretations, open and closed questions, confrontations, and self-disclosures. The therapist is clarifying, seeking information, probing and exploring, advising, restating or reframing. The therapist is providing information, minimal encouragement, or direct guidance. The therapist's statements are techniques and methods that are instrumental in producing processes of change.

A number of category systems have been developed to describe the therapist's statements within therapy sessions (e.g., Bandura, Lipsher, & Miller, 1960; Cooke & Kipnis, 1986; Elliott, 1979, 1985; Friedlander, 1982, 1984; Goodman & Dooley, 1976; Hill, 1978; Hill & O'Grady, 1985; Lennard & Bernstein, 1960; Murray, 1956; Porter, 1943; Snyder, 1945; Stiles, 1979; Strupp, 1957). The sheer number of category systems attests to the fact that therapists' statements may be conceptualized and described in different ways, depending on what aspects of the statements are highlighted. While there may be some redundancy, the classification systems differ in that they use different strategies to describe different features of the therapist's communication (Marsden, 1971; Russell & Stiles, 1979). One category system does not invalidate an alternative classification of therapist verbal behaviours. Moreover, one description of therapist statements does not negate an alternative conceptualization of therapist statements.

One alternative conceptualization of therapist

statements is presented by Mahrer (1985). In addition to being described as acknowledgements, restatements, clarifications, reflections, interpretations, and so forth, the therapist's statements may be regarded as communicative acts that implicitly or explicitly invite the client to respond in particular ways. In this view, the actual words spoken by the therapist may be seen as containing a behavioural request or direction for the client to follow in the immediately subsequent response. The therapist's statement is instructive, subtly or overtly guiding the client in the therapeutic process by designating the kind of verbal behaviour that the client should manifest in the next statement. The therapist's words may be seen as directly or indirectly shaping and channelling the client's response.

Some examples may help illustrate what is meant by therapist statements as behavioural requests. Consider the following therapist statement: "So look at him, your brother, just look right at him, and say, "You piss me off" - and say it like you mean it!" On the basis of this particular therapist statement, the client is to respond in the following statement by looking directly at his brother and saying with genuine meaning, "You piss me off"! The client is to express his (or her) feelings directly to the other person.

Here is another example. The therapist says: "As you see him now, how are you feeling toward him?" What verbal

behaviour is the client requested to carry out? The client is to (identify and) describe her feelings towards the other person. The following therapist statement contains a similar request. The therapist says: "How do you feel now? What's it like for you when you get silent like this?" Once again, the client is to (identify and) describe her feelings. In this specific case, the client is to describe the feelings which are present when she is silent.

In the examples given above, the therapist's behavioural request is relatively explicit, overt and direct. The next two therapist statements illustrate the difference between direct, explicit requests and indirect, implicit requests. The therapist says: "I think that what you had going was mighty important and I'd like to see you get to it a little bit more... Are you saying to him, "I don't want to say good-bye to you?" How is the client likely to respond in the following statement? It is highly probable that the client will either confirm, agree, and acknowledge that this is what he is saying to the other person or that the client may disagree with the therapist's understanding of what the client is feeling and meaning. The therapist's words are explicitly inviting (or requesting) the client to agree or disagree, to confirm or disconfirm. The following therapist statement also invites the client to agree or disagree, confirm or disconfirm, but the behavioural request is less explicit and direct. The

therapist says: "You're saying she made you feel guilty for being born". The therapist does not ask the client explicitly and directly if this is what he is saying. The therapist makes a declarative statement, yet with an implicit question of agreement or disagreement. If we consider how the client is likely to respond to the therapist's words, we arrive at the same request. It is highly probable that the client may either agree (confirm, acknowledge) that this is what he is saying or disagree. The therapist's words are implicitly and indirectly (though not necessarily intentionally) inviting the client to respond by agreeing or disagreeing.

In summary, this view of therapist statements focuses on one pragmatic aspect of therapists' communication. It suggests that it is possible to examine therapist statements as communicative acts which invite clients to manifest specific kinds of verbal behaviour in their subsequent statements. The therapist's requests may be put forth explicitly and directly or implicitly and indirectly.

Theoretical and Research Background

This perspective on therapist statements is based on literature that has conceptualized therapist statements as (a) linguistic "speech" acts and (b) interactional communication acts. It is also related, albeit indirectly, to process research on therapist intentions. Pilot work for this study suggested that therapist statements can be

understood as behavioural requests. It also indicated the proportion of therapist statements that may be understood as containing behavioural requests. These four backgrounds in the literature will be reviewed in the following sections.

Therapist Statements as Speech Acts

From the perspective of psycholinguistics, therapists' words and statements are seen as instances of communication, as linguistic acts, or mere "speech acts" (Labov & Fanshel, 1977; Shapiro, 1979). The speech act approach considers, among other things, the perlocutionary effect of verbal events. That is, it considers the consequences the speech act has on the actions, thoughts, feelings, and beliefs of the hearer (Austin, 1962; Davis, 1980; Searle, 1969; Searle & Vanderveken, 1985; Shapiro, 1979). The examination of therapist statements as behavioural requests also focuses on the effect that therapist statements, as perlocutionary speech acts, have on the client. The difference is that "perlocutionary effect" is a term used to refer to a wider range of effects, whereas the focus of "behavioural requests" in the present investigation is confined to the effect that the therapist's words are inviting with regard to the client's immediate verbal response. Still, the speech act approach does provide a precedent for examining therapist statements as requests that invite the client to respond in a particular manner.

Moreover, from the linguistic/psycholinguistic

perspective, some of the classes of speech acts emitted by the therapist may be viewed rather directly as behavioural requests. For example, in his taxonomy of illocutionary acts, Searle (1976, 1979; also Searle & Vanderveken, 1985) identifies "directives" as one class of speech acts. Members of this class include ask, order, command, request, beg, plead, pray, entreat, invite, permit, and advise. The illocutionary point of directives "consists in the fact that they are attempts (of varying degrees...) by the speaker to get the hearer to do something. They may be very modest attempts as when I invite you to do it or suggest that you do it, or they may be fierce attempts as when I insist that you do it" (Searle, 1976, p. 11). In the case of directives, the speaker's intention, want, wish, or desire is that the hearer do whatever it is that is being requested.

The class of therapist statements that Labov (1972) and Labov and Fanshel (1977) call "requests for action" corresponds to Searle's (1976, 1979) "directives" category. These speech acts include all verbal techniques in which the speaker is using verbal means to accomplish the end of getting the listener to do something, whether by command, request, or suggestion (Labov & Fanshel, 1977). These requests include requests for action, requests for information, requests for confirmation, requests for agreement, and requests for evaluation. Therapist

statements belonging to this class request or direct the client to do something, to behave in a certain way, to respond verbally or nonverbally in a defined manner. Labov and Fanshel (1977) go one step further in defining the effect or consequence (i.e., the perlocutionary effect) of this class of speech acts. In response to a request from the therapist, the client has three basic options: (1) to give the information, confirmation, or whatever is requested; to carry out the requested action or suggestion, (2) to put off (delay) the request, or (3) to refuse it.

Labov and Fanshel (1977) highlight the importance of requests as a class of speech act. They propose that this class of therapist statements can have a significant impact on the client: "Our examination of requests for action and information in actual discourse shows that their interactive significance goes far beyond the communicative functions we have discussed so far. We find that most of these requests are employed to accomplish other purposes which strongly affect the social and emotional relations of persons" (Labov & Fanshel, 1977, p. 93).

Other therapists statements fall into a class called "representatives" (Searle, 1976), or "assertives" (Searle, 1979; Searle & Vanderveken, 1985), or "representations" (Labov & Fanshel 1977). Such statements put forward the truth of a belief or observation, either by strongly asserting it, presenting it as a hypothesis, or gently

pointing in its general direction. Representations (of disputable events) include therapist statements that are assertions, interpretations, and evaluations (Labov & Fanshel, 1977). Representatives may have a correlated perlocutionary effect whereby the client accepts the general truth of this class of statements, even though the speaker may not in fact intend to produce that effect (Searle, 1969). According to Labov and Fanshel (1977), the rule of confirmation is operating in these instances of human discourse. That is, even when the statement is declarative (i.e., there is no interrogative form), representations are heard as requests for confirmation, for agreement or disagreement of the assertion, interpretation or evaluation. Accordingly, in response to the therapist's assertions, interpretations, and evaluations, the client may agree with, deny, or support the therapist's statement (Labov & Fanshel, 1977).

Thus, from the perspective of linguistic theory and psycholinguistic research, therapist statements may disclose themselves as requests and directives for how the client is to respond and what the client is to do, or as (intended or unintended) invitations for the client to accept the truth in the therapist's statement. By studying psychotherapy sessions and examining the therapist's statements as behavioural requests, it is possible to ascertain the proportion of therapist statements that contain such

requests (i.e., that have perlocutionary effects). Some argue that not all speech acts are definable in terms of their perlocutionary effect (e.g., Searle, 1969, 1976). Others, such as Labov and Fanshel (1977), suggest that "any speech act having clear interactional consequences can be seen as a request for a response of a certain kind" (pp. 101-102). In a similar vein, Shapiro (1979) states that "every illocutionary force is designed to have a perlocutionary effect on the auditor" (p.95). Regardless of whether all or only some of the therapist's statements contain behavioural requests, this literature indicates that one can begin to look at the therapist statement as potentially requesting, directing, or telling the client what to do.

In general, the linguistic and psycholinguistic perspective suggests that therapist statements may be seen as containing behavioural requests for the client to follow. These behavioural requests serve as demands or invitations for the client's subsequent verbal responses. This literature suggests that such subsequent responses as confirming and agreeing with the antecedent therapist proposition, or actually carrying out requested directives, may be understood in terms of the impact of the antecedent therapist statements as behavioural requests. Thus, particular types of requests (for verbal behaviour) in the antecedent therapist statements may be related to specific

classes of subsequent client response (verbal behaviour).

Therapist Statements as Interactional Communication Acts

There is another body of literature, relatively in keeping with the linguistic perspective, from which an understanding of therapist statements as behavioural requests can be derived. This literature advances a conceptualization of psychotherapy as a communicative interaction in which both parties, therapist and client alike, are exerting an influence on one another (Haley, 1963; Strong & Claiborn, 1982; Watzlawick, 1964, 1978; Watzlawick, Beavin & Jackson, 1967; Watzlawick & Weakland, 1977). The focus is on the interacting dyad and the pragmatics of the participants' communication from an interactional perspective. Therapist and client statements are viewed as direct or indirect attempts to influence, channel, and prescribe the other participant's subsequent communications and actions. This focus on the communication exchange or interaction in psychotherapy has led to a greater appreciation of how therapist statements direct and influence the client's behaviour. For example, the therapist's statements have been described as metacommunications (Pentony, 1981; Watzlawick, 1964), injunctive language forms or behavioural prescriptions (Watzlawick, 1978), and directives (Strong & Claiborn, 1982).

Pentony (1981) has noted that the therapist's use of

metacommunications influences the client's focus of attention and verbal behaviour. Metacommunications are high order communications which comment on lower level communications. For example, the client recounts some significant event. The therapist responds by commenting on ongoing client process behaviour or client state, such as the fist that the client is making, the tears that are welling up in the client's eyes, or that the client seems to be in a lot of pain. This shifts the client's focus of attention to the ongoing process behaviour or state, and influences the content of the client's subsequent response. To the extent that they invite a particular client response, these metacommunications may be understood as behavioural requests that are aimed at the client.

There is another precedent for viewing at least some therapist statements as containing behavioural requests in Watzlawick's (1978) argument for the use of directive interventions that explicitly prescribe particular behaviours. According to Watzlawick (1978), psychotherapists have "always utilized injunctive language forms when they deliberately (or, more likely outside of their awareness) have tried to motivate the behaviour of their clients toward certain goals" (p.132). These "behaviour prescriptions range from very simple direct commands to highly complex combinations of therapeutic double binds, reframing and illusions of alternatives"

(Watzlawick, 1978, p. 132). Watzlawick (1978) is referring to one particular class of therapist statements. However, once again the notion of therapist statements as vehicles that invite or direct the client to respond in a particular manner is put forth.

Strong and Claiborn (1982) have suggested that most therapist responses are directives. That is, they are communications that direct and guide the client's behaviour within the therapy session. These directives are subtle or blatant. They are presented as implicit suggestions or explicit commands. The following excerpt highlights the importance of taking a closer look at therapist statements for the different types of directives (i.e. behavioural requests) that they contain. "The client's response to each counselor communication is partially a function of how it is stated and the implications of complying with or defying the directive. From the interactional point of view, the debate over whether counselors should be directive or nondirective is a matter of the pragmatics of what directives, given the client's current behaviour, will successfully invite the client to respond in the direction of the therapeutic goals of the interaction" (Strong & Claiborn, 1982, p.167). Claiborn's (1982) description of therapist statements as "directives" is very much in line with an understanding of therapist statements as behavioural requests.

Psychotherapy process research based on the

interactional views of psychotherapy (e.g., Haley, 1963; Strong & Claiborn, 1982; Watzlawick & Weakland, 1977) has developed methods to study mutual influence processes, complementarity and symmetry in psychotherapy. This research examines therapist and client statements using atheoretical terms of discourse activity (i.e., flow of talk), such as topic determination, topic initiation, topic following, and topic relevant acts and responses (Friedlander, 1984; Friedlander & Phillips, 1984; Friedlander, Thibodeau & Ward, 1985; Tracey, 1985, 1986; Tracey & Miars, 1986; Tracey & Ray, 1984). This research examines the degree of structure implicit in therapist statements, that is, the extent to which the therapist's speech acts circumscribe or restrict the form and content of the client's subsequent responses (Friedlander, 1982; Friedlander et al., 1985). This research differs from the study of therapist statements as behavioural requests in that it gets at whether the therapist is initiating and determining topics, or at the degree of structure in therapist statements, rather than at what it is that the client is invited/requested to do and say in the subsequent statement. However, these studies do highlight the feasibility of looking at each participant's communication as responses in light of the antecedent statements made by the other participant. Moreover, their results indicate that at the level of discourse, the therapist statements may

be seen as structuring the client's subsequent behaviour and as initiating topics that may be subsequently followed by the client (Friedlander et al., 1985; Tracey & Ray, 1984).

In summary, from the interactional perspective therapist statements may be seen as direct or indirect, explicit or implicit, subtle or blatant attempts to channel the client's subsequent communication in certain directions. The therapist statement influences the client's focus of attention or prescribes particular behaviours. The therapist's statements are directives that guide the client to certain behaviours in the session. Thus, the descriptions of the therapist's communication from the interactional view suggest that therapist statements may disclose themselves as requests and directives for what the client is to do next. Therapist statements may be seen as behavioural requests that invite the client to respond in a particular manner.

Therapist Statements as Acts of Intention

One of the recent developments in psychotherapy process research is the study of therapist intentions (e.g., Elliott, 1979; Hill, Helms, Tichenor, Spiegel, O'Grady & Perry, 1988b; Hill & O'Grady, 1985; Martin, Martin, Meyer & Slemon, 1986). Research in this area examines therapist statements to see what the therapist is intending to accomplish. An understanding of therapist statements as behavioural requests is not derived directly from the

research on therapist statements as acts of intention. However, there are two ways in which the study of therapist intentions is related indirectly to the view of therapist statements as behavioural requests. For one, both perspectives represent an attempt to expand the study of therapist statements. Research on therapist intentions suggests a new way of getting meaning from therapist statements, in addition to identifying therapeutic methods and techniques, such as reflections, interpretations, and confrontations. That is, one can also look at what the therapist says and focus on the therapist's intention in making that particular statement. The research on therapist intentions demonstrates that there are different ways to understand, conceptualize and describe therapist statements. Another way may be to describe therapist statements in terms of the request for verbal behaviour that they contain.

A second way in which the study of therapist intentions is related to the study of behavioural requests is that it looks at therapist statements in terms of immediate consequences. The research on intentions presumes that when therapists make a statement they have an immediate purpose, goal, or intention with regard to the client's subsequent knowledge, feelings, thoughts, cognitions and behaviours. Accordingly, the individual therapist statements are examined in terms of the intended consequences of each statement. For example, the therapist's intentions include:

provide support, provide hope, promote catharsis, promote self-control, promote and reinforce change, overcome resistance, and challenge (Hill & O'Grady, 1985). These intentions refer to specific and immediate corresponding client reactions, or consequences, that are expected (intended) to occur. That is, in response to the therapist statement and corresponding to the therapist's intention, the client should feel supported, feel hopeful, feel relief, accept responsibility, learn or choose new ways of behaving, overcome a block/become unstuck, and feel challenged (Hill, Helms, Spiegel, & Tichenor, 1988a).

The study of behavioural requests also examines therapist statements in terms of immediate client consequences. The therapist statement is examined for the client response (i.e., reaction, consequence) that it requests or invites. In this general respect it is similar and related to the study of therapist statements as acts of intention. However, a distinction may be drawn between examining therapist statements as behavioural requests and the study of therapist intentions. The study of behaviour requests differs from the study of therapist intentions in the way that it defines what those consequences will be. Moreover, the study of therapist statements as behavioural requests refers to and yields a different type of immediate client consequence. The rest of this section takes a closer look at the differences that distinguish behaviour requests

from therapist intentions. These differences might serve to highlight what is unique in the study of therapist statements as behavioural requests.

First of all, the research on therapist intentions examines therapist statements and therapeutic process goals in a distinctively different manner. To determine the therapist's intentions it uses various methods of tape-assisted or stimulated process recall (Elliott, 1979, 1985; Elliott, Barker, Caskey & Pistrang, 1982; Elliott & Feinstein, 1978; Hill et al., 1988a, 1988b; Hill & O'Grady, 1985; Martin et al., 1986; Martin, Martin & Slemon, 1987, 1989). Research on therapist intentions usually asks the client (Elliott, 1979), or the therapist (Hill et al., 1988a, 1988b; Hill & O'Grady, 1985), or both client and therapist (Elliott, 1985; Elliott et al., 1982; Fuller & Hill, 1985; Martin et al., 1986, 1987, 1989) to identify the therapist's immediate intentions in making a particular statement. In very few cases are independent observers or judges used (eg. Hill, Carter & O'Farrell, 1983). Thus, it relies on the therapist's and client's description (formulation, classification) of the therapist's purposes and intentions. In contrast, the study of therapist statements as behavioural requests uses trained observers to examine the therapist statements. The questions it attempts to answer are different from the questions asked by research on therapist intentions. The research on intentions

ascertains what the therapist was trying to do or intended to accomplish in making a particular statement. The study of behaviour requests determines how the client is likely to respond (verbally), or what client verbal response is being invited or requested, on the basis of the therapist's words (i.e., behaviour rather than intentions).

A second difference between therapist intentions and behaviour requests is the type of immediate client consequence to which they refer. The various taxonomies of therapist intentions do not refer to the client's immediately subsequent verbal response. They do not specify what the client is to say in the next statement. The categories of therapist intentions identified by Martin and colleagues (1986, 1987, 1989) refer exclusively to subsequent client cognitive processes, such as expecting, attending, encoding, rehearsing, associating, metacognizing, retrieving and assembling. Elliott's taxonomy includes nine therapist intentions: gather information, guide in session, advise the client, communicate understanding of client's message, explain client to the client, reassure the client, disagree with the client, share self with the client and give general information. Only one of these categories (i.e., gather information) provides a general idea of what the client's subsequent verbal response should be (i.e., give information).

The same is true for the list of 19 intentions

identified by Hill and O'Grady (1985). In addition to the intentions that have been mentioned previously, their taxonomy includes: set limits, get and give information, focus discussion, clarify, identify cognitions and behaviours, identify and intensify feelings, promote insight, enhance the therapist-client relationship, and fulfill therapist needs. These intentions do not refer to the verbal behaviour that is expected or intended as a consequence of the therapist statement. The client consequences, or reactions, that correspond (conceptually) to these therapist intentions refer to covert client processes rather than to the client's verbal response. The 14 categories of positive client reactions developed by Hill and colleagues (1988a) refer to what clients feel or learn in reaction to the individual therapist statement. These reactions include feeling understood, supported, hopeful, relief, unstuck, or challenged. They include learning new ways to behave, accepting responsibility, gaining a better understanding of oneself, a new perspective, greater knowledge or information, becoming more deeply aware of thoughts, behaviours, goals, and feelings. These are the client consequences that are intended. These consequences do not refer to what the client is to say next. In contrast, the study of behavioural requests examines therapists' statements to determine the immediately consequent verbal response that is being invited or

requested.

Perhaps the most important difference between behaviour requests and therapist intentions is that the study of the former aspect of therapist statements does not attempt to decipher or consider what the therapist intends to do. Therapist statements as behavioural requests may be considered as a manifest expression of therapist intentions and therapeutic goals. However, therapists' stated intentions and the behavioural requests contained in their statements need not necessarily correspond.

Some of the examples given earlier in this chapter can serve to illustrate this point. The therapist says: "As you see him now, how are you feeling toward him?" The client is requested to describe her feelings towards the other person. This behavioural request may indeed correspond to the category of therapist intentions called identify, intensify, and accept feelings. However, it highly improbable that the therapist's intention in the following two statements is simply for the client to provide confirmation and agreement. The therapist says: "I think that what you had going was mighty important and I'd like to see you get to it a little bit more... Are you saying to him - I don't want to say good-bye to you?" The therapist says: "You're saying she made you feel guilty for being born". Examination of these statements as behavioural requests results in the following provisional conclusions: (a) the

likely client verbal response is that of confirmation and agreement, or alternatively disagreement, and (b) this is what the client is being directly, in the first case, and indirectly, in the second case, requested to do. This does not say anything at all about the therapist's intentions. The therapist's intention in these two statements may be, for example, to clarify, to identify feelings, or to promote insight. That is a separate issue. Therapist intentions may or may not correspond to behavioural requests. The study of therapist statements as behavioural requests only focuses on the therapist's words to decipher how the client is to respond, verbally, in the subsequent statement. The structure and content of therapist statements are examined to determine what verbal behaviour is invited and requested, intentionally or unintentionally.

In summary, the study of therapist intentions is indirectly related to the understanding of therapist statements as behavioural requests. They both derive new meanings from the individual therapist statement that go beyond previous category systems of therapist behaviour. They are both concerned with the immediate consequences of the therapist statement. There are also differences between therapist intentions and behavioural requests. The study of therapist intentions focuses on intended consequences, as defined by the therapist and/or the client. To date, these intended consequences have referred mainly to covert client

reactions and processes. The study of behaviour requests focuses on the consequence of the therapist's actual words with regard to the immediately subsequent client verbal response. The therapists' intentions may not necessarily correspond to the behavioural requests that are contained in their statements. The examination of therapist statements as behavioural requests may provide a unique and important description of client consequences that are invited, intentionally or unintentionally, by the therapist's verbal behaviour.

Preliminary Indications of the Prevalence of Behavioural Requests in Therapist Statements

Thus far the focus has been on the basis in the literature for viewing therapist statements as containing behavioural requests. The literature that has been reviewed suggests that therapist statements may be understood as containing behavioural requests. Given that this perspective on therapist statements is feasible, the present research is interested in ascertaining the proportion of therapist statements that contain behavioural requests. The pilot work for this investigation indicated that therapist statements may be described in terms of the behavioural requests that they contain (Mahrer, Clark, Comeau & Brunette, in press). Moreover, it indicated that a large proportion of therapist statements may contain behavioural requests. This study focused on a limited, three-session

therapy conducted by Dr. Joan Fagan (published verbatim in Fagan, 1974). Of 252 therapist statements in three sessions, 176 statements, or 70%, emerged as containing behavioural requests. These results are very similar to Friedlander's (1982) findings regarding the degree of structure in therapist statements. Friedlander (1982) analyzed samples from 34 initial and second counseling interviews. She found that 67% of the therapists' statements in the initial interview, and 65% in the second session had either a moderate or high degree of structure. That is, the majority of therapist statements contained either an implicit or an explicit request for the client's reaction. Thus, while not all therapist statements may contain behavioural requests, these studies do suggest that a significant proportion of statements in each session will contain such requests.

Summary

The literature reviewed above suggests that an understanding of therapist statements as behavioural requests is feasible and conceptually grounded. The research on therapist intentions highlights the utility of examining different aspects of therapist statements. Therapist statements may be described in terms of therapeutic methods and techniques, such as interpretation, reflection, acknowledgement, advisement, or confrontation. They may be described in terms of the therapist's intent in

making the statement. They may also be described in terms of the client response (i.e., verbal behaviour) that the therapist statement is requesting or inviting. From the linguistic, psycholinguistic, and interactional (communication) perspectives, certain classes of statements are viewed as explicit requests and directives for the listener to carry out particular behaviours. Other classes of statements are shown to indirectly invite a particular kind of response. Research on the degree of structure in therapists' communication and preliminary investigation of therapist statements as behavioural requests suggest that a substantial proportion of therapist statements may contain requests for verbal behaviour. It may be worthwhile to examine therapists' statements, to identify those statements that contain behavioural requests, and to define the verbal behaviours that these statements request or invite.

Client Statements as Responses to the Therapist's Behavioural Requests

In addition to studying therapist statements as behavioural requests, this research focuses on the client's verbal responses to the requests contained in the preceding therapist statements. By studying the client's verbal behaviour in therapy the researcher can see the degree to which the client's verbal behaviour conforms to the behavioural requests contained in the antecedent therapist statements. It is possible to assess if, following a

therapist statement containing some behavioural direction, the client does indeed manifest the verbal behaviour requested in the antecedent statement. The client might explicitly refuse to evidence the requested verbal behaviour, or the client might avoid the request by changing the subject. On the other hand, the client might evidence the requested verbal behaviour to varying degrees. By examining the client's statements it is possible to assess whether the client is evidencing the requested verbal behaviour to a great extent, to a mild or moderate extent, or not at all.

For example, the following therapist statement - client statement couplets from Fagan's (1974) sessions with Iris illustrate how the client statement may be seen as a response to the therapist's requests for verbal behaviour (Fagan's sessions were studied by Mahrer et al., in press; this excerpt can also be found in Mahrer, 1985):

T: As you see him, how are you feeling towards him? (The client is to identify and describe her feelings towards her grandfather.)

C: I miss him, actually. (The client provides a brief description of her feelings. She is manifesting the requested verbal behaviour to some extent.)

T: Would you say that to him now? (The client is to express her feelings directly to the other person. She

is to say "I miss you" directly to her grandfather.)

C: I miss you. (The client complies with the therapist's request. Her response is brief. It does not elaborate beyond the therapist's specific request. Her response may be regarded as conforming minimally to the therapist's request for verbal behaviour.)

T: Go ahead and say more about missing him and about what he meant to you. (The client is to continue talking directly to her grandfather, expressing her feelings for him, talking about missing him and what he meant to her.)

C: I miss sitting in your lap. (C. begins crying more heavily) And sitting out on the well with you, and you used to talk to Minnie Pearl, that was one of the chickens, she was crippled. (T: Umhmm) Um, I don't know... just sitting in the rocking chair, just following you around really, that's really about all I ever did, but I miss that. (The client manifests the requested verbal behaviour fully. She talks directly to her granfather in a manner that is vivid, expressive, and full with feeling.)

These couplets illustrate how, having formulated the therapist statement as a behavioural request, the client's statement may be viewed as a response to the therapist's antecedent request. The researcher can examine the client

statement to see whether or not the client is following the behavioural request contained in the antecedent therapist statement, and to what extent the requested verbal behaviour is manifested. The study of individual client statements across sessions can indicate to what degree, if at all, the level of conformity to the therapist's requests changes over the course of therapy. By organizing the behavioural requests into a set of categories, it is possible to study the evolving pattern of client responses to each dimension of requested verbal behaviour.

Research on Client Responses to Therapist Statements as Behavioural Requests

What does research have to say about the evolving pattern of client responses to the behavioural requests contained in therapist statements? Over the course of a series of sessions, what happens to the client's responses to the therapist's behavioural requests? Will the client become increasingly accomodating to the behavioural requests contained in the therapist's statements? Will the client's responses change gradually in the direction of manifesting the requested verbal behaviour? Would a gradual change be a simple linear increase in acquiescence to the therapist's requests over the course of therapy, or does the level of conformity correspond to particular stages of therapy? Can the pattern of client response be expected to vary in the initial, middle, and final sessions of therapy? Are there

qualitative differences in the client's responses which correspond to particular stages of therapy? Will there be differences across sessions in the extent to which the client carries out the requested behaviours and in the type of opposition that is manifested?

A preliminary investigation (Mahrer et al., in press) suggested that clients will increasingly manifest the requested verbal behaviours over a series of sessions. This study found progressive movement in client compliance and acquiescence to antecedent requests in one category of requested verbal behaviour. The percentage of statements in which the client manifested the requested verbal behaviour to a strong or moderate degree increased significantly from the first to the second and third sessions. The percentage of statements in which the client was not following the behavioural requests decreased significantly from one session to the next. Unfortunately, the frequencies for the other categories of requested behaviour were too low to permit examination of client response patterns over the series of sessions.

The expectation that the client will respond in the designated directions over a series of sessions gains additional, indirect support from clinical theory and research investigations into the role of influence in psychotherapy. This literature suggests that the therapist's frame of reference, goals, and expectancies are

transmitted to the client in therapy such that the client gradually adopts the therapist's frame of reference and meets these expectancies (Frank, 1959, 1975; Lennard & Bernstein, 1960, 1967). Lennard and Bernstein's (1960) analysis of psychotherapy sessions indicated that therapists provide clients with primary role system information. That is, the therapist statement gives explicit information that defines the therapist-client relationship, and what the rights, obligations, and performances of the participants are to be. This induction on the part of the therapist is aimed at increasing the complementarity of behaviour and expectations. Lennard and Bernstein (1960) found that the percentage of such communication was usually highest in the initial sessions of therapy. It decreased as the client assumed the client role and its accompanying appropriate behaviours and attitudes. A more subtle mechanism of transmission of the therapist's influence is suggested by Frank (1959, 1975). He reviewed content analyses of therapist and client verbalizations in treatment which point to the presence and effect of operant conditioning and social reinforcement. These analyses indicate that even subtle cues, or reinforcers, of which both therapist and client may be unaware, are potent in altering the client's productions in therapy (for example, see Murray, 1956; Salzinger & Pisoni, 1958).

The indication is that therapy is characterized by a

complementary relationship in which the client moves in the direction of assuming the client role and accepting the therapist's definition of the rights, obligations and expected performances of the participants (Haley, 1963; Lennard & Bernstein, 1967). This complementarity in turn appears to generate more instances of complementary behaviour. For example, Tracey, Heck and Lichtenberg (1981) examined initial sessions for 25 clients and found that the percentage of topic determinations was greater when role expectations were the same than when the therapist's and the client's role expectations differed. (Topic determination was defined as the proportion of successful topic initiations, initiations that are accepted and followed by the other participant in the subsequent statement, relative to the total number of topic initiations.) Thus, it would seem that, as clients move in the direction of accepting the therapist's definition of the therapeutic relationship and the client's role, they will move in the direction of following the response requests embedded in the therapist statements.

There are, however, indications that clients do not always move increasingly toward responding in the requested ways. Research comparing the effects of active-directive interventions to non-directive therapeutic styles indicated that clients, rather than acquiescing or complying with therapist demands, may tend to use various forms of

opposition (Ashby, Ford, Guerney & Guerney, 1957; Bergman, 1951; Carnes & Robinson, 1948; Frank, 1964; Gillespie, 1953; Patterson & Forgatch, 1985; Rottschaffer & Renzaglia, 1962; Snyder, 1945; Tourney, Bloom, Lowinger, Schorer, Auld & Grisell, 1966). However, while clients may tend to resist active and directive interventions within a single session, there are indications that defensiveness and resistance decreases as therapy proceeds (Anderson, 1969; Ashby et al., 1957). Thus, it is feasible that over a number of sessions, clients will show increasing tendencies to respond by manifesting the requested verbal behaviours.

Davis (1971), in an analogue study of an interview situation, found that a social competition model was more potent in predicting interviewee strategies and verbalizations than a social reinforcement model. His findings suggest that clients may resist, rather than comply with, therapist expectations in order to gain relative power and position. However, the findings are based on single interview sessions and his conclusions may not be an accurate description of what occurs over a series of sessions. In addition, his research did not use real clients and therapists or actual psychotherapy sessions and, therefore, may not be immediately assumed to hold true for actual therapeutic situations.

The findings mentioned above suggest that clients may resist the therapist's behavioural requests. Given that

these findings are based on an analysis of single sessions, the possibility of increasing indications of responsiveness to behavioural requests is not discounted. However, these findings do suggest that the pattern of client response may not necessarily be a simple one. Further support for predicting more complex patterns of client response is provided in a study by Lichtenberg and Barke (1981) which examined six single sessions of three well-known therapists. The authors found that, in terms of the communication interaction, there was variability across therapists and for any one therapist across clients. On the whole, the interactions between therapist and client were characterized more often by symmetrical and transitional relationships than by a complementary relationship, but there was no consistent trend across therapists or clients. This study underscores that predictions regarding the pattern of client responses in individual cases may not always be in the direction of increasing accommodation or compliance to the therapist's behavioural requests. While there is a basis in theory and research for predicting increasing client conformity to the behavioural requests contained in antecedent therapist statements, there is also a basis for expecting opposition (indirect avoidance and direct refusal) to the therapist's behavioural requests within single sessions.

Stage Differences in the Pattern of Client Response to

Requests for Verbal Behaviour

The issue of accommodation or opposition to the therapist's interventions may be best clarified by studying the therapist-client interaction on a session-by-session basis taking into account the stages and phases of therapy. The overall pattern of client responses across sessions may not be a simple linear progression in the direction of evidencing or not evidencing the requested behaviours.

It may be reasonable to expect that client responses in early sessions, as opposed to later sessions, would be relatively less accommodating to the behavioural requests contained in therapist statements. It has already been stated that, from a social influence perspective, clients gradually learn role-appropriate behaviours in therapy (Frank, 1959, 1975; Lennard & Bernstein, 1967). The initial sessions of therapy have been described as a "hooking" stage in which the therapist and the client are negotiating a working alliance (Cashdan, 1973; Friedlander & Phillips, 1984). That is, they are working towards an implicit agreement "about the locus of responsibility for guiding the treatment (eg., who determines the topic, who is most active) and resolving problems (eg, who questions, who advises, who challenges, who responds)" (Friedlander & Phillips, 1984, p.139). From the social influence perspective, this negotiation takes place at the relationship level of communication through the medium of language (Friedlander &

Phillips, 1984). It is therefore revealed in discourse, that is, in the flow of talk. Once a working alliance is achieved, there should be continuous active dialogue after a topic is initiated. Discontinuities in the flow of conversation reflect conflict or negotiation about who controls the interaction (Friedlander & Phillips, 1984). If the working alliance is being negotiated in the initial sessions, then one would expect to find relatively more discontinuities in the flow of conversation. In terms of the client's responses to the therapist's requests for verbal behaviour, one would expect to find relatively more instances in which the client does not manifest the requested verbal behaviour.

Research on single sessions of therapy does indicate that clients use various forms of opposition in response to therapist demands (directive interventions) (Ashby et al., 1957; Bergman, 1951; Carnes & Robinson, 1948; Davis, 1971; Gillespie, 1953; Patterson & Forgatch, 1985; Rottschaffer & Renzanglia, 1962; Snyder, 1945; Tourney et al., 1966). Similarly, Lichtenberg and Barke (1981) found that the initial sessions of three well-known therapists were characterized more often by symmetrical and transitory interactions than by complementary interactions. Their findings indicate that clients may not be responsive to the behavioural requests contained in therapists statements in the initial sessions.

On the other hand, Dietzel and Abeles (1975) and Tracey and Ray (1984) found a high degree of complementarity in both the early and late stages of therapy. The high degree of topic determination for both therapist and client (Tracey & Ray, 1984) clearly indicates that clients do follow the therapists' topic initiations in early sessions. This finding of high topic determination is seen as reflecting an accommodating attitude on the part of therapist and client in the interest of establishing rapport within the relationship.

Friedlander and Phillip's (1984) results indicated that both opposition and accomodation to the therapist's requests may be present in initial sessions. They conducted a sociolinguistic analysis of discourse in 56 segments (312 conversational turns) selected from the first and second sessions of 14 therapy dyads. Similar to Tracey and Ray (1984), they found that the most probable response to an antecedent statement was a topic relevant act. This is a response that is relevant to the immediate antecedent topic but adds to it by expanding its domain or scope. However, they also found that topic shifts could be expected fairly frequently. Their data indicated that topic shifts were likely to emerge roughly once in every six transitions, and to follow one another 18% of the time. Topic shifts constitute "an overt attempt to change the acknowledged topic to another...a discontinuous shift from the immediate

focus" (Friedlander & Phillips, 1984, p. 142). Frequent and successive topic shifts are viewed by these researchers to reflect a continuing negotiation about who controls the interaction in the session. Topic shifts may correspond to an avoidance of the therapist's requests (i.e., nonconformity) by changing the subject. Thus, this study suggests that opposition to or avoidance of the therapist's requests will occur fairly frequently in initial sessions, though not necessarily in the majority of client responses.

Cashdan's (1973) description of five stages in the counselling process (1. a hooking stage, 2. maladaptive strategies phase, 3. stripping stage, 4. adaptive strategies stage, 5. an unhooking stage) suggests that after the initial stage which aims at establishing therapeutic rapport and a working alliance, there are three stages of therapy characterized by struggles between therapist and client to control and define the nature of the relationship. Accordingly, one would expect to find evidence of client opposition to the behavioural requests contained in therapist statements in the middle phases of therapy.

There is research evidence that supports the expectation of client opposition in middle stages of therapy (Dietzel & Abeles, 1975; Tracey & Ray, 1984). Dietzel and Abeles (1975) examined the early, middle, and late sessions with 20 clients. Each client-therapist interaction was assigned a weight that would reflect the level of

complementarity in that behavioural exchange. They found a lower level of complementarity in the middle sessions of therapy in the successful therapy cases (but not in unsuccessful cases). This study focused on the client as a sender and the therapist as a respondent. Therefore, it is not directly relevant to the examination of client statements as responses to the therapist's requests. However, it does correspond to Cashdan's description of the middle stage of therapy as characterized by relatively greater conflict.

Tracey and colleagues (Tracey, 1986; Tracey & Miars, 1986; Tracey & Ray, 1984) have analyzed all the sessions for a number of time-limited psychotherapy dyads (15, 3, and 6 dyads, respectively). They examined each sequence of statements and assessed the degree of topic determination in each session. They found that all therapists had a high level of control (topic determination) over what was discussed in the sessions. When therapists initiated a topic, the clients tended to follow. In general, the therapists were found to have more control over the topic than the clients. However, Tracey and Ray (1984) also found that successful cases differed from unsuccessful cases in the pattern of topic determination across sessions. Successful cases were characterized by a pattern of high-low-high topic determination whereas unsuccessful cases were characterized by a constant level of topic

determination. A high degree of topic determination was seen to indicate a complementary relationship marked by little conflict, and a low degree of topic determination was seen to indicate a symmetrical relationship marked by conflict (attempts to control the nature and topic of communication). Tracey and Ray's (1984) finding of low topic determination in the middle stage of therapy suggests that clients may tend to oppose or avoid the therapist's requests for verbal behaviour in this stage of therapy. Their findings also support the suggestion that research findings of client resistance to the therapist's requests do not imply that clients persist in this direction across all therapy sessions. The high level of topic determination found in the final sessions of therapy indicates that clients do follow the topics that the therapist initiates as this stage.

Tracey and Ray's (1984) findings indicate that, while clients may generally manifest requested behaviours, there is a period of conflict that may in fact be an important aspect of the therapeutic process. Other studies by Tracey (1985, 1987) also indicate that the middle stage of therapy is different from the beginning and final stages. These studies do not focus specifically on the extent to which the client follows the topics that are initiated by the therapist in different stages of therapy. They examine therapist-client interactions in terms of interchain and

intrachain dependency, and in terms of the relative dominance of each participant. However, these studies consistently point to stage differences in general, and to unique aspects of the middle stage of therapy in particular.

Thus, there is some theoretical and research support, albeit indirect (e.g., Cashdan, 1973; Tracey & Ray, 1984), for expecting that (a) clients will increasingly manifest the requested verbal behaviours in later sessions, and (b) there may be a point in therapy, somewhere in the middle stage, in which clients may not follow the therapists' behavioural requests.

Qualitative Differences in Client Verbal Behaviour Corresponding to Stages of Therapy

Are there aspects of the client's responses to therapist statements that may differentiate the client's performance in the earlier stage of therapy from later stages? One possibility considered by the present researcher is that the inconsistency of findings with regard to single and initial sessions of therapy mainly exists when the focus is only on whether or not the client will carry out the requested verbal behaviours. It may be important to examine the extent to which the client manifests the requested behaviours and qualitative differences in the expression of opposition.

There is a theoretical basis for expecting qualitative differences in the client's responses over the course of

therapy. If the early sessions of therapy represent a "hooking" phase (Cashdan, 1973), then an accommodating attitude on the part of the client might be reflected in weak and moderate expression of the requested verbal behaviours. Given that the beginning of a relationship is somewhat tentative, significant manifestation of the requested verbal behaviours, responses in which the client is following the therapist's behavioural requests to a strong degree, may occur less frequently than in later sessions. Similarly, any evidence of opposition is more likely to be in the form of indirect avoidance rather than outright and direct expressions of refusal. By contrast, when therapy has reached "adaptive strategies" and "unhooking" phases (Cashdan, 1973) it may be expected that the client's responses have developed in the direction of strongly manifesting the requested behaviours. Similarly, if clients are developing in the direction of autonomy and independence, more assertive and direct communication of refusal may be evident when the client does not agree with the therapist or does not wish to follow the therapist's behavioural direction.

While these expectations are consistent with clinical theory, the researcher has not found any clinical or research studies that directly examine progressive developments in the extent and nature of client conformity and opposition to therapist statements as behavioural

requests over the course of therapy sessions. Accordingly, there is a need to see if these expectations are borne out by actual research findings.

In an indirectly related study, Friedlander and Phillips (1984) found that the most probable response in initial sessions was a topic relevant act. As responses to behavioural requests, topic relevant acts would not signify weak or moderate expression of the requested verbal behaviours. They would suggest full compliance with the therapist's requests. These findings do not support the expectations based on clinical theory. However, Friedlander and Phillips (1984) did not examine middle and later sessions of therapy. Therefore, their findings do not provide any indication of progressive changes and developments in the quality of discourse activity.

On the basis of the outcome literature there are rather indirect indications that clients' responses can move in the direction of both extremes, that is, towards strong, full expression of requested verbal behaviours or outright refusal. For example, the literature on deterioration effects of psychotherapy illustrates that therapy can move in both the direction of deterioration or improvement depending in large part on the outcome criteria the researcher chooses (Bergin, 1971; Bergin & Lambert, 1978). These reviews of the outcome literature emphasize the multidimensionality of personality change such that "a

particular therapy does not necessarily create change on all dimensions nor at the same rate in different dimensions" (Bergin, 1971, p.250). Given the multifactorial nature of the process of therapeutic change, their recommendation is to delineate the divergent processes of change and to think more precisely in terms of kinds of changes rather than in terms of general uniform or even multiform changes (Bergin, 1971; Bergin & Lambert, 1978). In the same manner that changes in only one direction are not evidenced in the study of psychotherapeutic outcomes, it is reasonable to expect that the process of psychotherapy will be characterized by developments both in the direction of conformity of client responses to antecedent behavioural requests and outright refusal to evidence the behavioural requests. It is interesting to note, however, that one process study that included a direct measure of outright refusal/denial to pursue the topic of immediately antecedent statements (while offering no other topic but only silence) found that this category of verbal behaviour never occurred in their ratings of therapist and client statements (Tracey & Ray, 1984). Still, the authors mention that this category was included because its occurrence was deemed possible.

There is also indirect support in one study of therapy process for expecting qualitative changes in the client's verbal behaviours over the course of therapy. Marmar, Wilner and Horowitz (1984) studied recurrent client states

in psychotherapy and found a qualitative difference in the client's level of engagement over the course of sessions. Their finding of a progressive decrease in the frequency of an artificial and engaging state and a concommitant increase in the frequency of a hurt but working state, while it does not address the issue of conformity or opposition in clients' responses, does show that the quality of the client's interactive behaviours changes as therapy progresses.

In the absence of direct research evidence, only tentative expectations may be formulated on the basis of theory. The researcher is inclined to expect that over the course of sessions there will be progressive developments both in conformity to antecedent behavioural requests and in opposition to the behavioural requests. Not only is the client expected to increasingly manifest the requested behaviours over the course of sessions, but the extent to which the client carries out the requested verbal behaviours is expected to shift over the course of therapy (from weak and moderate to strong evidencing of the behavioural requests). Similarly, when opposition does occur in later stages of therapy it is expected to differ qualitatively from the forms of opposition evidenced in earlier sessions in that it would be expressed as open and direct refusal to follow the behavioural request rather than as indirect avoidance.

Summary

On the basis of the existing research, the researcher is drawn towards the expectation that, in general, there will be increasing accommodation, acquiescence, or compliance to the behavioural requests contained in antecedent therapist statements. Theory and research also suggest that there will be qualitative differences in the client's responses which correspond to particular stages of therapy. This literature indicates that the client will respond with mild, indirect opposition and moderate compliance in early sessions. The client will respond with relatively greater avoidance and refusal in middle sessions of therapy. Later sessions should be characterized mainly by significant, full occurrence of the requested verbal behaviours with any client opposition being expressed as open and direct refusal.

An Initial Statement of the Research Hypotheses

From a linguistic and interactional communication perspective, the therapist's statements may be described as containing behavioural requests, invitations, or directions for the client to follow. The client statements may then be examined as immediate responses to the behavioural requests contained in the antecedent therapist statements.

From the theoretical and research backgrounds, the first general hypothesis is that, over a series of sessions, there will be an increasing occurrence of the requested

verbal behaviours. That is, an examination of client responses to the therapist's requests should indicate that over a series of sessions there is increasing conformity, compliance, and acquiescence to the antecedent behavioural requests.

The theoretical and research literature on complementarity and symmetry in psychotherapy, and on stages and phases of therapy, suggests that there is a basis for examining client responses to the behavioural requests contained in antecedent therapist statements on a session-by-session level. Accordingly, the second hypothesis is that the degree of conformity and acquiescence will reveal a significant valley in the middle sessions. Examination of client responses to antecedent behavioural requests should indicate that in the middle sessions, as opposed to initial and final sessions, there is decreasing conformity and increasing opposition to the antecedent behavioural requests.

The design of this research also allows for examination of the degree of conformity and type of opposition to antecedent requests for verbal behaviour. The third hypothesis states that there will be progressive developments in the quality of the client's responses across sessions. Specifically, the early sessions of therapy should be characterized mainly by client responses that reflect weak or moderate conformity and indirect avoidance

of the behavioural requests. On the other hand, the final sessions of therapy should be characterized mainly by strong, significant manifestation of the requested verbal behaviours. If opposition occurs at all, it should be expressed as direct, outright refusal to conform to the therapist statements as behavioural requests.

The design allows for identification and examination of categories in which the hypothesized increase in conformity of client responses is demonstrated versus categories in which the hypothesized changes do not occur. In this way the present research does not make assumptions about homogeneity of client process. However, there are no predefined categories. Behavioural requests emerge from examination of individual therapist statements and may then be organized into dimensions or categories. Given that the content of these categories is not known, there is no basis to look in the literature for predictions regarding increasing conformity to certain behavioural requests and not others. Accordingly, rather than making an hypothesis the following research question is formulated: Does the hypothesized pattern of client responses to antecedent behavioural requests occur for all categories of requested behaviour? If not, for which categories does the hypothesized pattern occur and in which categories is it not found?

Significance of the Study

Hypothesis 1

The first hypothesis states that over a series of sessions there will be an increasing occurence of the requested verbal behaviours. The implications of the findings with regard to this hypothesis are as follows.

1. The findings of this research may indicate that the behavioural requests contained in therapist statements have a role as one factor influencing the client's verbal behaviours in therapy. Psychotherapy research has already pointed to a number of factors that influence the client's statements and behaviours in therapy. For example, what the client says and does in therapy depends (a) on contextual factors, such as the immediate task in which the client is engaged (Greenberg, 1984) and the stage or phase of therapy (Tracey & Ray, 1984), (b) on the developing nature of the therapist-client relationship (Cashdan, 1973), (c) on therapist stylistic and expressive behaviours, such as directiveness-nondirectiveness, therapist activity level, and therapist specificity-ambiguity (Pope 1977, 1979), (d) on the therapist's use of specific therapeutic techniques and interventions (Auld & White, 1956; Dittman, 1952; Greenberg, 1984; Greenberg & Clarke, 1979; Greenberg & Dompierre, 1981; Greenberg & Higgins, 1980; Greenberg & Rice, 1981; Hill & Gormally, 1977; Kanfer, Philips, Matarazzo & Saslow, 1960; Speisman, 1959), and so forth. As one of a set of factors influencing the client's statements

in therapy, positive findings would indicate that therapist statements, conceptualized as behavioural requests and directives, do play a significant role in guiding, shaping and channelling subsequent client verbal behaviours (Labov & Fanshel, 1977; Searle, 1976; Watzlawick, 1978).

2. The findings bear implications for examining and identifying the effective and ineffective ingredients in traditional categories of therapist statements. A relationship between the therapist statements, conceptualized as behavioural requests and directives, and the client's subsequent verbal behaviour in therapy implies one means of identifying the therapeutic elements in therapist statements. Psychotherapy research has aimed at identifying the effective and ineffective ingredients in therapist statements classified as, for example, reflections, interpretations, open and closed questions, and so on. Researchers have studied these traditional categories of therapist statements in terms of their clinical intent and related aspects of these therapist statements, such as depth of interpretations (Auld & White, 1956; Dittman, 1952; Kanfer et al., 1960; Speisman, 1959), directiveness-nondirectiveness (see Pope, 1977, 1979 for review), level of communicated empathy (see Truax & Mitchell, 1971; Orlinsky & Howard, 1978 for reviews) to various indices of progressive or regressive client movement in subsequent client responses. If the behavioural requests

contained in therapist statements are related to subsequent client responses, then one effective ingredient in these traditional categories of therapist statements may be the behavioural requests that are communicated to the client in the wording of these statements. It may be worthwhile in future research to examine traditional categories of therapist statements, to identify the behavioural requests contained in these statements, and to explore to what extent the behavioural requests account for the effectiveness or ineffectiveness of these therapist interventions in achieving their clinical intent.

3. There are several paradigms and perspectives for understanding the therapeutic relationship. For example, psychoanalysis conceptualizes the interactions between client and therapist in terms of a transference relationship. Still others describe the relationship as a therapeutic alliance, a relationship between an empathic, accepting, authentic therapist and a client who, given the conducive atmosphere, is naturally inclined towards personal growth and development. Understanding that it is not the purpose of this research to conclude that any one model of the therapeutic relationship is superior to other models, the findings of the present study would bear implications for supporting a paradigm and perspective in which therapist statements are conceptualized as communication acts (Labov & Fanshel, 1977; Searle, 1976; Shapiro, 1979), and in which

the therapist-client relationship is understood in terms of a social interaction mediated by communicative interchange (Haley, 1963; Watzlawick, 1964, 1978). This paradigm serves to highlight the psycholinguistic aspects of therapist statements and how these aspects can mediate the communicative interaction between therapist and client. Positive findings in this research would serve to further emphasize the research usefulness of communication interaction models of psychotherapy process in accounting for patterns of process in therapy.

4. The method of research in the present study emphasizes the wording of therapist statements, as opposed to their clinical intent or praxis, in defining the behavioural requests contained in therapist statements. The importance of the actual wording of therapist statements is highlighted in psychotherapy research and clinical analyses. For example, Wachtel (1980) illustrates how the wording of a statement and the way of conveying a message can either help the client to hear and confront what is being said in a productive manner or arouse resistance and anxiety and lower the client's self-esteem. The grammatical structure of therapist statements (e.g., interrogative, declarative, imperative) reflects whether a message content is communicated in a manner that suggests movement toward dominance of the exchange or towards accepting the dominance of the other (Lichtenberg & Barke, 1981). In general,

researchers and clinicians have reiterated the instrumental importance of the correct wording of reflections, of interpretative statements, of Gestalt instructions, or of questions requesting information. If a relationship is shown in this study between the behavioural requests based on the wording of therapist statements and subsequent client responses, the findings may further emphasize the therapeutic importance of the actual wording of therapist statements in terms of the behavioural requests contained in these statements. When the therapist's statements are seen to invite or request particular client behaviours, the actual wording of therapist statements may be of paramount importance in understanding the client's subsequent verbal behaviours. Future research may go further in exploring the impact of linguistic and psycholinguistic aspects of the therapist statements on subsequent client responses. For example, it may be useful to examine the relationship between classes of requested behaviours (i.e., pragmatics of the therapist's communication) and the grammatical forms of therapist statements (i.e., syntactic aspect of the therapist's communication), and to then related each of these as well as their combined influence to subsequent client responses.

5. As noted earlier in this chapter, psychotherapy research highlights the importance of studying therapist goals and intentions (Elliot & Feinstein, 1978; Hill &

O'Grady, 1985). Research attempts to relate the client's responses and performances to the process and outcome goals of therapy and to the therapist's specific intentions in making a particular statement. The findings of this study would invite implications for examining the relationship between the nature of behavioural requests contained in therapist statements and the more traditional framings of therapist goals and intentions. Positive findings in this study would highlight the importance of finding a correspondence between explicit intentions and goals and the behavioural request contained in the wording of the therapist statement. It would be interesting in future research to examine whether traditional framings of therapist goals and intentions are actually communicated to the client in the therapist's words as behavioural requests and whether there is a goodness-of-fit between the kinds of goals and changes the therapist/therapy seeks to achieve and the behavioural requests that the therapist's statements invite from the client.

6. The findings of the present research bear implications for examining the relationship between changes in clients' responses to therapists' statements as behavioural requests and more traditional indices of process and outcome changes in client behaviours. Recent research highlights the importance of establishing the extent to which a pattern of client behaviour is meaningful by

relating the pattern to other process and outcome indices (eg. Greenberg, 1984; Tracey & Ray, 1984). Future research on therapist statements as behavioural requests can examine the extent to which developments in clients' responses to classes of requested behaviour correspond to client developments on other process and outcome dimensions.

Hypothesis 2

The second hypothesis states that examination of client statements on a session-by-session level should reveal decreasing conformity and increasing opposition to antecedent behavioural requests in the middle sessions of therapy, as opposed to initial and final sessions. The implications of the findings with regard to this hypothesis are as follows.

1. Within the clinical and research literature the psychotherapeutic process has been conceptualized as occurring in a series of stages and phases, where the changing nature of the therapist-client interaction and the therapeutic relationship can serve to identify the transition from one stage to another. Within this conceptualization of the therapeutic process, the middle stage is characterized by increasing conflict and struggle for control between therapist and client, where each party is attempting to influence the other in various ways while each is not following the other's influence (Cashdan, 1973; Dietzel & Abeles, 1975; Tracey & Ray, 1984). The findings

of this research bear implications for this description and conceptualization of the psychotherapeutic process. Findings of increasing opposition in middle sessions in the client's verbal behaviours (to the behavioural requests contained in antecedent therapist statements) would support other research findings of a stage of interpersonal conflict (Dietzel & Abeles, 1975; Tracey & Ray, 1984) and provide another indication of how this conflict is manifested in the client's verbal behaviours.

2. The findings of the present research bear implications for examining and understanding conflict between therapist and client in terms of the context of therapy, specifically the stage or phase in which the client manifests opposition to the behavioural requests contained in the therapist's statements. In clinical theory and research, conflict between therapist and client (e.g., rejection of interpretations, avoidance of exploration, refusal to follow process instructions, etc.) has been interpreted as reflecting upon (a) the client - for example, the client is uncooperative, resistant, defensive, difficult; (b) the therapist's intervention - for example, the intervention is not timely or not communicated correctly (e.g., the interpretation is too deep, the reflection is not sufficiently empathic); or (c) the therapy and therapeutic relationship in more general terms - for example, therapy is not productive, is not suitable, is at an impasse, or a

negative transference relationship is being manifested. The need to take into account the context of given therapist and client behaviours, and the misconceptions that arise when researchers aggregate process and treat all client behaviours homogeneously are increasingly emphasized in the psychotherapy literature (Rice & Greenberg, 1984). While client opposition to antecedent behavioural requests may be an indication of a resistant client, or an ineffective therapist intervention, or an impasse in the therapeutic process, the findings of this research may imply that at certain stages of therapy the presence of conflict is part and parcel of the developing course of productive psychotherapy (as illustrated by Dietzel & Abeles, 1975 and Tracey & Ray, 1984). Accordingly, positive findings might serve to emphasize that the meanings and implications of conflict between therapist and client, and of client opposition to therapist statements, are not uniform throughout therapy but vary depending on the stage in therapy in which conflict and client opposition are manifested.

3. The findings of the present research bear implications for identifying the stages in therapy in which therapists should persist in utilizing particular techniques and interventions (as behavioural requests) even though these may create conflict between therapist and client over the therapeutic agenda, and stages in which it may be more

beneficial to the overall process to maintain high complementarity and strong rapport and to minimize conflict between therapist and client. There are indications in the clinical and research literature to support the therapeutic use and usefulness of conflict at certain stages of therapy in breaking maladaptive behaviour and interaction patterns (Cashdan, 1973; Dietzel & Abeles, 1975; Tracey & Ray, 1984). The findings in this study may provide further evidence that conflict between therapist and client, in terms of client opposition to antecedent behavioural requests, may be followed by productive client behaviour in later stages of therapy rather than by deterioration of the therapeutic interaction.

4. Much of the research on the effectiveness or ineffectiveness of therapist interventions has used various measures of client response productivity and opposition in the client's responses as criteria for the effectiveness of interventions. For example, research on the depth of interpretations stresses the importance of making moderately deep interpretations, interventions that are a bit beyond the client's current level of awareness yet not so deep as to threaten the client and lead to client resistance. Similarly research comparing directive versus non-directive interventions has utilized measures of client acceptance, hostility, productive following, and so forth in assessing the relative efficacy of one style of intervention over

another. The findings of this research bear implications for the appropriateness of such criteria in determining the effectiveness or ineffectiveness of therapeutic interventions. If the findings of this study indicate that clients tend to not evidence the requested behaviours in the middle (and/or early) stage of therapy, but that they increasingly and significantly evidence the same class of requested verbal behaviours during the later stages of therapy, then one implication is that lack of acquiescence or responsiveness in the client's verbal responses to the therapist's interventions in earlier stages of therapy may not warrant research conclusions about the effectiveness or ineffectiveness of therapists' interventions. It may be worthwhile to differentiate, in research and practice, between client opposition to a class of behavioural requests that is manifested at a consistently high level throughout therapy and opposition that is only manifested at a particular stage of therapy.

5. In determining the effectiveness or ineffectiveness of therapeutic interventions and in assessing the client's response to specific techniques, psychotherapy research has tended to pool ratings of the client's process behaviours in a single session or across sessions. This aggregate approach in the study of client process has been criticized and the importance of studying patterns rather than rates has been emphasized in the literature (Gottman & Markman,

1978; Rice & Greenberg, 1984). The findings of the present research may further emphasize the importance of looking at the pattern of client responses over the course of sessions, of assessing the pattern of effects of similar intervention, rather than using collapsed, statistical measures or studying single sessions. It is only when the clients' responses to antecedent behavioural requests are examined on a session-by- session basis that peaks and valleys in client conformity to the antecedent behavioural requests become apparent.

6. The findings of the present research also bear implications for the selection of process and outcome measures at certain stages of therapy. Often researchers rely on therapist and client post-session reports of progress and satisfaction. If the overall therapeutic process is such that movement and progress include stages and phases of therapy that are marked by client opposition to the therapist's behavioural requests and by conflict (encounter, confrontation, struggle) between therapist and client, then session outcome or process measures that rely on therapist and/or client report may not be meaningful indications of therapeutic progress. It may be that therapy is progressing in the right direction even though the client and/or the therapist are not particularly satisfied with the process and outcome of certain sessions.

7. The findings of the present research bear

implications for studying patterns of client behaviour, that is, progressive changes in the client's verbal behaviours as related to the behavioural requests contained in antecedent therapist statements. The identification of stages and transitions in clients' in-therapy behaviours has been emphasized in recent psychotherapy research endeavors, such as in task analyses of interpersonal conflict resolution (Greenberg, 1984) and resolution of problematic reactions (Rice & Saperia, 1984). If client statements may be viewed as responses to the behavioural requests contained in antecedent therapist statements, it would be worthwhile to identify classes of behavioural requests and to then study the client's statements, over the course of a session or series of sessions, for progressive developments in client verbal behaviour with regard to these classes of requested verbal behaviour. This may lead to the identification of markers that indicate transition points in the nature of client responses. For example, increasing indications of opposition (avoidance of requested behaviours, refusal to evidence requested behaviours) in the client's verbal behaviours may serve as a marker for the beginning of a second phase in therapy (or within a session) (e.g., maladaptive strategies stage, Cashdan, 1973).

8. Research comparing successful versus unsuccessful therapy cases has shown that in successful cases, and not in unsuccessful cases, there was a middle stage of therapy that

was characterized by a symmetrical relationship, that is, increases in conflict between the therapist's and the client's agendas (Dietzel & Abeles, 1975; Tracey & Ray, 1984). In the present research there are no measures of the outcome of the therapy. The findings of this research with regard to the presence or absence of client opposition to antecedent behavioural requests bear implications for future research that compares the patterns of client responses in successful versus unsuccessful cases to see if the high-low-high complementarity pattern found by Dietzel and Abeles (1975) and Tracey and Ray (1984) can be replicated when therapist statements are conceptualized as behavioural requests.

Hypothesis 3

According to the third hypothesis, there will be progressive developments in the quality of the client's responses across sessions. The prediction is that early sessions of therapy will be characterized mainly by client responses that reflect weak or moderate evidencing and indirect avoidance of the requested verbal behaviours. The final sessions of therapy, on the other hand, should be characterized mainly by significant evidencing of the requested verbal behaviours. Opposition, should it occur, is expected to be expressed in a direct and forthright manner. The implications of the findings with regard to this hypothesis are as follows.

1. Psychotherapy researchers have increasingly pointed to "uniformity myths" as a problem that plagues research on psychotherapy process and outcome (Kiesler, 1973). The findings of this research may serve to emphasize the loss of valuable information inherent in classifying client responses into uniform, unidirectional statistical trends. For example, looking at client responses in terms of statistical proportions or percentages, research studies tend to conclude that clients generally respond favorably or generally respond unfavorably to a particular class of therapeutic interventions. The findings of this study bear implications for emphasizing that client responses to antecedent behavioural requests may progress both in the direction of significantly evidencing the requested verbal behaviours and in the direction of outright refusal to follow the behavioural directions contained in antecedent therapist statements, and for emphasizing the varying preponderance, or relative frequency, of one type of client response as opposed to another over the course of therapy.

2. Research has pointed to highly complementary relationships in both the early and late stages of therapy (Dietzel & Abeles, 1975; Tracey & Ray, 1984). In their research, Tracey and Ray (1984) classified all client responses that were not topic initiations (topic changes) as following the therapist's topic initiation and topic continuation, hence as a sign of a complementary

interaction. The findings of the present study may have implications for examining the extent to which the client is following the topic initiations over the course of therapy, in terms of the extent to which the client is evidencing the verbal behaviours requested in antecedent therapist statements. It may be possible to differentiate the different stages of therapy and to define different forms of complementarity on the basis of the quality of the client's response, that is, the extent to which the client is significantly evidencing the requested behaviours.

3. Rice and Greenberg (1984) have noted that the tendency to judge a given client behaviour, such as client disagreement, as either "good" or "bad" without taking into account the context of the client behaviour results from the underlying uniformity assumptions of aggregate designs. The findings of this research may bear implications for carefully examining and differentiating between the various ways in which clients oppose the therapist's behavioural requests and the context (the stages of therapy or phases in a session) in which opposition emerges. A shift from passive avoidance to outright and direct refusal to evidence requested behaviours, such that in later sessions there is both direct opposition and significant evidencing of requested verbal behaviours, may suggest that certain forms of client opposition are direct expressions of an assertive, autonomous adult rather than indications of resistance,

defensiveness, aggression, hostility, and so forth. Accordingly, rather than perceiving these forms of client opposition as problematic, such direct client behaviours may be reinforced and encouraged when they emerge in particular phases of therapy. In addition, future research may further investigate client responses and assess to what extent the directness or indirectness of client communication serves as an indicator of change in the pattern of client responses over the course of sessions.

Client Conformity to Different Categories of Requested Verbal Behaviour

The following research question has been put forth: Does the hypothesized pattern of client responses to antecedent behavioural requests occur for all categories of requested behaviour? If not, for which categories is the hypothesized pattern evidenced and for which categories is it not evidenced? The implications of the findings of this research are as follows.

1. The findings of this research may serve to highlight the role of the class or kind of behavioural request as a factor influencing the client's responses in therapy. Thus far, it has been suggested that the behavioural requests contained in therapist statements, in general, may be a factor that affects clients' performance in therapy. The importance of contextual factors, specifically the stage of therapy in which the client is

manifesting or not manifesting the requested verbal behaviour, has also been stressed. Examination of client responses to behavioural requests on a category by category basis represents a further attempt to avoid aggregating client process. There may be a relationship between the nature of the requested verbal behaviour and the degree of client conformity and acquiescence to antecedent behavioural requests. The pattern of client responses over the course of therapy may vary, depending on the class of behavioural request.

To the extent that the patterns are dissimilar for the different categories of requested behaviour, it would be worthwhile to identify and examine these classes of behavioural requests. There may be verbal behaviours that clients manifest readily and with relative ease throughout therapy. There may be behavioural requests that clients tend to oppose or avoid consistently. Certain types of verbal behaviour may be manifested only slightly in the initial stages of therapy, and increasingly evidenced to a full extent as therapy progresses, suggesting a learning process on the part of the client. Opposition and avoidance may occur only with particular kinds of behavioural requests and only in certain stages of therapy. The next step would be to explain the variation in patterns, to attempt to understand why the client manifests, or increasingly exhibits, certain kinds of verbal behaviour and not other

types of verbal behaviour. This kind of exploration may contribute to research on effective and ineffective ingredients in psychotherapy.

2. The findings of this research may suggest an additional way of describing schools of psychotherapy and the work of specific therapists. Therapists often describe their therapeutic work in terms of the theories they espouse and their use of certain therapeutic techniques and interventions. The findings imply a description of therapists, therapy, and psychotherapeutic approaches from the perspective of a communications paradigm, in terms of classes of behavioural requests that the therapist tends to use. The value of this type of description stems from its attempt to base itself on the close examination of actual psychotherapy, of the statements made by the therapist during therapy sessions. Future research can investigate commonalities and differences across therapeutic approaches, therapists, and clients.

CHAPTER II

METHODOLOGY

In the previous chapter, the feasiblity and usefulness of studying therapist statements in terms of behavioural requests, and of examining client statements as responses to these requests was suggested. It was hypothesized that certain patterns of client performance would emerge if a series of sessions between a client and therapist were examined in this manner. The purpose of this chapter is to describe the methodology that was developed to test the hypotheses put forth in the previous chapter.

Rather than discussing methodological issues in a separate chapter, the rationale that underlies particular strategies and choices in this research is presented within the body of this chapter. The chapter begins with a description of the data pool. Then the procedures that were followed in examining the data will be outlined.

The Data Pool

This study begins with the selection and preparation of the data pool. The selection was guided by an initial assumption that this study required verbatim data from a series of sessions conducted by actual therapists with actual clients. This assumption was based in the researcher's interest in examining (a) therapist's

statements as behavioural requests and client statements as responses to these requests, and (b) the evolution of the client's verbal responses to the therapist's behavioural requests over the course of time.

The following sections provide a description of the data pool. The first section begins by specifying the number of therapy cases that were selected for this study. A description of each case is then provided. The second section identifies how many and which sessions were chosen from each case. The third section discusses the form, or medium, of data presentation chosen for this study. The fourth section describes the guidelines followed in preparing the data for presentation. The final section defines the scoring unit, or unit of study, in this research.

Choice of Therapy Cases

Two therapy cases were selected for this study. What were the considerations that resulted in this selection? One consideration was the researcher's preference to study therapists with different approaches to psychotherapy. It would then be possible to assess the applicability of the method to various therapeutic approaches.

Given this preference, the availability of data which met the requirements of this study had to be considered. For each therapist-client dyad a series of sessions was required. These sessions had to come from the beginning,

middle, and final stages of the therapy case. Given these basic requirements, the researcher was looking for therapy cases in which most, if not all, of the sessions were recorded verbatim.

The required data was not found among the published transcripts of therapy sessions conducted by exemplar therapists. In most cases either single sessions or excerpts from a series of sessions are published. On rare occasions, two or three sessions with one client have been published (for example, Fagan, 1974). Multiple sessions with the same client were also not found in the American Academy of Psychotherapists' collection of tapes and transcripts. Thus, unavailability of the required data precluded investigation of the therapeutic work of exemplars in the field of psychotherapy.

Two therapy cases were made available for this research. Since both cases met the study's requirements, it was decided not to generate new material specifically for this research. In each of the selected cases therapy had been terminated and most, if not all, sessions had been recorded verbatim.

The two cases represent different approaches to psychotherapy. In one case, the therapist primarily uses Gestalt therapy techniques. This case could serve as a replication of the pilot work done by Mahrer and colleagues (in press). That study had shown that the proposed method

was applicable to a Gestalt approach. The second case represents a psychodynamic (object relations) approach to psychotherapy. Examination of this case would be one step in the direction of assessing the appropriateness of the method to different therapeutic approaches.

The following sections provide a further information about each of the two therapy cases selected for this study.

Case One: Bill Maloney. The first case consists of 19 sessions conducted by Bill Maloney. Of these 19 sessions, the first 16 were recorded on videotape for research purposes by Dr. Henry Edwards' psychotherapy research team at the University of Ottawa. The client subsequently saw Bill Maloney three additional times in his private practice (personal communication). These three sessions were not recorded.

Bill Maloney is a therapist, counsellor and educator with a Master degree in education. He has completed training in Transactional Analysis and Gestalt Therapy. In addition to an active private practice in individual, couple and family counselling, his work experience includes six years as a professor of counselling at the graduate level. At the time that he saw the present client, Bill Maloney had approximately 4 to 5 years experience in individual psychotherapy. The theoretical frameworks that guide him conceptually in his therapeuitc work include Berne's Transactional Analysis, Gestalt Therapy, Roger's

Client-Centered Therapy, and Jung's Analytic Theory. In terms of techniques, his approach to psychotherapy is primarily Gestalt.

The client is a married man in his early thirties (32 years old). The content of the sessions suggests that the client had no previous experience in psychotherapy. The following information was provided by the therapist regarding this therapy case (personal communication). The therapist assessed the client as having difficulty making meaningful contact with the environment and taking from it what he needs psychologically. These difficulties were perceived to be related to low self esteem and unfinished business revolving around feelings of rejection. The therapist's general evaluation of this case is that it was successful but that the client had more work to do.

Case Two: William Barry. The second case consists of 19 consecutive sessions conducted by Dr. William Barry. All the sessions were recorded on audiotapes. Dr. Barry was a clinical psychologist. In addition to his private practice, he was a full-time professor at the University of Ottawa for 30 years. His years of experience included teaching psychotherapy and supervising graduate students in clinical psychology. At the time that he saw the present client, Dr. Barry had 25 years of experience in individual therapy. His approach to psychotherapy was psychodynamic, specifically Object Relations.

The following description of this client was derived from information available in the audiotapes. The client was a woman in her late twenties (age 29). She had been married twice and was separated from her second husband. She began to see Bill Barry upon completion of a hospital program for substance abusers. Her presenting problems included (1) difficulties and symptoms related to withdrawal and recovery from substance abuse, (2) problems in forming close adult heterosexual relationships, partly related to lack of trust, and (3) ongoing difficulties with family members. Therapy focused on (1) supporting the client's efforts to abstain from substance use, (2) supporting her efforts to reorganize her life, and (3) exploration of past and present personal relationships (familial and marital/ heterosexual).

The client decided to terminate therapy when she became pregnant and returned to a previous relationship (personal communication). It is the impression of the researcher that this case may also be regarded as one in which the client had more work to do.

Choice of Sessions

Having gained access to these two therapy cases, the next step was the selection of sessions from each case. Two questions were considered in the selection of appropriate material. First, how many sessions are required in order to generate categories of requested verbal behaviour, and to

examine the degree to which the client responds to these requests? Second, which of the sessions in each case will be examined?

The decision in this research was to study 12 sessions, six from each therapy case. The option of examining the whole series of sessions was discounted as unrealistic, given the amount of time and work needed to transcribe and rate 35 sessions. The guiding criteria in selecting the number of sessions were: (1) The study must produce an adequate number of behavioural requests, based on the study of individual therapist statements, and (2) The dimensions that were derived on the basis of these individual requests for verbal behaviour had to be represented by a sufficient number of therapist statements to allow for further analysis of the data.

Previous research did not provide a clear indication of the number of sessions that would fulfill these criteria. The results of the pilot study (Mahrer et al., in press) did suggest that three sessions would be insufficient to test the research hypotheses. The first criterion was met in that study. An adequate number of behavioural requests were generated from the study of individual therapist statements. However, there were problems at the level of the second criterion. Though dimensions of requested behaviour were successfully identified, there was an uneven distribution of therapist statements in the different

dimensions as well as across sessions. Some dimensions were represented by only a few therapist statements, framed as behavioural requests. In some sessions there were few or no therapist statements for certain dimensions. This uneven distribution had serious implications for the study when attempts were made to assess the client's verbal responses along requested behavioural dimensions. Because of low cell frequencies, a statistical analysis of the client's verbal responses over the course of three sessions could not be done for four out of five generated dimensions. The number of sessions (per case) were doubled in the present research in an attempt to avoid the problems encountered in the pilot study. It was estimated that six sessions per case would be needed in order to test the research hypotheses.

On what basis were the sessions selected? In order to examine the pattern of the clients' responses to requested verbal behaviours over the course of therapy, two sessions were chosen, for each case, from the early, middle, and final stages of therapy. Representation of the various stages of therapy was a basic requirement in this research. The choice of specific sessions from each stage was based on the estimated number of statements per session. All sessions were reviewed and those with the most statements were selected for examination.

Of the 19 sessions conducted by Maloney, sessions 2, 3, 7, 10, 15 and 16 were selected for this study. Though the

last three sessions with this client were not recorded, it was felt that sessions 15 and 16 could still be viewed as representing the final stage of therapy. Of the 19 sessions conducted by Barry, sessions 1, 3, 10, 11, 17 and 18 were selected for this study. Following is a brief description of each session.

Maloney:

1. Session 2 - There are 223 therapist and client statements in this session. The focus of the session is the client's difficulty in asserting himself with others, in expressing his feelings and having his needs met. The in-therapy, immediate experiencing of his difficulties is used to identify and highlight thoughts and feelings that prevent the client from expressing himself to significant others.

2. Session 3 - There are 195 therapist statements and 194 client statements in this session. The session explores (a) the client's indecisiveness and lack of self confidence, (b) difficulties he has in expressing himself authentically in interpersonal situations, and (c) childhood experiences of interpersonal loss.

3. Session 7 - This session has 222 therapist and client statements. In this session the client explores his difficulties in forming friendships by reliving early experiences in which he felt rejected and inadequate.

4. Session 10 - This session has 199 therapist

statements and 198 client statements. The session focuses on the client's desire to be more assertive. Through various experiential exercises, the client experiences the internal blockages which prevent him from expressing defiance and disagreement.

5. Session 15 - This session has 146 therapist and client statements. In this session the client relives early childhood events in an attempt to understand why he is unable to eat many foods.

6. Session 16 - There are 174 therapist and client statements in this session. The theme in this session is the client's lack of spontaneity. Exercises illuminate how his performance is hampered by a tendency to plan his actions and reactions when he is in the presence of other people. The client's attempts to anticipate the other person's agenda diverts his energy from the task at hand.

Barry:

1. Session 1 - There are 82 therapist client statements in this session. The client expresses a sense of dissatisfaction and disappointment with life. She focuses on the emotional turmoil that is ever present within her, and on her troubled relationship with her husband and her mother.

2. Session 3 - This session has 72 therapist and client statements. It focuses mainly on the client's gloomy picture of a future in which her dreams will not be

fulfilled. Throughout this session, the therapist places the client's present condition, thoughts and feelings of hopelessness and despair in the context of withdrawal from substance abuse.

3. Session 10 - There are 76 therapist and client statements in this session. The session focuses on recent events in the client's life and on her plans for the immediate future. The client also explores feelings of loneliness resulting from disrupted relationships.

4. Session 11 - This session has 97 therapist and client statements. The focus of the session is on events and changes in the client's present life, such as moving into her own apartment for the first time and going back to work.

5. Session 17 - This session has 101 therapist and client statements. In this session the client explores the impact of her relationship with her mother on her current inability to commit herself in a relationship with her boyfriend.

6. Session 18 - There are 72 therapist statements and 71 client statements in this session. The client explores the abrupt dissolution of her relationship with her boyfriend and then proceeds to review the history of her heterosexual relationships.

Form of Data Presentation

Three forms of data presentation are used in

psychotherapy process research: written transcripts, audiotapes, and videotapes. Written transcripts were needed in this study in order to insure that judges were basing their ratings on the same information. Of all the data forms, written transcripts are the least cumbersome when it comes to clearly demarcating (numbering) therapist and client statements. Moreover, given that the behavioural requests are based in the therapist's actual words, it was very important that judges examine the same words. Error and variance in the judges' understanding of what is being said in the session are more likely to occur with audiotapes and videotapes. Thus, the form of data presentation chosen for this research was the verbatim written transcript.

The possibility of using written transcripts in combination with either audiotapes or videotapes was considered. The use of videotapes was ruled out because they were only available for Maloney. As a result of this decision, this study is limited to the examination of requests for verbal behaviour. While written transcripts are sufficient to generate the requests for non-verbal behaviour, and to generate categories of requested non-verbal behaviour (given that the behavioural requests are based in the therapist's words rather than on non-verbal features of the communication), videotapes would be needed to assess the extent to which the client is carrying out the requested non-verbal behaviours.

It was feasible to use both transcripts and audiotapes. The use of audiotapes would contribute little, if anything, in the first phases of the study. The requests for verbal behaviour that judges were to generate were based strictly on the therapist's words. When the therapist asks, "how do you feel about that?", the behaviour request is the same regardless of whether the therapist says it softly or forcefully, quietly or in a loud clear voice. The pilot study (Mahrer et al, in press) clearly indicated that verbatim transcripts were sufficient to generate behavioural requests.

The only advantage in using audiotapes is that they might provide qualitative non-verbal information which may be helpful in rating the extent to which the client is following a behavioural request. Yet it is at this last phase in the research project that the use of audiotapes would be most complicated. The strategy in this study is to present therapist and client statement couplets in a random order to the judges who are rating the client's responses to requests for verbal behaviour. In this way judges will be unaware of which session contains the couplet and where in the session a couplet occurs. While it is feasible to splice audiotapes and randomize the excerpts, this undertaking would not necessarily yield enough benefits to justify the amount of technical work required.

To summarize, the only medium of data presentation used

in this study is verbatim written transcripts. While videotapes may have made it possible to examine client conformity to requests for non-verbal behaviour, unavailability of videotapes for the Barry sessions precluded this option. The technical complexity of preparing audiotapes for use in this study was seen to outweigh their potential contribution.

Transcription of the Data

The loss of qualitative nonlanguage information could be reduced to some extent through the quality of the transcription. Verbatim transcripts of the 12 sessions were prepared by the researcher and one other person (who had an academic background in psychology and experience as a psychotherapist). Each person transcribed six sessions. The general aim in preparing the transcripts was to replicate as faithfully as possible the audiotaped version of the sessions.

The specific guidelines that were followed in transcribing the sessions are as follows. Noises in the session were to be noted and, if possible, identified. Such noises would include, for example, someone opening or closing a door, the phone ringing, or the sound of shuffling feet.

An emphasis was placed on capturing the quality of speech of the therapists and clients. Pauses were noted and identified as natural breaks in a sentence, short pauses or

long silences. Speech dysfluencies or disturbances, such as coughing, stuttering and "ah" (uhm, uh) sounds, were recorded in the transcripts. Qualities of the interaction, such as interruptions by the therapist or the client, were identified. When therapist and client were speaking at the same time, the words that were said simultaneously were identified. All these elements in the transcript combine to provide the reader with a sense of the flow of speech in the session.

Indications of the clients' feeling or emotional state were provided by (a) describing the tone of voice when speech was not simply conversational, and (b) reporting expressions of affect. For example, the quality of tone could be sad and subdued, soft and compassionate, energetic, excited, assertive, or authoritative. One of the participants may be speaking louder than normal, or more quietly. Expressions of affect that were reported included brief chuckles, strong laughter, sighs, soft crying, and loud sobbing.

Unit of Study

The units of study suitable for psychotherapy process research include single words, phrases, clauses, sentences, statements, topic areas, the interaction exchange, and time segments (Kiesler, 1973). This research investigates the client's response to the request for verbal behaviour contained in the therapist's words. Every therapist

sentence may contain a request for verbal behaviour. Any one therapist statement may contain more than one request. However, if we wish to examine the client response, the logical cut-off would be the point at which the therapist stops talking and the client starts speaking. Likewise, the subsequent cut-off point would be where the client stops talking and the therapist begins to speak. The unit of study that best fits this is the complete statement. Kiesler (1973) defines the statement 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).

Certain therapist and client utterances were not considered to be "interruptions of speech". Simple acknowledgements that were expressed while the other person spoke were not treated as separate statements. Aborted efforts to speak when the other person was speaking were also not recorded as separate statements. The general guideline was that a new statement would be marked by an obvious and clear break between the therapist's and client's words.

Summary

This study called for verbatim data from a series of psychotherapy sessions. Two therapy cases were selected for this study. Of the 19 sessions conducted by Maloney, 16

consecutive sessicns had been recorded on audiotapes. All of the 19 sessions conducted by Dr. Barry had been recorded on audiotapes. Six sessions were selected from each therapy case. They were chosen to represent the early, middle, and final sessions for each therapist. For Maloney, sessions 2, 3, 7, 10, 15, and 16 were selected for examination. For Dr. Barry, sessions 1, 3, 10, 11, 17, and 18 were selected. Verbatim written transcripts were chosen as the form of data presentation. Inclusion of qualitative, non-language information was emphasized in the preparation of these transcripts. The unit of study chosen for this research is the "statement".

Procedure

There were four phases in this study. In the first phase, individualized requests for verbal behaviour were generated. In the second phase, these individualized requests for verbal behaviour were grouped into categories of requested verbal behaviour. The third phase ascertained the goodness-of-fit between the general categories of requested behaviour and a sample of the therapist statements included in each category. In the fourth phase, the client's verbal performance, or progress over time, was assessed on these categories of requested verbal behaviour. In the following sections, each phase of the study will be described separately.

Phase 1: Identifying Requests for Verbal Behaviour

The purpose of this phase of the investigation was twofold. One goal was to identify the therapist statements that do contain requests for verbal behaviour. The second and primary purpose was to identify the specific requests for verbal behaviour that are contained in these therapist statements. This would then provide the researcher with a list of requests for each therapist.

Judges

Four judges participated in the first phase of the research. They were all students at the doctoral level in clinical psychology. Each judge had at least two years of previous experience as raters in psychotherapy process research projects.

Requests for Verbal Behaviour: Instructions

An instruction manual was prepared for this phase of the study (see Appendix A). An overview of these instructions is presented in this section. The aim is to provide the reader with (a) the specific definition of "behavioural request" given to the judges, and (b) a sense of the procedure the judges were to follow in rating a therapist statement.

The manual explains that there are two steps to follow in examining a therapist statement. The first step is to determine whether or not the therapist statement contains a behavioural request. A therapist statement is defined as containing a behavioural request if it provides a relatively

clear, specific, and concrete indication of what the client's subsequent verbal behaviour is to be. On the basis of these statements, the judge should have a relatively clear picture of what the client is to say next, what the subsequent verbal response should be. The manual gives examples of therapist statements that do contain requests for verbal behaviour and inert statements that do not contain requests for verbal behaviour.

The second step applies to therapist statements that are judged to contain a behavioural request. For these statements, judges were to define the nature and content of the requested verbal behaviour. This is done by framing an answer to the following question: On the basis of this individual therapist statement, how is the client to respond in the next statement? The manual provides guidelines that judges were to follow in describing the behavioural request. These guidelines instruct the judges to: (1) Imagine that they are the client, (2) Focus on the immediately subsequent client response, (3) Use simple, non-technical language, (4) Frame one request per statement, and (5) Refer only to verbal behaviour.

Training of Judges

In the initial meeting, each judge was given a copy of the instruction manual. The instructions were carefully reviewed and discussed. A sample of therapist statements, taken from the pilot study (Mahrer et al., in press), were

provided at the end of the manual. These training examples were used to illustrate the method. When the judges indicated that they understood the instructions, the researcher distributed the written transcript of the first session. A second meeting was held when ratings of the first session had been completed. The purpose of this meeting was to make sure that judges understood the method. The ratings were reviewed and discrepancies between the judges were discussed. This meeting also provided an opportunity to clarify any difficulties the judges had encountered in rating the data. A last training session was held when ratings of the first six sessions had been completed. At this time, judges were given individual feedback on any systematic errors or biases in their ratings.

Generating the List of Requests for Verbal Behaviour

The therapy sessions were presented to the judges in the following order. Judges rated Maloney's sessions first, then proceeded to examine Barry's sessions. For each therapy case, the sessions were presented, one at a time, in chronological order. The therapist statements were left in their original order.

For this phase of the research there was no need to randomize therapist statements. The behavioural request contained in a statement is not contaminated by knowledge of previous or subsequent therapist statements. On the

contrary, knowledge of these statements can serve to clarify the specific request put forth in the target therapist statement. It was felt that many therapist statements would not make sense when taken out of the context of previous therapist and client statements. For example, the therapist statement, "can you tell him that now" is ambiguous in the absence of previous statements that indicate "what" the client is to tell and to "whom".

Rather than segmenting each interview, for example, into weekly assignments, judges were given the verbatim written transcript of an entire session. The latter approach had the following advantages. The judges worked independently. With the exception of the first session, there were no "team" discussions of the ratings. All the ratings were recorded and submitted in writing to the researcher. With this strategy, the judges' ratings were not influenced by their colleagues' decisions. Moreover, for each judge there could be greater consistency in the ratings. Steps were also taken to minimize the disadvantages of distributing complete therapy sessions. Since there was no formal forum to discuss problems in rating the data, judges were encouraged to approach the researcher with any difficulties they encountered. Enough time was allotted to judges such that they would not have to hurry and complete the ratings in one sitting. Depending on the length of the session, judges were given two to three

weeks to complete their ratings. In addition, judges usually had a rest period between sessions. This reduced the likelihood that ratings would be affected by fatigue, boredom, or "set".

The sessions were rated over a period of one year. Judges rated every therapist statement in each of the 12 sessions. In total, they rated 1,659 therapist statements. Examining each statement individually, they answered the following questions: (1) Does this therapist statement contain a request for verbal behaviour? and (2) If yes, what is the request for verbal behaviour?

In order to determine which therapist statements, and behavioural requests, would be included in the second phase of this study, the researcher collated the ratings. The judges' decisions regarding whether or not a therapist statement contained a request were recorded. The criterion level of agreement was set at 75%. In order for a statement to be included in the subsequent phases of this investigation, a minimum of three out of the four judges had to agree that the statement did contain a request for verbal behaviour.

When the majority of judges had agreed that a statement did contain a behavioural request, the researcher then reviewed the request for verbal behaviour that each judge had written down. The extent to which the judges agreed on the nature of the requested behaviour was assessed. For the

majority of therapist statements, there were minor to moderate variations in the wording of the requests. Variations in the wording of a request were accepted as long as it was clear that the judges were formulating essentially the same request. The following example illustrates how, despite variations in the exact wording of the request, the essence of the requested verbal behaviour can remain the same.

Therapist Statement: How do you feel about coming here?

Behavioural Request: The client is to describe his feelings about coming to therapy.

Behavioural Request: The client is to say how he feels about coming to therapy.

Behavioural Request: The client is to tell the therapist how the client feels about coming to therapy.

There were very few cases in which the judges had agreed that the therapist statement contained a request, but disagreed on the content of the requested verbal behaviour. Variations in the wording of requests were considered to be indicative of disagreement when the variations resulted in fundamental changes in the essence of the requested verbal behaviour. For example:

Therapist Statement: Resentment?

Behavioural Request: The client is to say what it is that he resents.

Behavioural Request: The client is to say whether he feels resentment.

Behavioural Request: The client is to say more about feeling resentful toward his mother.

To meet the criterion level of agreement, the majority of judges had to agree on the nature of the requested verbal behaviour. That is, if three out of four judges had originally agreed that the statement contained a request, then two of these judges, or 66%, had to agree on the nature of the request. If all four judges had agreed that the statement contained a request, then the criterion level of agreement was 75%. When the majority of judges agreed on the nature of the request, the researcher formulated a final version of the requested verbal behaviour. Variations in the wording of a request were reflected in the final version. For example, for the former illustration cited above, the final version of the request was: The client is to say/describe how he feels about coming to therapy.

Thus, the therapist statements that were included in the next phase of the investigation met the following criteria. The majority of judges had agreed that the statement contained a request for verbal behaviour and had agreed on the nature of the requested verbal behaviour.

Phase 2: Constructing Categories of Requested Verbal Behaviour

In the first phase of this study a list of requested verbal behaviours was generated for each of the two therapists. The purpose of the second phase of the research was to organize these individual requests into dimensions or categories of requested verbal behaviour. In the following section the choices in methodology will be discussed and the procedures that were followed in generating a set of categories for each therapist will be described.

Choice of Judges

Who would examine the individual requests and organize them into a set of categories? Three options were considered. One option was that a team of judges would work independently on the development of the category systems. The second option was that the researcher would construct the categories alone. The researcher opted for a third alternative, that is, to undertake the development of the category systems, but work with consultants who would provide feedback and suggest modifications. This decision was based on the following considerations.

The advantages and disadvantages of using a team of judges were considered. The main advantage would be the possibility of assessing the extent to which judges generate similar categories of requested behaviour. There may be

more confidence in the objectivity and validity of the categories if a number of individuals, working independently, come up with the same categories. However, this option presented certain difficulties. The immediate problem was that people who were interested and willing to devote the amount of time and work needed to develop the categories were not available. Yet, even if a team of judges could be found, it was not expected that they would independently generate the same categories. The categories that are generated depend on which aspects of the requests for verbal behaviour are emphasized. It was expected that a team of judges would generate some dissimilar, but equally valid, categories of requested behaviour. A number of problems would arise if judges did not agree on one set of categories. Given the possibility of different, but equally viable and valid categories, on what basis is one to decide which judge is "right"? The conventional course of action is to discard the data upon which judges do not reach a criterion level of agreement. In this case, by giving priority to different features of the requests, judges could disagree on (a) the number of categories, (b) the nature of the categories, and (c) the specific requests that belong to each category. Given that it is not the primary purpose of this research to create a category system, a significant reduction of the data pool at this stage of the investigation was not warranted. The problems posed by

using a team of judges were seen to outweigh the advantages.

In having one person undertake the development of the categories, the problems presented by disagreement among judges are circumvented. The disadvantage of this option is the lack of input and feedback from different perspectives. There is no assurance that the categories would make sense to other people. The goodness-of-fit between the individual requests and the categories to which they are allocated is uncertain. If the categories were to be constructed by the researcher, a system of checks and balances was needed.

One way to ascertain that the categories do make sense is to work with consultants as the categories are being constructed. This was a feasible combination of the first and second options. In the process of developing the categories, the researcher worked with four consultants. Separate meetings with each consultant took place following the first and second sweeps (see Procedure in the Construction of Categories) of each therapist's list of requests. Each person was given the requests for one session and asked to organize them into categories of requested behaviour. The categories that they derived were discussed and compared to those that had been identified by the researcher. The consultants' input and their feedback on the categories that had been constructed by the researcher were taken into account in the final drafting of

the category systems.

A Set of A Priori Guidelines

The results of the pilot study (Mahrer et al., in press) suggested that some guidelines were needed regarding the distribution of dimensions and representative requests across sessions. In that study, the frequencies were too low, for four out of five categories, to permit statistical analysis in the assessment of client responses. Given that the categories are based in the nature of specific requests, it is difficult to establish guidelines prior to the actual execution of the study. The requests can change from one session to another and from one therapist to another. Depending on the nature of the requests the number of categories may vary for the two therapy cases. Depending on the distribution of the requests, a category may emerge in all or only some of the six sessions, and it may be represented by a different number of requests in each session. Therefore there was no basis for predetermining (a) the exact number of categories to be generated, (b) the number of individual requests that would fall in each category, or (c) the exact distribution of categories and requests across sessions.

A feasible solution was to adopt some general and flexible criteria that would set minimum standards. For example, an upper limit in the number of categories could be set. This upper limit should insure a managable set of

categories that include and account for the individual requests, yet would not impose an unrealistic constraint on the data. It was also possible to establish criteria regarding the minimum number of representative requests needed in a session for each category. These upper and lower limits were based on (a) an estimated average of 100 therapist statements per session, and (b) an expectation that approximately 70% of these statements would contain requests for verbal behaviour (Mahrer et al., in press). Accordingly, the selected upper limit was 10 categories overall for each therapy case. A category need not be present in every session. However, to qualify as a category of requested behaviour, it had to emerge in at least two of the six sessions. The category also had to be represented by a minimum of 7 individual requests in at least two of the six sessions.

Procedure in the Construction of the Categories

The categories of requested verbal behaviour were constructed for one therapy case at a time, beginning with Maloney's sessions. The same procedure was followed in the construction of categories for Maloney's and Barry's cases. It took two runs, or sweeps, through the data to derive the final category system for each of the two therapy cases. The following sections provide a description of what was done in these two sweeps.

First sweep. The purpose of the first sweep was to

derive specific categories by grouping together requests that were identical or similar in nature. Each request in the first session was examined individually and compared to the preceding requests. An answer was framed to the following question: Is this request similar to, or different from, the previous requests? Similar requests would be grouped together, and the researcher would determine whether subsequent requests belonged in the same category of requested verbal behaviour.

For example, the following two requests were viewed to be similar in nature: (1) The client is to say how he is, and (2) the client is to say/describe how he feels about coming to therapy. Both requests ask the client to describe his feelings or feeling state. On the other hand, the request "the client is to repeat what he just said" was judged to be different from the previous two requests. It does not belong in a category which requires "description of feelings".

When all the requests in the first session had been examined, the same procedure was repeated for each subsequent session until requests for verbal behaviour had been organized into groups for each of the six sessions. These categories tended to be very specific and remained close to the original requests.

At the completion of the first sweep it became apparent that the frequency of requests in some categories was

insufficient. While some of the categories were found in every session and/or had a relatively high frequency of representative individual requests, other categories either did not emerge in more than one session or had relatively few requests. Some isolated requests did not fit any of the identified categories.

At this point, there were 21 categories of requested verbal behaviour for Maloney's sessions. There were 10 categories of requested verbal behaviour for Barry's sessions.

Second sweep. The purpose of the second sweep was to reduce the number of categories of requested verbal behaviour such that each category would occur in more than one session and be represented by a sufficient number of requests.

In the second sweep, the categories that had been derived in the first run through the data, and the individual requests that were included in each group, were examined. All categories were left somewhat open to change. However, the primary focus was on the isolated requests and those categories of requested verbal behaviour that did not occur in many sessions or had relatively few requests.

Each category of requests (or isolated request) was examined in light of (1) the other categories in that session, and (2) the categories derived for the other

sessions. Then an answer was framed to the following questions. Are these two categories similar or different? In what ways are they similar? In what ways are they different?

This exercise provided a set of general themes that could be used to reorganize the individual requests and the categories of requested behaviour. For example, degree of facticity was a theme that distinguished between requests that called for essentially factual, demographic, or logistical information and requests that required psychological understanding on the part of the client. The degree of experiential immediacy was a theme that distinguished, for example, between a request to describe a past event and a request to relive it, in fantasy, in the session.

Not all the themes that were identified could be given equal weight because this would increase, rather than reduce, the number of categories. The researcher selected the themes that would be given greater priority in the reorganization of the categories and requests. However, the themes which were not used as a basis for separate categories were subsequently addressed in the title and description of the categories. For example, object of discussion was a theme that differentiated between requests that referred to the client, to other people, and to events or situations. Rather than creating separate categories for

each "object of discussion", the fact that the requests referred to the clients themselves, or to other people, or to situations and events, was noted in the title or description of the categories.

Some of the general themes that had been identified in Maloney's requests were applicable to Barry's case as well. A choice was made to give greater weight to themes that had emerged in both therapy cases. The two category systems would then reflect not only differences between the two therapists, but those aspects that were common to, and consistent across, the two therapy cases.

On the basis of the selected themes, and taking into account (a) the consultants' feedback following the first sweep and (b) the a priori guidelines, the requests were reorganized as follows. Categories that had relatively few requests, and in which the individual requests could easily be redistributed among other categories, were discarded. New general categories were formed by taking all or some of the requests in a category and integrating them with all or some of the requests from other categories.

Some of the categories that had been identified in the first sweep were considered to be related and to belong to a larger dimension. In this case, the construction of more general categories entailed simple integration of the previously identified categories. In other cases, only some of the individual requests in a category shared a common

theme with all or some of the requests in other categories. A common general theme made it possible to integrate previously isolated requests and specific categories of requested verbal behaviour into a redefined dimension.

The reorganization of the requests resulted in a reduction in the number of categories. At the conclusion of the second sweep, there were nine categories of requested verbal behaviour for Maloney's case. There were five categories of requested verbal behaviour for Barry's case. While these categories do not account for all of the requests for verbal behaviour that had been identified in the first phase of this investigation, they do include most of the requests for verbal behaviour (see RESULTS). With the exception of one category in each therapy case, all the categories were found in more than one session and were represented by a sufficient number of individual requests. Following a final review of this category system and feedback from consultants, some minor revisions were made. The final set of categories for the two therapy cases is presented in the next chapter (see RESULTS).

Summary

In the second phase of this study, the list of individual requests for verbal behaviour were examined. In an initial sweep through the data, a set of specific categories was derived, for each session individually, by combining requests that were identical or highly similar in

nature. In the second sweep, these categories, and the individual requests included in each category, were reviewed. The researcher identified ways in which the categories were similar and different, thereby deriving general themes that could be used to reorganize the requests into a smaller group of categories. At the conclusion of the second phase the researcher had, for each therapy case, a set of general categories of requested behaviour and a list of representative therapist statements, or individual requests, in each category.

Phase 3: Ascertaining the Goodness-of-Fit Between Therapist Statements and the Categories of Requested Verbal Behaviour

The purpose of the third phase of this investigation was to ascertain that the therapist statements, that is, the individual requests for verbal behaviour, did fit the categories to which they had been assigned. Given that the researcher had developed the category systems and determined which statements belonged to which category, there was a need to check and, where necessary, modify the researcher's work. Accordingly, in phase three of this study judges had to assess whether the individual therapist statements did belong in the categories to which they had been assigned, and to discriminate between therapist statements that fit a particular category and those that did not.

Judges

A new team of three judges participated in this phase of the study. This group included a clinical psychologist, a doctoral student in clinical psychology, and an undergraduate student doing her Honour's project in psychotherapy process research. The latter two judges each had one year of experience as raters on a psychotherapy research team.

Training of Judges

One meeting was held to train the judges. Written instructions that had been prepared for this phase of the investigation were presented to the judges (see Appendix B). In general, these instructions directed the judges to read the title and description of a category and, after referring to a designated list of therapist statements, to determine whether each therapist statement fit or did not fit the category in question.

The judges first read the instructions by themselves. Then the instructions were reviewed and discussed. A sample of statements included in one category was used to demonstrate the steps that the judges were to follow in rating the therapist statements. There was no formal training subsequent to the first meeting. However, regular contact was maintained to address any difficulties the judges encountered in doing the ratings.

The Unit of Study and Rating Sample

The researcher had two options with regard to the unit

of study that would be used in this phase of the investigation. The unit could be the individual request for verbal behaviour or the original therapist statement. The decision to choose the latter option was based on the following considerations. In the last phase of this study, judges would not be given a list of individual requests for verbal behaviour. They would be presented with therapist and client statement couplets. It would therefore be advantageous to ascertain the goodness-of-fit between original therapist statements and the categories in which they had been included. Another reason for this choice was that the goodness-of-fit between the general categories and the individual requests assigned to each category would be more rigorously tested if judges were presented with the original therapist statements. Given that the requests are based in the wording of therapist statements, if the categories make sense judges should be able to see the link, where it exists, between the original statement and the category. They should be able to reach agreement as to whether or not the individual statements fit the categories.

Two options were considered with regard to sample size of therapist statements. One option was to have judges rate all the therapist statements that were included in the various categories. While this would be an exhaustive test of the goodness-of-fit between the categories and the individual therapist statements, it was not viewed to be

necessary. Instead, a sample of therapist statements representing each category and each session was selected.

This sample included 280 therapist statements from Maloney's sessions and 179 statements from Barry's sessions. The composition of the sample was as follows. There were instances in which the researcher was uncertain about the goodness-of-fit between a therapist statement and the category to which it had been assigned. Therefore, these statements were included in the sample. In addition, the researcher randomly selected a sample of the remaining statements from each category and each session. This sample included (1) 10% of the statements which the researcher had judged to fit the given category and (2) an equivalent number of "distractors", therapist statements that had been assigned to other categories and did not fit the category in question. The researcher included "distractors" in the sample on the premise that, if the categories made sense, judges would be able to discriminate between the therapist statements that belonged in a category and those that did not.

Procedure in Assessing Goodness-of-Fit Between Therapist Statements and Categories of Requested Verbal Behaviour

The following material was distributed in the initial meeting: (1) the written instructions (see Appendix B), (2) verbatim written transcripts of the 12 sessions, (3) the category system for each therapist, and (4) the list of

therapist statements that the judges were to examine and rate.

The judges completed the ratings for one category at a time, beginning with the set of categories constructed for Maloney. For each therapist statement, they answered the following question: Given this particular category, does this statement qualify as fitting into this category? The judges had three responses from which to choose: (1) Yes, it fits, (2) No, it does not fit, or (3) I am not sure. After rating the statements from one session, they proceded to examine the set of target therapist statements in the subsequent session, until all the statements in the given category had been rated.

The criterion level of agreement was set at 66%. In order to conclude that a therapist statement belonged to a category of requested verbal behaviour, at least two out of the three judges had to agree that the statement fit the category.

Application and Use of the Ratings

As stated earlier, the purpose of the third phase of this study was to check that the researcher had adequately defined the categories of requested verbal behaviour and had correctly determined which therapist statements belonged to particular categories. In addition to ascertaining that the researcher's work in phase two had been sufficiently reliable, the purpose of phase three was to use the judges'

ratings and feedback to make appropriate modifications. This section will describe, in general, what was done on the basis of the judges' ratings. (Changes made on the basis of the ratings are reported here, rather than in the results chapter, because they describe the researcher's procedure and had implications for the next phase of this research.)

The description of some categories was modified in order to clarify the type of requests included in a given category and to highlight aspects that distinguished that category from others.

Statements were discarded from further investigation when judges agreed that the statement did not fit the category to which it had been assigned or when judges failed to reach criterion level of agreement. In Maloney's case, 27 statements, or 4.3%, were discarded. In Barry's case, eight statements, or 1.8% were discarded. Overall, 35 statements, or 3.3%, were deleted from further investigation.

Eight of Maloney's statements were reassigned to different categories of requested verbal behaviour, based on the judges' feedback that an alternative classification was more appropriate. The statements in two of the categories (categories 1 and 2, both therapists) were pooled due to the judges' difficulty in discriminating between them. Some, but not all, of the therapist statements belonging to these two categories were discarded (when judges failed to reach

criterion level of agreement or agreed that the statement did not fit the category). The judges in the fourth phase of this research would be asked to determine which of the two categories each therapist statement fit best.

Phase 4: Assessing the Clients' Responses to Requests for Verbal Behaviour

In the fourth and final phase of this study the focus shifted to the client. The purpose of this phase was to assess the clients' verbal performance on the categories of requested verbal behaviour. In light of these categories, the client statements could be regarded as responses to the requests for verbal behaviour contained in antecedent therapist statements. Examination of the clients' statements would indicate the extent to which the clients' verbal responses conformed to the therapists' requests for verbal behaviour over the course of a series of sessions.

Presentation of the Data in Phase 4

The client statements that the judges were to rate were those that followed therapist statements which had been assigned to one of the categories of requested verbal behaviour. The data was presented to the judges in the form of therapist statement-client statement couplets. That is, judges had the therapist statement that contained the request for verbal behaviour as defined by the category and the immediately subsequent client response. For the most part, it was sufficient to provide only the target couplet.

However, there were cases in which the judges needed more information in order to rate the client statement. For example, consider the following therapist statement: "Uh-hmm. What sort of things?". It is clear that the client is to identify the "sort of things that...." but, in the absence of the previous client statement, the judges have no way of knowing that the client is to identify the sort of "thoughts" she has when "her imagination runs wild". The researcher examined each couplet and determined if the judges would require more information in order to assess the extent to which the client is manifesting the requested verbal behaviour. If necessary, one or more previous client and/or therapist statements were included in the excerpt.

The order of presentation was altered for this phase of the study. Earlier in this chapter, it was mentioned that the client statements would be presented to the judges in random order. This was done by pooling the statements in the six sessions, for each therapy case and category of requested behaviour individually. Then, for each category, the statements were randomized such that judges would not know where in a session and in which session the particular statement occurred. New transcripts were prepared. Each contained the name and description of a category followed by the randomized set of couplets that belonged to that category.

The Client Response Rating Scale

A four point rating system was used to assess the target client statements in the fourth phase of the study. The scale is a modified version of the rating system used by Mahrer and colleagues (in press) in the pilot project. That study used a three point rating scale as follows: (++) The patient is being the prescribed kind of person to a strong degree, is significantly evidencing the prescription, being and doing the prescribed change; (+) The patient is being the prescribed kind of person to a moderate degree, is being and doing the prescribed change moderately, free of avoidance and resistance; (-) The patient is not being the prescribed kind of person, not evidencing or doing the prescribed change; the patient is disregarding, avoiding, refusing, disagreeing, questioning, objecting.

The modifications were in line with this study's interest in the quality of the client's responses. To differentiate between ways of not following a request, the scale has a separate classification for passive, indirect avoidance and for outright, open, and direct refusal. The positive poles were also altered. Rather than focusing on a moderate versus strong display of the requested verbal behaviours, the scale attempts to discriminate between instances in which the client conforms partially or slightly to the therapist's request and instances in which the client complies fully with the request for verbal behaviour.

The complete form of the client response rating scale

can be found in Appendix C. This form includes (a) a definition of each point on the scale, (b) specific criteria and guidelines for each point on the rating scales, and (c) examples of the type of client statements that would receive each rating. Following is the summary form of the client response rating scale.

1. The client actively refuses to do it: The client clearly, directly and openly refuses to manifest the requested verbal behaviour. The client clearly, openly and directly objects to, disagrees with, or questions the behavioural request.
2. The client passively avoids doing it: Rather than openly refusing to carry out the requested verbal behaviour, the client avoids it in an indirect manner. To be rated as passsive avoidance the client must really not be manifesting the requested verbal behaviour. If the client does it even a little bit or in an incomplete manner, the client statement is rated as partial conformity (i.e., 3).
3. The client manifests the requested verbal behaviour to some extent: The client is following the therapist's request to a moderate or weak extent, is displaying the requested verbal behaviour slightly or partially. The requested verbal behaviour is present but cursory, weak, incomplete or barely present. The client is doing it a little

bit, or is doing part of it.

4. The client is following the behavioural request well, is manifesting the requested verbal behaviour fully: A client statement is rated as 4 when the client gives a full response. Upon reading the client's statement, the reader senses that the client is doing it well, that the client is complying fully with the therapist's request for verbal behaviour.

Judges

A new team of six judges was used in this phase of the study. The judges were ongoing participants on a psychotherapy process research team. They all had previous experience in rating therapist and client statements. The team included four doctoral students in clinical psychology and two judges who had completed their B.A. in psychology and whose honours project had been in the area of psychotherapy process research.

Training of Judges

Judges were trained in the following manner. In the initial meeting they were given: (1) written instructions that had been prepared for this phase of the study (see Appendix D), (2) the summary and long form of the client response rating scale (see Appendix C), (3) the title and description of one of the categories of requested verbal behaviour (for training purposes, Category 1 in Maloney's

case was selected), and (4) the transcript containing the randomized set of couplets belonging to that category. The judges began by reading the instructions and examining the client response rating scale by themselves. The researcher then reviewed and discussed this material with the judges. The researcher demonstrated the steps that the judges were to follow in rating the data. Then the judges were asked to go through the steps by themselves, using Category 1 and the first five couplets for illustrative purposes.

A second meeting with the judges, one week later, was also held for training purposes. At that time, having done some of the ratings, the judges had gained some experience with the task. Specific difficulties that the judges had encountered were discussed. The judges' ratings of the first 25 excerpts, or couplets, were reviewed in the group. The purpose of this review was to use disagreement among judges to engender further questions and discussion. Though there was no formal training subsequent to this meeting, regular contact was maintained to address any difficulties the judges encountered in doing the ratings.

Procedure in Rating Clients' Responses to Requests for Verbal Behaviour

Transcripts were distributed during weekly meetings. Each transcript contained the name and description of a category, followed by the excerpts belonging to that category. The judges were to examine the target client

statements in light of (a) the given category of requested verbal behaviour and (b) the specific request for verbal behaviour contained in the immediately antecedent therapist statement. For each client statement, they were to assess the extent to which the client was manifesting the requested verbal behaviour. Using the four-point rating scheme, judges were to determine if the client was actively refusing to follow the request, passively avoiding it, displaying the requested behaviour partially, or fully complying with the antecedent request.

The judges worked independently. All ratings were recorded and submitted in writing during the meetings. When judges had completed one set of ratings, they were given the subsequent set of transcripts. The number of transcripts distributed each week depended on how many excerpts were included in the categories. On average, judges had to rate 100 client statements per week. Judges did the ratings for one therapy case at a time, beginning with the categories that had been constructed for Maloney.

For each client statement, the criterion level of inter-rater agreement was set at 67%. For example, if four of the six judges rated the statement as a 3 on the client response scale, then that client statement qualified as a response in which the client was partially conforming to the therapist's request. Two additional steps were taken in order to minimize the loss of data at this stage. Response

biases were calculated for each category of requested verbal behaviour (by following the procedure for assessing response biases described in Mahrer, Peterson, Theriault, Roessler, & Quenneville, 1986). The judges' ratings could then be weighted to take into account the presence of any significant response biases. This would usually serve to break the deadlock between two client response ratings. In addition, in those instances where the judges failed to reach criterion level of agreement, and response biases did not account for the deadlock between two adjacent response ratings, the researcher, who had independently rated all the target client statements before the judges had submitted any of their ratings, served as a "master judge" and tie breaker.

Research Hypotheses

A provisional statement of the research hypotheses and questions was presented in the first chapter of this thesis. Given the research methodology that has been described in the present chapter, these general hypotheses may be restated and a set of specific expectations may be presented, as follows.

Hypothesis 1

The main research hypothesis is that over the series of six sessions, there will be an increasing occurrence of the requested verbal behaviours. Occurrence of the requested verbal behaviour means that the client is

complying, conforming, or acquiescing to the antecedent request by the therapist. Thus, an examination of the clients' responses should indicate that, over the series of sessions, there is greater conformity and acquiescence to the antecedent requests.

Specifically, it is expected that the proportion of client statements rated as 3 or 4 on the Client Response Rating Scale will be higher in the fifth and sixth sessions of each therapy case than in the first and second sessions. In terms of stages of therapy, it is expected that the proportion of client statements rated as 3 or 4 on the Client Response Rating Scale will be higher in the final stage than in the beginning stage of therapy. (Chi-square analyses will be used to test for significant differences across sessions, and across stages, in the number of client responses rated as conforming (i.e., rating = 3 or 4) versus not conforming (i.e., rating = 1 or 2) to the therapist's antecedent requests for verbal behaviour.)

Hypothesis 2

The literature on complementarity and symmetry in psychotherapy, and on stages and phases of therapy, suggests that there is a basis for examining the clients' responses to the requests contained in antecedent therapist statements on a session-by-session level. On the basis of the theoretical and research literature, the general hypothesis is that the degree of conformity and acquiescence will

reveal a significant valley in the middle sessions. Examination of client responses to antecedent requests should indicate that in the middle sessions, as opposed to initial and final sessions, there is decreasing conformity and increasing opposition to the antecedent requests for verbal behaviour.

Thus, given a session by session analysis of the degree of client conformity and acquiescence to antecedent requests for verbal behaviour, it is expected that the highest incidence of passive avoidance and active refusal on the part of the client should occur in the third and fourth sessions of each series. There should be relatively more client statements rated as 1 or 2 in the middle sessions than in either the initial or final sessions of each case. (Chi-square analyses will be used to test for significant differences across sessions, and across stages, in the number of client responses rated as conforming (i.e., rating = 3 or 4) versus not conforming (i.e., rating = 1 or 2) to the therapist's antecedent requests for verbal behaviour.)

Hypothesis 3

It is expected that the quality of the client's responses, as indicated by the four-point rating scale, will change over the course of the six sessions. The early sessions of therapy should be characterized mainly by client responses that reflect a weak or moderate display and indirect avoidance of the requested verbal behaviours. The

final sessions of therapy should be characterized mainly by strong, full manifestation of the requested verbal behaviours. If opposition occurs in the final sessions, it is expected to be expressed as direct, outright refusal to conform to the requests contained in the therapist statements. (Chi-square analyses will be used to test for significant differences between the initial and final sessions/stages of therapy in the number of client responses rated as avoiding or conforming partially (i.e., rating = 2 or 3) versus conforming fully (i.e., rating = 4) to the therapist's antecedent requests for verbal behaviour.)

Again, the general hypothesis is restated in terms of a set of specific expectations. Given examination of the findings on the graduated four-fold degree of conformity and acquiescence, it is hypothesized that:

(a) The percentage of client statements rated as 4 will gradually increase over the course of sessions. The client will move in the direction of displaying the requested verbal behaviours to a full extent. (Chi-square analyses will be used to test for significant differences across sessions in the proportion of client responses indicative of full compliance, i.e. rated as 4.)

(b) The percentage of client statements rated as 3 will gradually decrease over the course of sessions. There will be decreasing evidence of following a request for

verbal behaviour slightly or partially. (Chi-square analyses will be used to test for significant differences across sessions in the proportion of client responses rated as conforming partially (3) to the therapist's antecedent requests.)

(c) The percentage of client statements rated as 2 will decrease from the middle to the final sessions. Indirect avoidance of requests should occur less frequently in the fifth and sixth sessions than in the third and fourth sessions of each series. (Chi-square analyses will be used to test for significant differences across sessions in the proportion of client responses rated as passively avoiding (2) the therapist's antecedent requests.)

(d) The percentage of client statements rated as 1 is expected to increase as therapy progresses from the initial to the middle stages, then decrease in the final sessions but stabilize at a low and consistent rate. Thus, display of direct and outright opposition should reach a peak in the third and fourth sessions of each series. Direct refusal is expected to occur rarely, or not at all, in the first and second sessions of each series. Opposition to the therapists' requests in the fifth and sixth sessions is expected to be in the form of open, direct refusal, but to occur less frequently than in sessions three and four. (If raw frequencies are sufficiently high, Chi-square analyses will be used to test for significant differences

across sessions in the proportion of client responses rated as directly refusing to comply (1) with the therapist's antecedent requests.)

Client Conformity in Specific Categories of Requested Verbal Behaviour.

The design allows for the identification and examination of categories in which the hypothesized pattern of client responses is demonstrated versus categories in which the hypothesized changes do not occur. Homogeneity of client process was not assumed in the present research. However, it was only in the course of conducting the investigation that the exact nature of the categories was defined. Requests for verbal behaviour were identified through the examination of individual therapist statements, and then were organized into categories. Given that the content of categories was not known a priori, there was no basis for looking in the literature for predictions regarding increasing conformity to certain types of therapist requests.

Accordingly, rather than stating a hypothesis, the following general research questions were formulated in the first chapter. Does the hypothesized pattern of client response to antecedent requests occur for all categories of requested verbal behaviour? If not, in which categories is the hypothesized pattern found and in which categories is it not found? Given the specific changes that were predicted

in the first three hypotheses, these general questions may now be restated as follows.

1. Is there an increase in the occurrence of requested verbal behaviours over the course of sessions for each category of requested verbal behaviour? When each category is examined individually, is the proportion of client statements rated as 3 or 4 consistently higher in the final sessions than in the beginning sessions of therapy? (Given sufficient data, Chi-square analyses will be used, as described for the first hypothesis.)

2. In each category of requested verbal behaviour, will the highest incidence of passive avoidance and outright refusal occur in the middle sessions of therapy? (Given sufficient data, Chi-square analyses will be used, as described for the second hypothesis.)

3. Given examination of the findings on the graduated four-point scale of conformity and acquiescence, will the predicted developments in the quality of the clients' responses occur consistently for each category of requested verbal behaviour? When each category is examined individually, will there be a gradual decrease over the course of sessions in the slight and partial display of requested verbal behaviours? Will there be a gradual increase in full compliance to the requests for verbal behaviour? Will passive avoidance and direct refusal to carry out requests emerge with the greatest frequency in the

middle sessions? (Given sufficient data, Chi-square analyses will be used, as described for the third hypothesis.)

CHAPTER III

RESULTS

The purpose of this chapter is to present the outcome of each phase of this investigation. The chapter is divided into four major sections, corresponding to each of the four phases of the study: Phase 1 - therapist statements as behavioural requests; Phase 2 - categories of requested verbal behaviour; Phase 3 - goodness-of-fit between therapist statements and categories of requested verbal behaviour; and Phase 4 - client responses to therapists' requests for verbal behaviour.

Results of Phase 1: Therapist Statements as Behavioural Requests

In the first phase of this research a team of four judges rated the therapist statements in 12 sessions. They determined which of the statements contained requests for verbal behaviour and identified the requests for verbal behaviour contained in these therapist statements. The results of phase 1 of this study will be presented in the following section. First the level of inter-rater agreement in determining whether or not the therapist statements contain a behavioural request will be reported. Then the proportion of therapist statements judged to contain behavioural requests will be presented.

Level of Inter-Rater Agreement

This section reports on the level of inter-rater agreement on (a) whether or not the therapists' statements contained behavioural requests, and (b) the nature of the requested verbal behaviour. The criterion for agreement was set at 75 percent.

The level of inter-rater agreement as to whether or not the therapist's statements contained behavioural requests was tabulated for each therapy case and each session. These data are presented in Tables 1 and 2, for the cases by Maloney and Barry respectively. Each table presents (a) the total number of therapist statements in each individual session and for the six sessions combined, (b) the number of statements upon which the judges reached criterion level of agreement, and (c) the percentage of statements that met criterion level of agreement.

A comparison of Tables 1 and 2 reveals that the level of agreement as to whether or not the therapist's statements contain a request is slightly higher in the rating of Barry's statements than in the rating of statements made by Maloney. When the data were pooled for both therapy cases, there was a total of 1,657 therapist statements. Overall, the judges agreed on 1,509, or 91.1%, of the 1,657 statements.

To be included in the subsequent phase of the investigation, the judges had to agree not only that a

Table 1

Maloney: Level of Agreement Across Sessions on Whether or Not the Therapist Statements Contain Behavioural Requests

Session	No. of Statements Rated	Statements Attaining Criterion	
		N	%
1	223	201	90.1
2	195	170	87.2
3	222	210	94.6
4	198	164	82.8
5	145	130	89.7
6	174	157	90.2
Total	1157	1032	89.2

Table 2

Barry: Level of Agreement Across Sessions on Whether or Not the Therapist Statements Contain Behavioural Requests

Session	No. of Statements Rated	Statements Attaining Criterion	
		N	%
1	82	76	92.7
2	72	67	93.1
3	76	74	97.4
4	97	91	93.8
5	101	99	98.0
6	72	70	97.2
Total	500	477	95.4

statement contained a behavioural request, but also on the nature of the requested behaviour. In the case conducted by Barry, all 444 statements met the criterion level of agreement with regard to the nature of the requested behaviour. Of the 664 statements by Maloney, the judges reached criterion level of agreement on 662 statements, or 99.7%. The two statements that failed to meet criterion level of agreement were deleted from further investigation. Seven additional statements were discarded because they contained requests for nonverbal behaviour.

Proportion of Statements that Contain Requests for Verbal Behaviour

What proportion of the therapists' statements contain requests for verbal behaviour? The number and percentage of the therapist statements containing behavioural requests were tabulated for each therapy case as well as each session individually. These findings are presented in Tables 3 and 4. Of the total number of 1,657 statements, 1099 statements, or 66.3%, contained a request for verbal behaviour. Thus, the findings show that a substantial proportion of therapist statements, in fact a large majority, do contain requests for verbal behaviour.

Examination of Tables 3 and 4 reveals that the proportion of therapist statements judged to contain behavioural requests is consistently higher for the sessions conducted by Barry than for those conducted by Maloney.

Table 3

Number and Percentage of Therapist Statements that Contain Behavioural Requests in Maloney's Sessions

	Statements Containing Behavioural Requests	
Session	N	%[a]
1	109	48.9
2	125	64.1
3	136	61.3
4	104	52.5
5	85	58.6
6	96	55.2
Total	655	56.6

[a] Percentages are based on the total of therapist statements in each of the six sessions.

Table 4

Number and Percentage of Therapists Statements that Contain Behavioural Requests in Barry's Sessions

	Statements Containing Behavioural Requests	
Session	N	%[a]
1	72	87.8
2	62	86.1
3	69	90.8
4	83	85.6
5	91	90.0
6	67	93.1
Total	444	88.8

[a] Percentages are based on the total of therapist statements in each of the six sessions.

Overall, 88.8% of Barry's statements were judged to contain requests for verbal behaviour, whereas 56.6% of Maloney's statements were rated as containing requests for verbal behaviour. That is, 32.2% more of Barry's statements were seen to contain requests for verbal behaviour.

Results of Phase 2: The Categories of Requested Verbal Behaviour

In the second phase of this investigation the individual requests for verbal behaviour (identified in Phase 1) were organized into a set of categories for each therapy case. The outcome of phase 2, that is, the resulting category systems and the assignment of individual statements into the respective categories, is presented below.

Categories of Requested Verbal Behaviour: Maloney

Maloney's statements were organized into nine categories of requested verbal behaviour. Of the 655 statements by Maloney judged to contain a request for verbal behaviour (in Phase 1), 631 statements were assigned to these categories. The remaining 24 statements, or 3.7%, were deleted from further investigation because, given the requests that these statements contained, they did not fit into this category system and occurred too infrequently to be organized into additional categories. Following is a brief description of each category of requested verbal behaviour. (For a fuller description of each category, see

Appendix E).

Category 1. In this category of requested verbal behaviour, the client is to reflect upon what the therapist is saying, to seriously consider and weigh the therapist's words, and to confirm, acknowledge, verify, agree, accept the therapist's words. These words may be the therapist's impressions, intuitions, feelings, thoughts, images, views, observations, descriptions, understanding, opinions, and assessments of the client, the other person, or situations and events (past, present, or future).

This category of requested verbal behaviour was found in each of Maloney's six sessions. Of the 631 statements that contained requests for verbal behaviour and were assigned to the various categories, 192 statements, or 30.4%, were assigned to this category in Phase 2.

Category 2. In this category of requested verbal behaviour the client is to answer yes or no in response to the therapist's direct and indirect questions about the client, about other people, or about past, present, and future events.

Though there are some similarities between Category 1 and Category 2, the difference is that the requested response in Category 1 is clearly confirmation, acknowledgement, or agreement, whereas in Category 2 there is more room for the client to answer no, to disconfirm, to disagree.

This category of requested verbal behaviour occurred in all six of Maloney's sessions. Of the 631 statements that contained requests for verbal behaviour, 106 statements, or 16.8%, were assigned to this category in phase 2.

Category 3. In this category of requested verbal behaviour the client is to understand, describe, assess, or explain himself, the other person, or the situation psychologically.

The client is to be aware of and describe aspects of himself, such as his feelings, experiencing, reactions, physical self, thoughts, beliefs, concerns, and difficulties in present situations and past events. The client is to identify particular individuals and events, or aspects of self, the other person and situations that are the source of some cognition, feeling, belief, or behaviour. The client is to understand, explain, evaluate, and account for aspects of himself (e.g., his behaviour or desires), the personal significance of specific events, or his past and present relationships.

This category of requested verbal behaviour was found in each of the six sessions. Of the 631 therapist statements that were assigned to the various categories, 94 statements, or 14.9%, were assigned to this category in phase 2.

Category 4. In this category of requested verbal behaviour the client is to provide general demographic and

descriptive information about himself, the other person, or situations and events.

The client is to provide general, factual information about himself or others and aspects of his or their day to day life (e.g., age, occupation, physical appearance, dietary habits). The client is to identify, recount, or describe earlier life events, past situations, recent incidents, or the present scene.

This category of requested verbal behaviour was found in each of Maloney's sessions. Of the 631 therapist statements, 76 statements, or 12%, were assigned to this category in phase 2.

Category 5. In this category of requested verbal behaviour the client is to talk directly to the other person. He is to "make contact" and express himself directly to the other person. The client is to share his feelings, experiencings, and reactions directly with the other person. He is to say whatever comes to mind or to say specific words that are either provided by the therapist or previously stated by the client himself.

This category of requested verbal behaviour was found in five of Maloney's sessions. It occurred with sufficient frequency in two of the sessions and with low frequency in three out of the five sessions. In all, 48 of the 631 therapist statements, or 7.6%, were assigned to category 5.

Category 6. In this category of requested verbal

behaviour the client is to play the role of younger self, part of self, body part, or other person, and to speak as that younger self, part of self, body part or other person. In the role of the other person, or younger self, or part of self, or body part the client is to describe his feelings, experiencing, thoughts, and beliefs. He is to describe the other person or the scene/situation. He is to respond to the other person, answer questions, say particular words, repeat something, or simply continue speaking.

This category of requested verbal behaviour was found in three of Maloney's sessions. In one of these three sessions, it occurred with low frequency. Of the 631 therapist statements, 36 statements, or 5.7%, were assigned to category 6.

Category 7. The client is to clarify or repeat his words, sentence, or statement. In this category of requested verbal behaviour, it is clear from the therapist's words that the therapist did not hear the client's words, or that he forgot an earlier statement, or that he does not understand.

This category of requested verbal behaviour was found in all of Maloney's sessions. It occurred with relatively low frequency in four of the six sessions. Of the 631 therapist statements, 35 statements, or 5.5%, were assigned to category 7.

Category 8. In this category of requested verbal

behaviour, the client is to say it again, to continue saying it, to just keep saying it over and over. "It" is a specific sentence, or set of words, or even just sounds (i.e., paralanguage). The client is to simply repeat the words and sounds or to modify them in a particular way (e.g., say it louder).

This category of requested verbal behaviour was found in all of Maloney's sessions. It occurred with low frequency in four of the six sessions. Of the 631 therapist statements, 31 statements, or 4.9%, were assigned to category 8.

Category 9. In this category of requested verbal behaviour the client is to make a decision, indicate his choice or preference, say what he wants or needs to do. The decisions and choices the client is requested to make may be related to a fantasized scene with another person, or to some other aspect of therapy and the therapy session.

This category of requested verbal behaviour occurred infrequently. It was found in three of the six sessions, with relatively low frequencies. In all, 13 of the 631 therapist statements, or 2.1%, were assigned to category 9.

Categories of Requested Verbal Behaviour: Barry

Barry's statements were organized into five categories of requested verbal behaviour. All of the statements that were identified as containing requests for verbal behaviour (in Phase 1) were seen to fit adequately into these

categories. Following is a brief description of each category of requested verbal behaviour. (For a fuller description of each category, see Appendix E).

Category 1. In this category of requested verbal behaviour the client is to reflect upon what the therapist is saying, to seriously consider and weigh the therapist's words, and to confirm, verify, acknowledge, agree with, or accept the therapist's words. These words may include the therapist's impressions, views, opinions, observations, descriptions, understanding, assessment, explanations, and interpretations of the client, the other person, or the situation.

This category of requested verbal behaviour occurred in all six of Barry's sessions. Of the 444 statements that contained requests for verbal behaviour, 222 statements, or 50%, were assigned to this category in the second phase of this research.

Category 2. In this category of requested verbal behaviour the client is to answer yes or no in response to the therapist's direct and indirect questions about the client and her day to day life, about the other person, or about past, present, and future events and situations.

In this case, as in Maloney's, the difference between categories 1 and 2 is that the requested response in category 1 is clearly confirmation, acknowledgement, or agreement, whereas in category 2 there is much more room for

the client to answer no, to disconfirm, to disagree.

This category of requested verbal behaviour occurred in all six of Barry's sessions. Of the 444 statements that contained requests for verbal behaviour, 128 statements, or 28.8%, were assigned to this category in phase 2.

Category 3. In this category of requested verbal behaviour the client is to understand, describe, assess, or explain herself, or the other person, or the situation psychologically.

The client is to understand and to describe, report, evaluate, or explain aspects of herself, such as her general state of mind, her feelings, reactions, thoughts, views, actions, choices, behaviour, symptoms and problems. The client is to understand, assess and explain her interpersonal relationships, the other person, or situations, events, and incidents.

This category of requested verbal behaviour was found in all six of Barry's sessions. It occurred with low frequency in three out of the six sessions. Of the 444 statements that contained requests for verbal behaviour, 41 statements, or 9.2%, were assigned to category 3 in phase 2.

Category 4. In this category of requested verbal behaviour the client is to provide general demographic and descriptive information about herself, the other person, or situations and events.

The client is to provide general, factual information

about herself and aspects of her day to day life (e.g., her financial situation and material circumstances). She is to identify and provide general information about a particular person, about past, recent, current, and future events, or interpersonal situations.

This category of requested verbal behaviour occurred in all six of Barry's sessions, but with low frequency in three of the sessions. Of the 444 statements that contained requests for verbal behaviour, 43 statements, or 9.7%, were assigned to category 4 in phase 2.

Category 5. In this category of requested verbal behaviour the client is to clarify, explain, or specify the meaning of her words. She is to explain or clarify what she means by saying something. She is to specify to whom or what she is referring when she says something. She is to complete her unfinished thoughts, utterances, or sentences.

This category of requested verbal behaviour occurred with low frequency in four of Barry's sessions. Of the 444 statements that contained requests for verbal behaviour, 10 statements, or 2.3%, were assigned to category 5.

Summary

A brief description of the nine categories of requested verbal behaviour that were identified for Maloney's case and the five categories that were identified for Barry's case has been provided above. Some categories of requested verbal behaviour were found in every session. Other

categories occurred in only some of the sessions. Certain types or categories of requested verbal behaviour occurred with greater frequency than others.

Results of Phase 3: Goodness-of-Fit Between Categories of Requested Behaviour and Individual Therapist Statements

The purpose of the third phase of this investigation was to ascertain that the therapist statements fit the categories to which they had been assigned. Three judges rated a sample of the therapist statements, assessing the goodness-of-fit between the individual therapist statements and the various categories of requested verbal behaviour. The judges were given a total of 458 therapist statements, which were broken down as follows: (a) 94 therapist statements which had been assigned to their respective categories with a fair amount of certainty, (b) 93 statements that were viewed as not fitting a particular category, intended as distractors, and (c) 271 statements that had been tentatively assigned to various categories but where the researcher felt unsure about the goodness-of-fit. The judges' ratings were used to check and, where necessary, modify the researcher's work in phase 2.

The following section presents (1) the level of inter-rater agreement for all 458 statements, and (2) the findings pertaining to the goodness-of-fit between the individual therapist statements and the categories to which

they had been previously assigned by the researcher.

Level of Inter-Rater Agreement

How often did the judges agree as to whether or not the therapist statements fit the categories? The criterion level of agreement was set at 66.6%, or two out of the three judges. Of the 280 statements rated from Maloney's sessions, the judges reached agreement on 258 statements, or 92.1%. Of the 178 statements rated from Barry's sessions, the judges agreed on 167 statements, or 93.8%. Overall, the judges met criterion level of agreement on 425 of 458 statements, or 92.8%. As described in the previous chapter, when criterion level of agreement was not attained, the statements were either discarded or, based on the judges' feedback, reassigned to another category (see Chapter 2, Application and Use of Ratings in Phase Three, pp. 105-107).

The level of interrater agreement was also calculated for each category of requested verbal behaviour. These data are presented in Table 5 for Maloney's categories and in Table 6 for Barry's categories. These tables indicate that the level of inter-rater agreement is generally high across categories.

Goodness-of-Fit Between the Categories of Requested Behaviour and Assigned Statements

Is there a good fit between the therapist statements and the categories of requested verbal behaviour to which they had been assigned? How many of the therapist

Table 5

Maloney: Level of Agreement on the Goodness of Fit Between Therapist Statements and the Categories of Requested Verbal Behaviour

Category	No. of Statements Rated	Statements Attaining Criterion	
		N	%
1	53	44	83.0
2	62	58	93.5
3	47	43	91.5
4	41	38	92.7
5	17	17	100.0
6	27	27	100.0
7	15	14	93.3
8	13	13	100.0
9	5	4	80.0
Total	280	258	92.1

Table 6

Barry: Level of Agreement on the Goodness of Fit Between Therapist Statements and the Categories of Requested Verbal Behaviour

Category	No. of Statements Rated	Statements Attaining Criterion	
		N	%
1	50	47	94.0
2	76	71	93.4
3	25	22	88.0
4	19	19	100.0
5	8	8	100.0

statements fit the categories to which they had been previously assigned by the researcher? Did the judges' ratings correspond to the researcher's original assignments? These questions are answered by reporting the findings on (1) the accuracy of the judges' discrimination between therapist statements that fit a particular category and therapist statements that did not fit the particular category, and (2) the extent to which the judges agreed with the researcher's tentative assignment of "unsure" statements.

As stated previously, the sample of statements presented to the judges included 94 statements that were viewed by the researcher as belonging to the particular category of requested verbal behaviour, and 93 distractors, statements viewed as not fitting the category (statements that had been assigned to other categories and should not fit this one). The judges' ratings on these statements may be considered in terms of correct inclusion, correct rejection, incorrect inclusion, and incorrect rejection. These data can provide one indication of the goodness-of-fit between the categories and the individual statements that had been assigned to them.

The findings on the judges' accuracy in discriminating between distractors and therapist statements that did belong in the respective categories are presented in Table 7 for the case by Maloney and in Table 8 for the case by Barry.

Table 7

Number and Percentage of Therapist Statements Accurately Discriminated Regarding Their Goodness of Fit in Maloney's Categories of Requested Verbal Behaviour

Judges' Assessment of Statement	Accuracy of Discrimination					
	Correct		Incorrect		Total	
	N	%	N	%	N	%
Inclusion in Category	49	44.9	8	7.3	57	52.3
Rejection from Category	47	43.1	5	4.6	52	47.7
Total	96	88.1	13	11.9	109	

Table 8

Number and Percentage of Therapist Statements Accurately Discriminated Regarding Their Goodness of Fit in Barry's Categories of Requested Verbal Behaviour

Judges' Assessment of Statement	Accuracy of Discrimination					
	Correct		Incorrect		Total	
	N	%	N	%	N	%
Inclusion in Category	40	51.3	7	9.0	47	60.3
Rejection from Category	31	39.7	0	00.0	31	39.7
Total	71	91.0	7	9.0	78	

Of the 109 statements selected from Maloney's case, the judges correctly included and correctly excluded 96 statements, or 88.1%. The judges' level of accuracy is slightly higher for Barry's case than for Maloney's case. Of 78 statements selected from Barry's case, 71 statements, or 91.1%, were included or rejected correctly. In both therapy cases, the judges' ratings did not correspond perfectly to the researcher's assignments. However, in the large majority of cases there does seem to be a goodness-of-fit between the categories of requested verbal behaviour and the therapist statements that were assigned to these categories.

The sample of statements presented to the judges also included 271 statements that had been tentatively assigned to the various categories, but where the researcher felt unsure about the goodness-of-fit. How many of these therapist statements fit the categories to which they had been previously assigned by the researcher? Of the 171 statements in Maloney's case, the judges agreed that 117, or 68.4%, fit the categories to which they were assigned. Of the 100 statements in Barry's case, the judges agreed that 79, fit the categories to which they were assigned. Overall, for both therapists, 75 statements, or 27.7%, did not fit the categories to which they had been tentatively assigned, either because the judges agreed that the statements did not fit the category (51 statements, or

18.8%) or because they failed to reach agreement (24 statements, or 8.9%). With the exception of statements assigned to categories 1 and 2, those statements that did not fit the categories were either discarded or reassigned to other categories (see Chapter 2, pp. 105-107 for more information on application and use of the rating in this phase). Overall, 196 statements, or 72.3%, were rated as fitting the categories to which they had been assigned. These findings indicate that, even in those instances where the researcher was unsure about the goodness-of-fit, the majority of statements did fit the categories to which they had been previously assigned.

In summary, the findings of phase 3 of this research indicate that the researcher's assignment of the therapist statements to the various categories was fairly reliable. In the large majority of cases the judges' ratings did correspond to the researcher's original assignments. The majority of therapist statements were judged to fit the categories of requested verbal behaviour to which they had been previously assigned There does seem to be a fairly adequate goodness-of-fit between the therapist statements and the categories of requested verbal behaviour to which they were assigned.

Results of Phase 4: The Degree of Client Conformity to Therapist Statements as Requests for Verbal Behaviour

The first three phases of this investigation focused on the therapists' statements as requests for verbal behaviour. The fourth phase of this investigation proceeded to focus on the clients' immediate response to these requests. The client statements were given a rating on a four-point scale of client conformity and acquiescence to the requests for verbal behaviour contained in the antecedent therapist statements. The following sections present the results of the fourth phase of this study in light of the questions and hypotheses that have been put forth earlier.

The judges' level of agreement in rating the client statements will be reported first. The subsequent sections examine the extent to which each client manifests the verbal behaviours that are requested in antecedent therapist statements. Specifically, these sections present the findings of this research in answer to the following questions: (1) What is the overall level of client conformity to the therapist's antecedent requests for verbal behaviour? (2) Does the level of client conformity increase over the course of therapy? (3) Does the level of client opposition to antecedent requests correspond to particular stages of therapy? (4) Are there progressive developments in the quality of the client's responses over the course of

sessions? (5) Does the level of client conformity vary depending on the category of requested verbal behaviour?

Level of Inter-Rater Agreement

Six judges examined the client statements on a four-point client response rating scale. The criterion level of agreement was set at 66.6%. That is, to be assigned a certain rating, four out of 6 judges had to agree on the rating. Overall, the judges reached criterion level of agreement on 825 out of 1040 client statements, or 79.3%. Judges agreed on 476 out of 604 client statements, or 78.8%, in Maloney's case. In their ratings of Barry's therapy case, judges agreed on 349 out of 436 statements, or 80%. The level of interrater agreement for each category of requested verbal behaviour is presented in Appendix F. The level of interrater agreement tended to be similar and consistent across categories, with the exception of categories 4, 6 and 7 in the Maloney's case. In these three categories the level of interrater agreement was lower than in the other categories of requested verbal behaviour.

The results presented above indicate that, for the majority of client statements, the judges did agree on the extent to which the client manifested the requested verbal behaviour. In order to maximize the number of client statements, the judges' response biases were taken into consideration; where necessary, a master judge's previous (i.e., independent) ratings were used as a tie breaker (as

described in Chapter 2, p. 114). The final number and percentage of client statements in each category of requested verbal behaviour that were assigned a rating presented in Appendix G. Overall, 1000 out of the 1040 client statements, or 96.2%, received a rating and were examined in subsequent analyses. The 40 statements that were not assigned a rating were discarded from further analysis.

Overall Level of Client Conformity

What was the overall level of client conformity to therapist statements as requests for verbal behaviour? This first question refers to the occurrence of requested verbal behaviours in general, collapsing across sessions and across categories of requested verbal behaviour for each therapy case. In Maloney's case, only two (0.3%) of the 584 client statements were rated as active refusal (see Table 9, p. 149). Passive avoidance accounted for 104, or 17.8%, of the client's responses. The overall levels of partial conformity and full compliance were nearly identical, with 236 statements, or 40.4%, rated as partial conformity, and 242 statements, or 41.4%, rated as full compliance. The number of instances in which the client manifested the requested verbal behaviour, either partly or fully, was significantly higher than the number of instances in which the client refused to conform or avoided the request ($\underline{X}^2$ =272.71, df=3, $\underline{p}$<.001). The chi square was still

significant when the frequencies of active refusal and passive avoidance were combined ($\underline{X}^2$=60.67, df=2, $\underline{p}$<.001). Partial and full conformity combined account for 81.8% of the client's responses. Overall, Maloney's client tended to conform to the requests for verbal behaviour contained in antecedent therapist statements. In Maloney's case there were moderately high levels of partial conformity and full compliance, a moderate degree of passive avoidance, and a very low degree of outright refusal.

Out of the 416 client statements in Barry's case, 154 statements, or 37%, were rated as partial conformity, and 254 statements, or 61.1%, were rated as full compliance (see Table 10, p. 149). None of the statements were rated as active refusal and only eight statements, or 1.9%, were rated as passive avoidance. The frequencies in the four client response rating groups were significantly different than what might be expected from an even distribution ($\underline{X}^2$=433.0, df=3, $\underline{p}$<.001). In this case too, the $\underline{chi}$ square was significant when two of the client response groups, active refusal and passive avoidance, were collapsed into one cell ($\underline{X}^2$= 220.75, df=2, $\underline{p}$<.001). The number of instances of active refusal and passive avoidance were significantly lower than the frequency of partial or full compliance. In this case the number of instances in which the client manifested the requested verbal behaviours to a full extent was markedly higher than the number of

statements indicative of partial conformity. Partial conformity and full compliance combined accounted for 98.1% of the client statements. Thus, overall, Barry's client tended to conform to the requests for verbal behaviour contained in antecedent therapist statements. In Barry's case, there was a high degree of manifesting the requested verbal behaviour to a full extent, a moderately high degree of doing it partly, and a very low degree of passive avoidance.

While in both cases the clients tended to conform to the behavioural requests contained in antecedent therapist statements, the two therapy cases did differ significantly from each other. The researcher combined the frequencies of two of the client response rating groups, active refusal and passive avoidance. Expected frequencies would be too low if active refusal was kept as a separate response group. The Chi Square showed that the frequency of non-conformity was significantly greater in Maloney's case than in Barry's case ($X^2 = 75.69$, df=2, $p < .001$). Observed frequency of full compliance was lower than the expected frequency for Maloney and higher than the expected frequency for Barry. Thus Barry's client manifested a higher level of full compliance to antecedent requests for verbal behaviour.

Hypothesis 1: Level of Client Conformity Over the Course of Therapy

What was the level of conformity to therapist

statements as behavioural requests in each of the six sessions representing the beginning, middle, and end of therapy? Did the level of client conformity change over the course of sessions? The expectation in this research, stated in the first hypothesis, was that over the series of six sessions, there would be increasing occurrence of the requested verbal behaviours. Specifically, it was expected that the proportion of client statements rated as either partial conformity (3) or full compliance (4) on the Client Response Rating Scale would be significantly higher in the two final sessions of therapy than in the beginning and middle sessions.

The overall findings in this research are presented in Tables 9 to 12 and Figures 1 to 4. The number and percentage of statements classified as active refusal (1), passive avoidance (2), partial conformity (3), and full compliance (4) in each of the six sessions are presented in Table 9 and Table 10. These results were also combined (sessions 1 and 2, sessions 3 and 4, sessions 5 and 6) and are presented as three stages of therapy in Tables 11 and 12. A graphic representation of the clients' pattern of responses over the six sessions is presented in Figures 1 and 2, and over the three stages in Figures 3 and 4. These figures depict the increases and decreases across therapy in the percentage of client statements that fell into each of the client response rating groups.

Table 9

Overall Distribution of Client Responses Across Sessions in Maloney's Case

	Session [a]													
	1 (2)		2 (3)		3 (7)		4 (10)		5 (15)		6 (16)		Total	
Client Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Active Refusal	0	0	0	0	0	0	2	2.4	0	0	0	0	2	0.3
Passive Avoidance	26	26.5	14	12.6	38	29.5	10	12.2	5	6.7	11	12.4	104	17.8
Partial Conformity	41	41.8	39	35.1	53	41.1	28	34.1	34	45.3	41	46.1	236	40.4
Full Compliance	31	31.6	58	52.3	38	29.5	42	51.2	36	48.0	37	41.6	242	41.4
Total	98		111		129		82		75		89		584	

[a] Numbers in parentheses represent actual session numbers in this therapy case.

Table 10

Overall Distribution of Client Responses Across Six Sessions in Barry's Case

	Session [a]													
	1 (1)		2 (3)		3 (10)		4 (11)		5 (17)		6 (18)		Total	
Client Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Passive Avoidance	1	1.4	2	3.5	2	3.1	0	0	2	2.4	1	1.6	8	1.9
Partial Conformity	31	44.9	21	36.8	21	32.3	31	38.8	32	38.6	18	29.0	154	37.0
Full Compliance	37	53.6	34	59.6	42	64.6	49	61.3	49	59.0	43	69.4	254	61.1
Total	69		57		65		80		83		62		416	

Note: There were no instances of active refusal in this therapy case.

[a] Numbers in parentheses represent actual session numbers in this therapy case.

Figure 1
Overall Pattern of Client Responses
Across Sessions in Maloney's Case

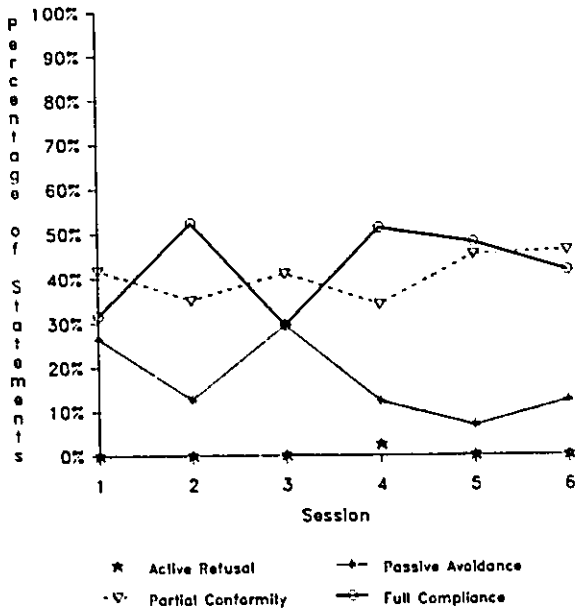
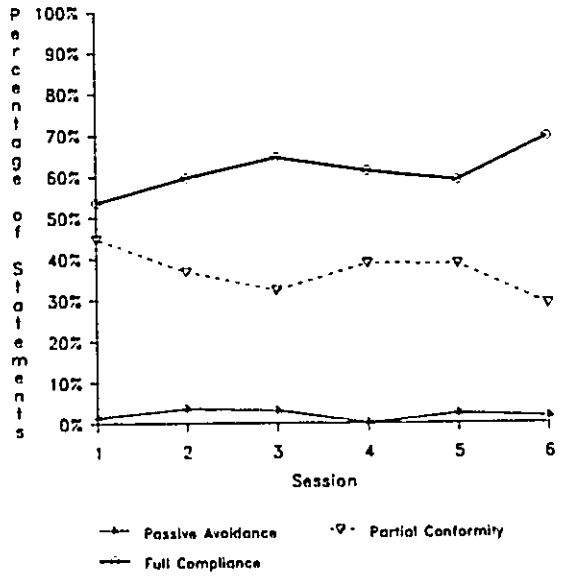


Figure 2
Overall Pattern of Client Responses
Across Sessions in Barry's Case



Note: There were no instances of active refusal in this therapy case

Table 11

Overall Distribution of Client Responses
Across Stages in Maloney's Case

	Stage of Therapy						
	Initial		Middle		Final		Total
Client Response	N	%	N	%	N	%	N
Active Refusal	0	0	2	0.9	0	0	2
Passive Avoidance	40	19.1	48	22.7	16	9.8	104
Partial Conformity	80	38.3	81	38.4	75	45.7	236
Full Compliance	89	42.6	80	37.9	73	44.5	242
Total	209		211		164		584

Table 12

Overall Distribution of Client Responses
Across Stages in Barry's Case

	Stage of Therapy						
	Initial		Middle		Final		Total
Client Response	N	%	N	%	N	%	N
Passive Avoidance	3	2.4	2	1.4	3	2.1	8
Partial Conformity	52	41.3	52	35.9	50	34.5	154
Full Compliance	71	56.3	91	62.8	92	63.4	254
Total	126		145		145		416

Note: There were no instances of active refusal in this case.

Figure 3
Overall Pattern of Client Responses
Across 3 Stages in Maloney's Case

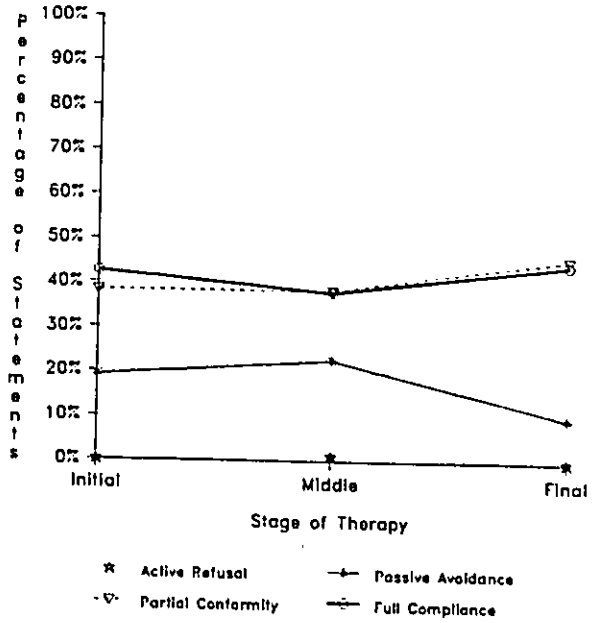
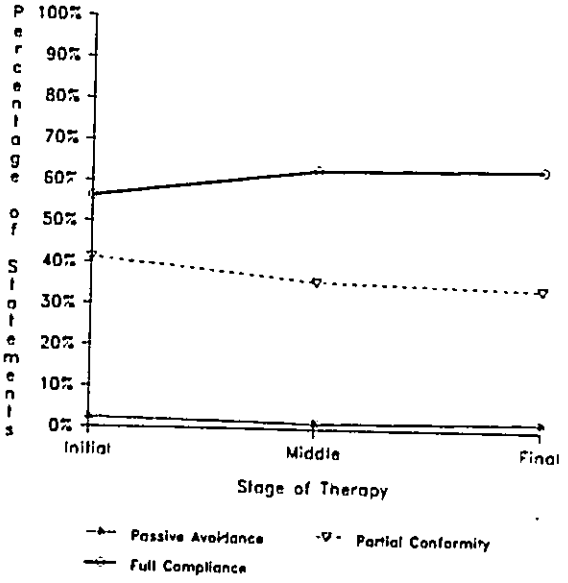


Figure 4
Overall Pattern of Client Responses
Across 3 Stages in Barry's Case



Note: There were no instances of active refusal in Barry's case

The findings presented in these tables and figures will be discussed in the following sections with regard to the first hypothesis. The results for Maloney's case will be presented first, followed by the results for Barry's case.

Case One - Maloney. What was the level of conformity to antecedent requests in each of the six sessions? Partial and full conformity to antecedent requests accounted for (a) 73.4% of the target client statements in session 1, (b) 87.4% of the statements in session 2, (c) 70.6% of the statements in session 3, (d) 85.3% of the statements in session 4, (e) 93.3% of the statements in session 5, and (f) 87.7% of the statements in session 6. In general, the level of conformity to the requests contained in antecedent therapist statements was high throughout the six sessions.

Did the level of conformity change over the course of the six sessions? When the frequency of conformity (partial conformity and full compliance) versus nonconformity (active refusal and passive avoidance) was analyzed across sessions, there was a significant difference between the six sessions ($\underline{X}^2 = 27.29$, df=5, $\underline{p}<.001$). There were significant fluctuations in the level of conformity over the course of the six sessions.

Was there an increase in conformity to antecedent requests over the course of the sessions? The percentage of statements in which the client conformed to the antecedent requests was clearly higher in the last two sessions than in

sessions 1 and 3 ($\underline{X}^2$=20.99, df=3, $\underline{p}$<.001). However, the level of conformity in the last two sessions was not significantly greater than the level of conformity in sessions 2 and 4 ($\underline{X}^2$=2.64, df=3, .30<$\underline{p}$<.50). What sets the last two sessions apart is that the level of conformity was high and the level of nonconformity was relatively low in both sessions ($\underline{X}^2$=1.5, df=1, .20<$\underline{p}$<.30). Whether this consistency implies that the level of conformity was significantly and meaningfully higher in the final sessions of therapy is questionable. Nor can it be concluded that there was consistently increasing conformity to antecedent requests over the course of sessions.

Thus, the findings show that the level of conformity was generally high throughout the six sessions. Rather than increasing steadily over the course of these sessions, the level of conformity fluctuated from session to session. The level of conformity in the last two sessions was somewhat higher than in two of the previous four sessions. Therefore, with regard to the first hypothesis, the findings do offer some support, albeit weak and only partial support.

When the findings are analyzed in terms of stages of therapy, did the level of sheer conformity to antecedent requests for verbal behaviour change over the course of the three stages of therapy? Partial and full conformity to antecedent requests accounted for 80.9% of the client statements in the beginning stage of therapy, 76.3% of the statements in the middle stage, and 90.2% of the statements

in the final stage of therapy. When the rates of conformity (partial conformity and full compliance) and nonconformity (active refusal and passive avoidance) across stages were analyzed, there was a significant difference between the three stages ($\underline{X}^2$= 12.29, df=2, $\underline{p}$<.01). The level of conformity did change over the course of the three stages. There was a slight but insignificant decrease in conformity from the initial to the middle stage of therapy ($\underline{X}^2$=1.3, df=1, .20<$\underline{p}$<.30) and then an increase in the final stage of therapy. The level of conformity was significantly higher in the final stage of therapy than in the beginning ($\underline{X}^2$ =6.34, df=1, $\underline{p}$<.02) and middle ($\underline{X}^2$=12.37, df=1, $\underline{p}$<.001) stages. Thus, when the findings are analyzed in terms of stages of therapy, the results support the first hypothesis.

With regard to Hypothesis 1, the findings for Maloney's case may be summarized as follows. The level of conformity was significantly higher in the last two sessions than in two of the previous four sessions of therapy. The level of conformity was significantly higher, and the degree of nonconformity significantly lower, in the final stage of therapy than in the initial and middle stages. These findings tend to support the first hypothesis. However, given the absence of large and substantial increases in the level of conformity, the support for the first hypothesis is weak.

In addition, the findings show that the level of conformity fluctuated significantly from session to session

(in the first four sessions) in Maloney's case. However, even with these fluctuations, the level of conformity to the requests for verbal behaviour was generally high throughout the six sessions and three stages.

Case Two - Barry. What was the level of conformity to antecedent requests in each of the six sessions? Partial and full conformity to antecedent requests accounted for (a) 98.5% of the target client statements in session 1, (b) 96.4% of the statements in session 2, (c) 96.9% of the statements in session 3, (d) 100% of the statements in session 4, (e) 97.6% of the statements in session 5, and (f) 98.4% of the statements in session 6. The level of conformity to the requests contained in antecedent therapist statements was consistently very high across the six sessions.

Did the level of conformity change over the course of the six sessions? It was not possible to test for statistically significant differences in the distribution of conformity versus nonconformity across the six sessions because the number of statements rated as passive avoidance was too low. However, given the percentages presented above, it is highly unlikely that the level of conformity changed significantly over the course of the six sessions. Client conformity to antecedent requests was not higher in the last two sessions than in the previous four sessions. The occurrence of requested verbal behaviours did not

increase over the course of the sessions. The findings do not support the prediction put forth in the first hypothesis. Instead, the findings show that the level of conformity in this case was consistently and invariably very high throughout the six sessions.

Analysis of the findings in terms of stages of therapy yielded similar results. Partial and full conformity to antecedent requests accounted for 97.6% of the client statements in the beginning stage of therapy, 98.7% of the statements in the middle stage, and 97.9% of the statements in the final stage of therapy. Rather than increasing over the course of therapy, conformity to antecedent requests for verbal behaviour was consistently high across the three stages. The number of statements rated as passive avoidance in each stage was still too low for a Chi Square analysis. However, it is highly unlikely that the difference between stages represents a significant change in the level of conformity to antecedent requests. These findings do not support the first hypothesis.

In summary, the findings in Barry's case consistently indicate that the level of conformity and acquiescence to antecedent requests for verbal behaviour did not increase, or change significantly, over the course of therapy. The level of conformity was essentially the same, and consistently high, across the six sessions and over the three stages of therapy. Thus, for the case conducted by

Barry, hypothesis 1 is rejected.

Hypothesis 2: Opposition to Antecedent Requests for Verbal Behaviour Over the Course of Therapy

The focus of the previous section was on the degree of client conformity over the ccurse of therapy. The present section will examine the occurrence of client statements indicative of lack of conformity, compliance, or acquiescence. As was the case in the previous section, the questions and hypotheses refer to nonconformity in general, regardless of the category of requested verbal behaviour.

The second hypothesis in this research stated that in the middle stage of therapy, as opposed to initial and final stages, there would be decreasing conformity and increasing opposition to the antecedent requests for verbal behaviour. Given a session by session analysis of the degree of client conformity and acquiescence to antecedent requests for verbal behaviour, it was expected that the highest incidence of passive avoidance and active refusal (nonconformity) on the part of the client would occur in the third and fourth sessions of each series. It was also be expected that there would be relatively more client statements rated as 1 or 2 (active refusal or passive avoidance) in the middle stage of therapy than in either the initial or final stages of each therapy case.

The findings of this research with regard to the second hypothesis will be presented in the following sections. The

results for the therapy case conducted by Maloney will be reviewed first, followed by the results for Barry's therapy case.

Case One - Maloney. In this case, opposition to antecedent requests for verbal behaviour was usually manifested as passive avoidance of the request (see Tables 9 and 11). Only two of the 106 instances in which the client did not comply with the antecedent requests were rated as active refusal to manifest the requested verbal behaviour.

The percentage of client statements rated as active refusal or passive avoidance (nonconformity) ranged from a low of 9.8% of the statements in the final stage of therapy to a high of 23.6% of the statements in the middle stage of therapy (see Table 11 and Figure 3). With 19.1% of the statements classified as not conforming to antecedent requests, the level of nonconformity in the initial stage of therapy was only slightly lower than the level of nonconformity in the middle stage.

In Maloney's case, the lowest level of conformity and highest level of opposition to antecedent requests for verbal behaviour was found in the middle stage of therapy. When the frequency of conformity (partial conformity and full compliance) and nonconformity (active refusal and passive avoidance) across stages was analyzed, there was a significant difference between the three stages ($\underline{X}^2$=

12.285, df=2, $p<.01$). Further analyses showed that there was no significant difference between the initial and middle stages of therapy in the level of conformity versus nonconformity ($X^2=1.3$, df=1, $.20<p<.30$). Thus, the level of nonconformity in the middle stage of therapy did not reflect a very large and dramatic increase in client opposition to antecedent requests. However, the level of nonconformity was significantly higher in the middle stage of therapy than in the final stage ($X^2=12.37$, df=1, $p<.001$). Therefore, when the findings in Maloney's case are examined in terms of stages of therapy, the second hypothesis is partially confirmed.

What is the level of nonconformity to antecedent requests for verbal behaviour when the findings are examined in each of the six sessions? The percentage of client responses rated as active refusal or passive avoidance ranged from a low of 6.7% of the statements in the fifth session to a high of 29.5% in the third session of therapy (see Table 9 and Figure 1). When the frequency of conformity (partial conformity and full compliance) and nonconformity (active refusal and passive avoidance) was analyzed across sessions, there was a significant difference between the six sessions ($X^2= 27.29$, df=5, $p<.001$). The rate of nonconformity fluctuated significantly across sessions.

Did the highest incidence of nonconformity on the

part of the client occur in the middle sessions of the therapy case? Of the two middle sessions, only session three was characterized by an increased level of opposition and a decreased level of conformity. This was not the case in the fourth session. In session four, active refusal and passive avoidance accounted for only 14.6% of the client statements. The level of nonconformity in this session was not significantly different from the level of nonconformity in sessions two, five, and six ($\underline{X}^2$ =2.64, df=3, .30<$\underline{p}$<.50). On the other hand, a comparison of sessions three and four indicated that there was a significant difference between these two sessions in the level of conformity versus nonconformity ($\underline{X}^2$=6.09, df=1, $\underline{p}$<.02). Thus, examination of the findings on a session by session basis reveals that the level of nonconformity was not consistently elevated in both of the sessions that represent the middle stage of therapy.

Thus, when the findings were examined session by session, the second hypothesis was partly confirmed. The hypothesis was supported by the findings for session three but not by the findings for session four. The third session did have the highest incidence of nonconformity. The level of nonconformity in that session did appear to be significantly higher than in four of the five remaining sessions. However, the percentage of the statements in which the client did not comply with the antecedent

request for verbal behaviour was only slightly and insignificantly higher in session three than in the first session ($\underline{X}^2$=.24, df=1, .50<p<.70). The presence of a moderately high level of client nonconformity in the first session, and a relatively low level of opposition to antecedent requests in the fourth session, suggests that in this case increased levels of client opposition may not necessarily be a function of the stages and phases of therapy.

In summary, when nonconformity over the course of therapy is examined in Maloney's case, the second hypothesis seems to be partly confirmed. There was a significant difference between the three stages and between the six sessions in the client's level of opposition to antecedent requests. The level of nonconformity was significantly higher in the middle stage of therapy than in the final stage of therapy. However, closer inspection reveals that, of the two middle sessions, the level of nonconformity was significantly elevated only in session three. The low level of client nonconformity in the fourth session did not indicate decreasing conformity and increasing opposition in the middle stage of therapy. Moreover, the level of client opposition in the first session of the therapy case was only slightly lower than the level of opposition in the third

session. The latter two findings do not support the presence of a relationship between client opposition and stages of therapy in this case.

Case Two - Barry. With Barry's client, opposition to antecedent requests for verbal behaviour manifested itself as passive avoidance of the request. Direct refusal to manifest the requested verbal behaviour was absent in this therapy case. The level of nonconformity to antecedent requests was consistently very low throughout the three stages and six sessions of therapy. The percentage of client statements rated as passive avoidance ranged from a low of 1.4% of the statements in the middle stage of therapy to a high of 2.4% of the statements in the initial stage of therapy (see Table 12 and Figure 4). When each session was examined individually, the percentage of statements rated as not conforming to the antecedent requests ranged from a low of 1.4% of the statements in the first session to a high of 3.5% of the statements in the second session (see Table 10 and Figure 2).

The frequency of passive avoidance was too low for a chi square analysis of the distribution of nonconformity and conformity across sessions or stages. However, it is highly unlikely that there was a significant difference between sessions or between stages in the distribution of nonconformity to antecedent requests for verbal behaviour. The results are rather straightforward in Barry's case.

Opposition to antecedent requests for verbal behaviour did not increase in the middle sessions of the therapy case. The middle stage of therapy were not characterized by decreasing conformity and increasing opposition. For Barry's client the second hypothesis is rejected.

Hypothesis 3: Progressive Developments in the Quality of Client Responses to the Behavioural Requests

The 4-point client response rating scale makes it possible to go beyond a dichotomy of conformity versus nonconformity in the examination of the clients' responses to antecedent requests for verbal behaviour. The scale attempts to address qualitative aspects of the clients' responses, specifically (a) how fully the client manifests the requested verbal behaviour when the client does comply with the antecedent request, and (b) the form in which opposition manifests itself when the client does not comply with the antecedent request for verbal behaviour. It is therefore possible to examine progressive developments in the quality of the clients' responses to antecedent requests over the course of the six sessions.

The third hypothesis stated that, given examination of the findings for each response type on the four-point scale, there would be progressive developments in the quality of the clients' responses to antecedent requests for verbal behaviour. That is, progressive developments would occur in the full expression of requested verbal behaviours

and in outright refusal to conform to the requests. The early sessions of therapy would be characterized mainly by client responses that reflect weak or partial expression and indirect avoidance of the requested verbal behaviours. The final sessions of therapy would be characterized mainly by strong, full manifestation of the requested verbal behaviours. If opposition occured in the final sessions, it was expected to be expressed as direct, outright refusal to conform to the requests contained in the therapist statements.

These expected differences between the initial and final sessions in the quality of the client's responses did not occur in either of the therapy cases. In Maloney's case, there was no significant difference between the initial and final stages of therapy in the level of full compliance versus passive avoidance and partial conformity ($\underline{X}^2$=.14, df=1, .50<$\underline{p}$<.70). Partial conformity and passive avoidance accounted for 57.4% of the client statements in the initial stage of therapy, and for 55.5% of the statements in the final stage (see Table 11). Full compliance accounted for 42.6% of the client statements in the first stage of therapy, as opposed to 44.5% of the statements in the final stage. These findings show a striking consistency in the quality of the client's responses in the beginning and final phases of therapy. The level of full conformity was moderately high, and equally so

in the initial and final stages of therapy.

A closer look at the first and last two sessions reveals that there were significant differences among the four sessions in the frequency of full compliance versus passive avoidance and partial conformity ($\underline{X}^2$=9.83, df=3, $\underline{p}$<.05). Passive avoidance and partial conformity accounted for (1) 68.3% of the client statements in the first session, (2) 47.7% of the statements in the second session, (3) 52% of the statements in the fifth session, and (4) 58.4% of the statements in the sixth session. Full compliance accounted for (1) 31.7% of the statements in the first session, (2) 52.3% of the statements in the second session, (3) 48% of the statements in the fifth session, and (4) 41.6% of the statements in the sixth session. As these percentages indicate, there was a greater difference between sessions one and two than between the initial and final sessions. The combined level of partial conformity and passive avoidance exceeded the level of full compliance in the first session, as well as in the two final sessions. While the level of full compliance was moderately high in the final two sessions, neither of these sessions were characterized primarily by full expression of the requested verbal behaviours.

In Barry's case, there were no significant differences between the initial and final stages of therapy ($\underline{X}^2$=1.42, df=1, .20<$\underline{p}$<.30), or between the four sessions ($\underline{X}^2$=3.47,

df=3, .30<p<.50) in the frequency of full compliance versus passive avoidance or partial conformity. Passive avoidance and partial conformity accounted for (1) 43.7% of the client statements in the first stage of therapy (session 1 = 46.4%, session 2 = 40.4%), and (2) 36.6% of the statements in the final stage of therapy (session 5 = 41%, session 6 = 30.6%). Full compliance accounted for (1) 56.3% of the statements in the inital stage of therapy (session 1 = 53.6%, session 2 = 59.6%), and (2) 63.4% of the statements in the final stage of therapy (session 5 = 59%, session 6 = 69.4%). The majority of client statements in both the initial and final sessions of therapy reflected full compliance with the antecedent requests for verbal behaviour.

Thus, the findings in both therapy cases did not support the third hypothesis. The combined level of partial conformity and passive avoidance was not higher in the initial stage of therapy than in the final stage. The level of full compliance was not significantly higher in the final stage of therapy than in the initial stage of therapy. The findings did not indicate the presence of progressive developments in the quality of the client's responses over the course of therapy. Instead, they show that the initial and final stages of therapy are quite similar in the extent to which the client fully manifests the requested verbal behaviours.

The findings also did not confirm the specific

predictions regarding the pattern of full compliance, partial conformity, passive avoidance, and direct refusal over the course of therapy. It was hypothesized that the percentage of client statements rated as full compliance would increase over the course of sessions. In Maloney's case there were significant fluctuations in the level of full compliance across sessions ($\underline{X}^2$=11.58, df=5, $\underline{p}$<.05). However, the level of full compliance did not increase over the course of therapy (see Table 9). If anything there was a slight gradual decrease over the last three sessions. In Barry's case the slight increases in the proportion of full compliance over the course of sessions (see Figure 2) were not found to be statistically significant ($\underline{X}^2$= 2.35, df=5, .70<$\underline{p}$<.80). The findings indicate that the level of full compliance was consistently high throughout the six sessions (see Table 10).

It was hypothesized that the percentage of client statements rated as partial conformity would decrease over the course of sessions. There was no significant difference among the sessions in the percentage of statements rated as partial conformity in Maloney's case ($\underline{X}^2$=3.12, df=5, .50<$\underline{p}$< .70) or Barry's case ($\underline{X}^2$=4.19, df=5, .50<$\underline{p}$<.70). In both cases there were moderately high levels of partial conformity throughout the six sessions (see Tables 9 & 10).

It was hypothesized that the percentage of client statements rated as passive avoidance would decrease from

the middle to the final sessions. In Maloney's case, there were significant fluctuations across the six sessions in the percentage of statements classified as passive avoidance ($\underline{X}^2$ =24.19, df=5, $\underline{p}$<.001). The level of passive avoidance was lower in the fifth session than in the third session (6.7% versus 29.5% of the client statements). However, the level of passive avoidance was nearly identical in the fourth and sixth sessions (12.2% and 12.4%). At best, these findings may be regarded as providing weak support for this prediction in Maloney's case. In Barry's case, the level of passive avoidance did not decrease from the middle to the final sessions. The incidence of passive avoidance was very low throughout the six sessions, ranging from a low of 1.4% of the statements in sesson 1 to a high of 3.5% of the statements in session 2 (see Table 10).

There were only two instances of direct refusal in Maloney's case and none in Barry's. These findings do not support the prediction that direct opposition increases from the initial to the middle stage of therapy, and then decreases in the final stage. Moreover, the findings do not indicate that any opposition to the therapists' requests in the final sessions of therapy is in the form of open, direct refusal.

In summary, the findings did not substantiate the predictions regarding progressive developments in the quality of the client's responses over the course of

therapy. In Barry's case, the levels of passive avoidance, partial conformity, and full compliance were stable and consistent throughout the six sessions. The findings in Maloney's case did not indicate that the degree (fullness) of conformity and the type of opposition correspond to particular stages of therapy. There were significant fluctuations from session to session in the levels of passive avoidance and full compliance, but no consistent downward or upward trends in the quality of the client's responses.

The Level of Client Conformity to Categories of Requested Verbal Behaviour

To what extent does the level of client conformity to the therapist's requests change, depending on the kinds of verbal behaviour that the therapist is inviting? Does the same pattern of client response to antecedent requests occur in all categories of requested verbal behaviour? If not, which categories differ from the overall pattern that was found in each therapy case? The findings will be presented in the following sections for Maloney's case and Barry's case respectively.

Conformity in Maloney's Categories of Requested Verbal Behaviour. The session by session findings for each of the nine categories of requested verbal behaviour by Maloney are presented in Tables 13 to 21 and Figures 5 to 13. The tables report the number and percentage of client

statements in each session (where the category occurred) rated as active refusal, passive avoidance, partial conformity, and full compliance. The figures are a graphic representation of the client's pattern of responses over the sessions in which the category occurred. They depict the increases and decreases across therapy in the percentage of client statements that fell in each applicable response classification. (The stage by stage findings for Maloney's categories are given in Appendix H in Tables H.1 to H.7 and Figures H.1 to H.7.)

The level of client conformity in Maloney's case was found to vary, depending on the type of verbal behaviour requested by the therapist. The chi square analysis indicated that there was a significant difference between the categories in the levels of nonconformity (active refusal and passive avoidance), partial conformity, and full compliance (χ^2=155.28, df=14, $p<.001$). (In this analysis the researcher compared the combined frequency across sessions in the first eight categories of requested verbal behaviour. The frequency in category 9 was too low.) The level of nonconformity was greater than expected in categories 5 and 6, but relatively low in categories 1, 4, and 7. The level of partial conformity exceeded the expected frequency in categories 1 and 2, but was relatively lower in categories 5, 6, 7, and 8. The observed level of full compliance was greater than expected in categories 4,

Table 13

Distribution of Client Responses Across Sessions for Category 1 in Maloney's Case

	Session [a]													
	1 (2)		2 (3)		3 (7)		4 (10)		5 (15)		6 (16)		Total	
Client Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Active Refusal	0	0	0	0	0	0	1	4.2	0	0	0	0	1	0.5
Passive Avoidance	0	0	4	7.4	1	4.3	4	16.7	1	3.6	4	10.0	14	6.7
Partial Conformity	27	69.2	21	38.9	17	73.9	6	25.0	17	60.7	22	55.0	110	52.9
Full Compliance	12	30.8	29	53.7	5	21.7	13	54.2	10	35.7	14	35.0	83	39.9
Total	39		54		23		24		28		40		208	

[a] Numbers in parentheses represent actual session numbers.

Table 14

Distribution of Client Responses Across Sessions for Category 2 in Maloney's Case

	Session [a]													
	1 (2)		2 (3)		3 (7)		4 (10)		5 (15)		6 (16)		Total	
Client Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Active Refusal	0	0	0	0	0	0	1	7.1	0	0	0	0	1	1.5
Passive Avoidance	1	16.7	2	33.3	5	27.8	1	7.1	0	0	1	8.3	10	14.7
Partial Conformity	5	83.3	2	33.3	9	50.0	8	57.1	5	41.7	6	50.0	35	51.5
Full Compliance	0	0	2	33.3	4	22.2	4	28.6	7	58.3	5	41.7	22	32.4
Total	6		6		18		14		12		12		68	

[a] Numbers in parentheses represent actual session numbers.

Figure 5
Pattern of Client Responses Across
Sessions in Category 1 – Maloney

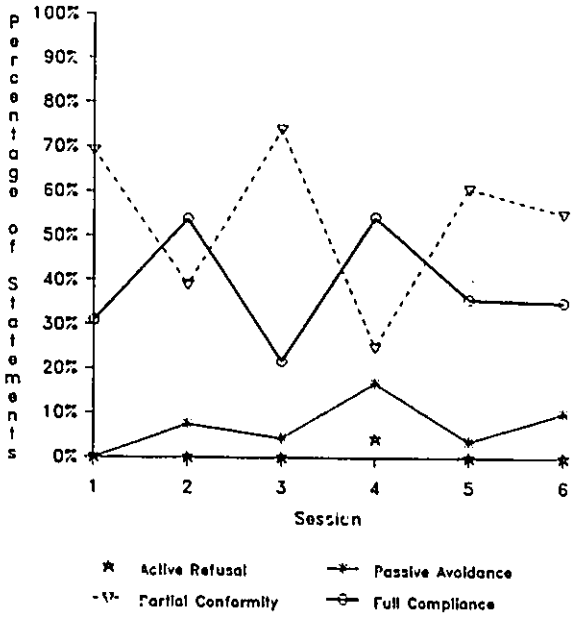


Figure 6
Pattern of Client Response Across
Sessions in Category 2 – Maloney

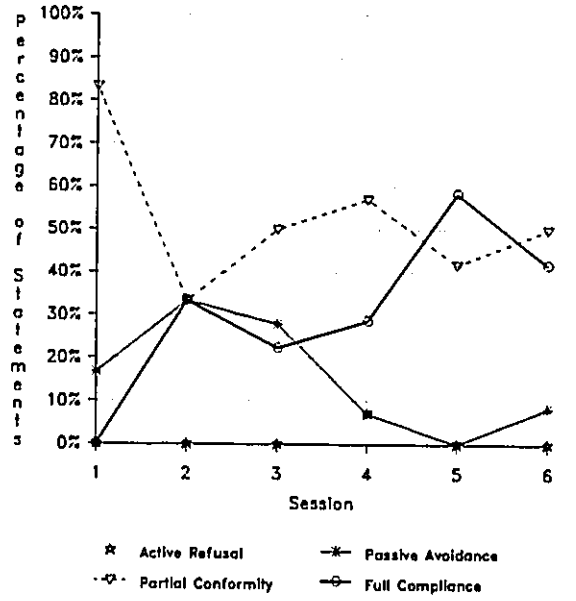


Table 15

Distribution of Client Responses Across Sessions for Category 3 in Maloney's Case

	Session [a]													
	1 (2)		2 (3)		3 (7)		4 (10)		5 (15)		6 (16)		Total	
Client Response [b]	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Passive Avoidance	8	50.0	2	9.5	4	28.6	0	0	0	0	4	22.2	18	20.2
Partial Conformity	4	25.0	8	38.1	8	57.1	9	69.2	4	57.1	6	33.3	39	43.8
Full Compliance	4	25.0	11	52.4	2	14.3	4	30.8	3	42.9	8	44.4	32	36.0
Total	16		21		14		13		7		18		89	

[a] Numbers in parentheses represent actual session numbers.

[b] There were no instances of active refusal in Category 3.

Table 16

Distribution of Client Responses Across Sessions for Category 4 in Maloney's Case

	Session [a]													
	1 (2)		2 (3)		3 (7)		4 (10)		5 (15)		6 (16)		Total	
Client Response [b]	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Passive Avoidance	0	0	2	15.4	1	11.1	1	11.1	0	0	1	6.7	5	8.2
Partial Conformity	4	44.4	5	38.5	2	22.2	2	22.2	4	66.7	7	46.7	24	39.3
Full Compliance	5	55.6	6	46.2	6	66.7	6	66.7	2	33.3	7	46.7	32	52.5
Total	9		13		9		9		6		15		61	

a Numbers in parentheses represent actual session numbers.

b There were no instances of active refusal in Category 4.

Figure 7
Pattern of Client Reponses Across
Sessions in Category 3 – Maloney

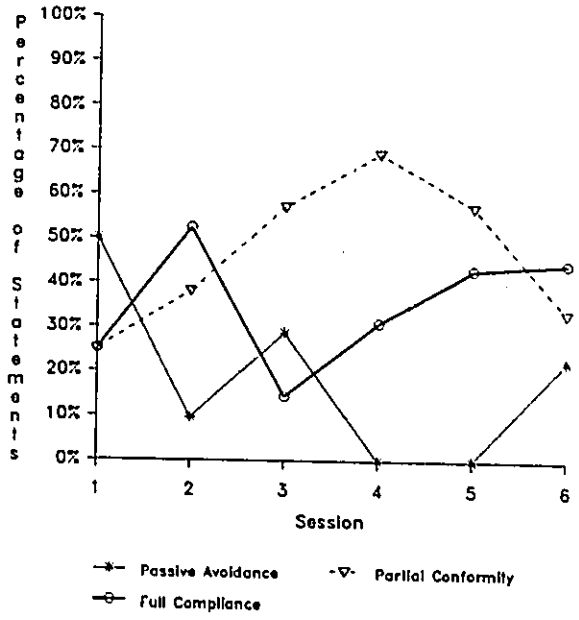


Figure 8
Pattern of Client Responses Across
Sessions in Category 4 – Maloney

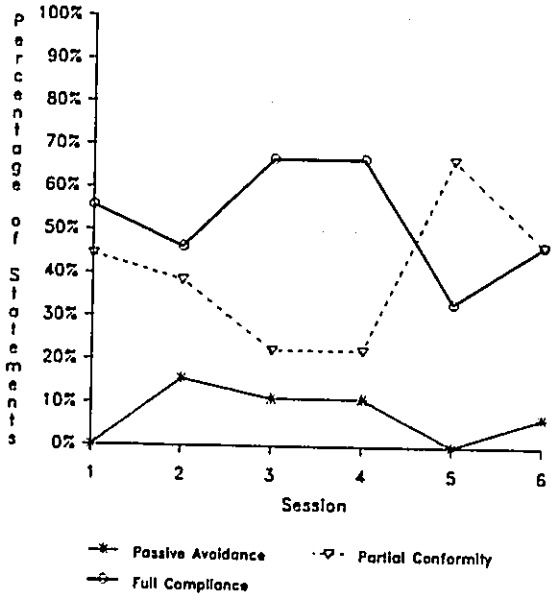


Table 17

Distribution of Client Responses Across Sessions for Category 5 in Maloney's Case

	Session [a]											
	1 (2)		2 (3)		3 (7)		4 (10)		6 (16)		Total	
Client Response [b]	N	%	N	%	N	%	N	%	N	%	N	%
Passive Avoidance	7	100.0	4	100.0	16	53.3	3	60.0	0	0	30	63.8
Partial Conformity	0	0	0	0	7	23.3	1	20.0	0	0	8	17.0
Full Compliance	0	0	0	0	7	23.3	1	20.0	1	100.0	9	19.2
Total	7		4		30		5		1		47	

Note: This category of requested verbal behaviour did not emerge in Session 5 (15).

[a] Numbers in parentheses represent actual session numbers.

[b] There were no instances of active refusal in Category 5.

Table 18

Distribution of Client Responses Across Sessions for Category 6 in Maloney's Case

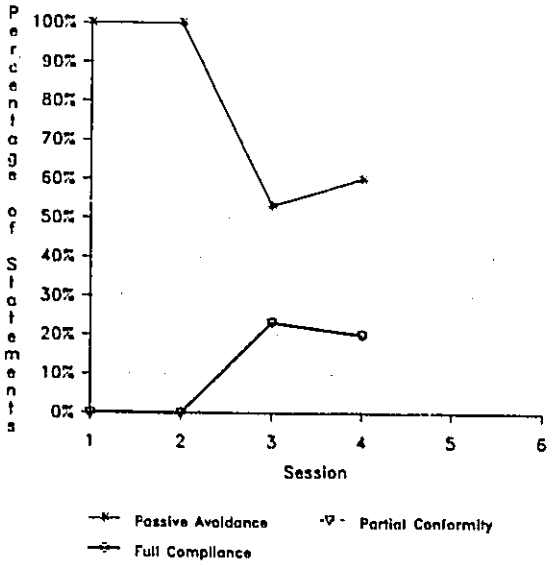
	Session [a]							
	1 (2)		3 (7)		5 (15)		Total	
Client Response [b]	N	%	N	%	N	%	N	%
Passive Avoidance	1	33.3	8	34.8	4	36.4	13	35.1
Partial Conformity	1	33.3	7	30.4	3	27.3	11	29.7
Full Compliance	1	33.3	8	34.8	4	36.4	13	35.1
Total	3		23		11		37	

Note: This category of requested verbal behaviour did not emerge in Sessions 2 (3), 4 (10), and 6 (16).

[a] Numbers in parentheses represent actual session numbers.

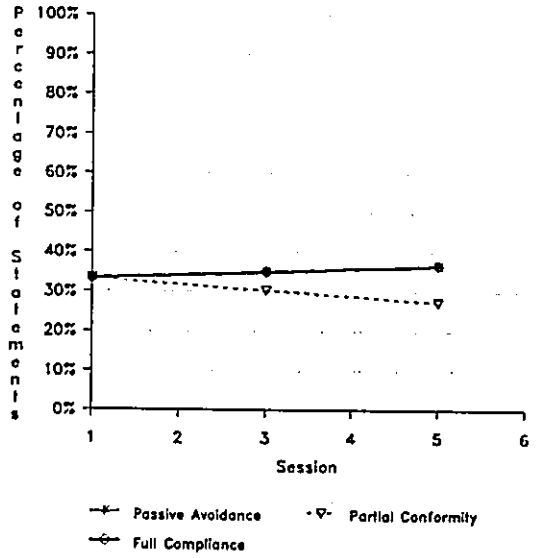
[b] There were no instances of active refusal in Category 6.

Figure 9
Pattern of Client Reponses Across
Sessions in Category 5 – Maloney



Note: This category did not occur in session 5 and had only one instance in session 6 (rated as full compliance)

Figure 10
Pattern of Client Responses Across
Sessions in Category 6 – Maloney



Note: This category did not occur in sessions 2, 4 and 6.

Table 19

Distribution of Client Responses Across Sessions for Category 7 in Maloney's Case

	Session [a]													
	1 (2)		2 (3)		3 (7)		4 (10)		5 (15)		6 (16)		Total	
Client Response [b]	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Partial Conformity	0	0	0	0	0	0	1	16.7	1	12.5	0	0	2	6.5
Full Compliance	8	100.0	2	100.0	5	100.0	5	83.3	7	87.5	2	100.0	29	93.5
Total	8		2		5		6		8		2		31	

[a] Numbers in parentheses represent actual session numbers.

[b] There were no instances of active refusal or passive avoidance in Category 7.

Table 20

Distribution of Client Responses Across Sessions for Category 8 in Maloney's Case

	Session [a]													
	1 (2)		2 (3)		3 (7)		4 (10)		5 (15)		6 (16)		Total	
Client Response [b]	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Passive Avoidance	2	66.7	0	0	1	50.0	1	9.1	0	0	1	100.0	5	16.7
Partial Conformity	0	0	3	30.0	0	0	1	9.1	0	0	0	0	4	13.3
Full Compliance	1	33.3	7	70.0	1	50.0	9	81.8	3	100.0	0	0	21	70.0
Total	3		10		2		11		3		1		30	

[a] Numbers in parentheses represent actual session numbers.

[b] There were no instances of active refusal in Category 8.

Figure 11
Pattern of Client Responses Across
Sessions in Category 7 – Maloney

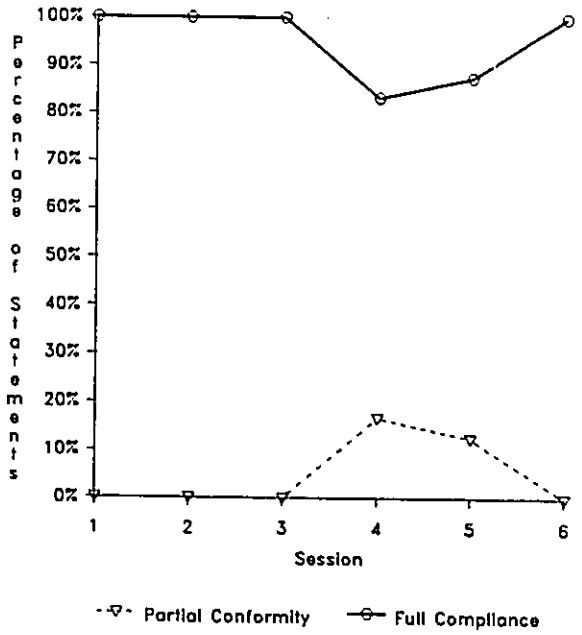
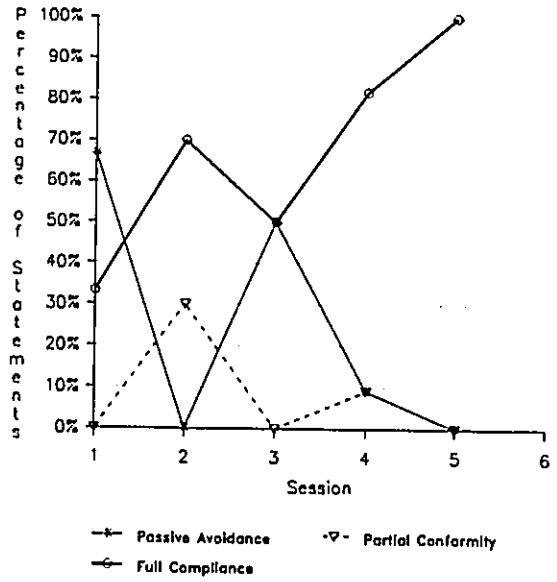


Figure 12
Pattern of Client Responses Across
Sessions in Category 8 – Maloney



Note: Session 6 had only 1 instance
of category 8.

Table 21

Distribution of Client Responses Across Sessions for Category 9 in Maloney's Case

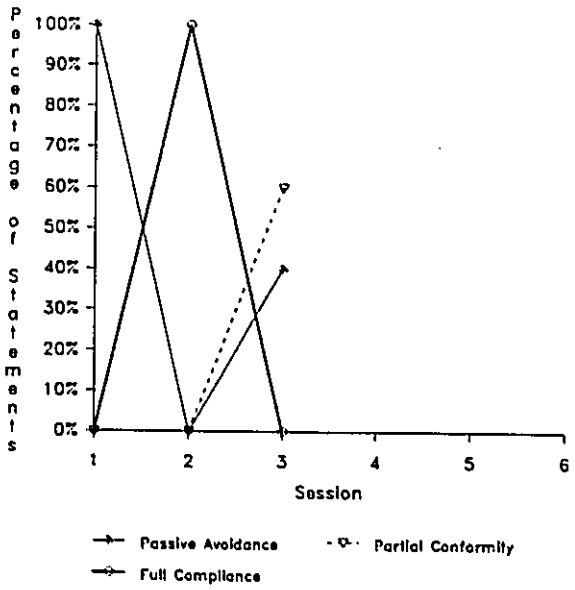
	Session [a]							
	1 (2)		2 (3)		3 (7)		Total	
Client Response [b]	N	%	N	%	N	%	N	%
Passive Avoidance	7	100.0	0	0	2	40.0	9	69.2
Partial Conformity	0	0	0	0	3	60.0	3	23.1
Full Compliance	0	0	1	100.0	0	0	1	7.7
Total	7		1		5		13	

Note: This category of requested verbal behaviour did not emerge in Sessions 4 (10), 5 (15) and 6 (16).

[a] Numbers in parentheses represent actual session numbers.

[b] There were no instances of active refusal in Category 9.

Figure 13
Pattern of Client Responses Across
Sessions in Category 9 – Maloney



Note: Category 9 did not occur in sessions 4, 5 and 6. Percentages in session 2 are based on an N of 1.

7, and 8, and was relatively lower in categories 1, 2, 3, and 5. Thus, the level of conformity to antecedent requests was not the same in all categories of requested verbal behaviour.

Which categories differ from the overall pattern that was found in Maloney's case? As presented earlier in this chapter, the general, overall findings in this case (collapsing across sessions and categories) indicated (1) a moderately high degree of full compliance (41.4%), (2) a moderately high degree of partial conformity (40.4%), (3) a moderate degree of passive avoidance (17.8%), and (4) a very low degree of outright refusal (.3%). Chi square analyses indicated that there were significant differences between these general findings and the findings for categories 1, 5, 6, 7, and 8.

There was a significant difference between category 1 and the overall findings in the levels of nonconformity, partial conformity, and full compliance (χ^2=17.56, df=2, p<.001). In category 1, there was (1) a high level of partial conformity (52.9%), (2) a moderately high level of full compliance (39.9%), (3) a low level of passive avoidance (6.7%), and (4) a very low level of outright refusal (.5%). The general trend was similar in category 1 and in the overall findings. For the most part, the client responded to requests to consider the therapist's words and acknowledge, confirm, or agree by manifesting the requested

verbal behaviour either partially or fully. However, compared to the overall findings, there was a significantly higher level of partial conformity and a lower level of nonconformity in category 1. Examination of the pattern of client responses across sessions indicated that the higher levels of partial conformity in category 1 occurred in sessions 1, 3, 5, and 6 (see Table 13 and Figure 5). Whereas in the overall findings the level of passive avoidance was higher in sessions 1 and 3, in category 1 the level of passive avoidance was consistently low across sessions.

There was a significant difference between category 5 and the overall findings in the frequency of nonconformity, partial conformity, and full compliance ($\underline{X}^2=53.7$, df=2, $\underline{p}<.001$). In category 5, there was (1) a high level of passive avoidance (63.8%), (2) a moderate level of full compliance (19.2%), and (3) a moderate level of partial conformity (17%). There were no incidents of outright refusal in this category of requested verbal behaviour. Instead of manifesting moderately high levels of partial and full conformity and a moderate level of passive avoidance, the client did the opposite in category 5. When the therapist instructed the client to speak directly to the other person, the client tended to avoid manifesting the requested verbal behaviour. The level of passive avoidance was higher than the levels of partial and full conformity in

each session (see Figure 9). Table 17 indicates that category 5 occurred with greatest frequency in the third session. Accordingly, the client's high level of avoidance in this category of requested verbal behaviour is one factor that contributed to the overall findings of greater nonconformity in the third session of therapy.

There was a significant difference between category 6 and the overall findings in the frequency of nonconformity, partial conformity, and full compliance ($\underline{X}^2$=6.57, df=2, $\underline{p}$<.05). When requested to role play and speak as another person or some specific aspect of himself, the client responded with moderately high and nearly equal levels of passive avoidance (35.1%), partial conformity (29.7%), and full compliance (35.1%). The level of passive avoidance was significantly higher in category 6 than in the overall findings. Figure 10 indicates that this was the case for each session in which this category occurred. Category 6 also occurred with greatest frequency in the third session (see Table 18). Accordingly, the client's high level of avoidance in this category of requested verbal behaviour is another factor that contributed to the overall findings of greater nonconformity in the third sessions of therapy.

There was a significant difference between category 7 and the overall findings in the frequency of nonconformity, partial conformity, and full compliance ($\underline{X}^2$=32.54, df=2, $\underline{p}$<.001). The client consistently responded to requests for

simple repetition and clarification with a very high level of full compliance (93.5%). In category 7 there was a low level of partial conformity (6.5%), and no incidents of passive avoidance or outright refusal. Throughout the six sessions, the level of full compliance was much higher in category 7 than in the overall findings (see Table 19 and Figure 11). Throughout the six sessions, the levels of passive avoidance and partial conformity were much lower in category 7 than in the overall findings.

There was a significant difference between category 8 and the overall findings in the frequency of nonconformity, partial conformity, and full compliance ($\underline{X}^2$=10.82, df=2, $\underline{p}$<.01). When requested to repeat and/or modify specific words, sentences, and sounds, the client manifested (1) a high level of full compliance (70%), (2) a moderate level of passive avoidance (16.7%), and (3) a moderate level of partial conformity (13.3%). There were no incidents of outright refusal in this category of requested verbal behaviour. The level of full compliance was significantly higher in category 8 than in the overall findings. The level of partial conformity was significantly lower in category 8 than in the overall findings.

The findings for category 9 showed that the client responded to requests to state a decision, choice, or preference with (1) a high level of passive avoidance (69.2%), (2) a moderate level of partial conformity (23.1%),

and (3) a low level of full compliance (7.7%). The percentage of statements rated as passive avoidance was much higher in category 9 than in the overall findings. The levels of partial conformity and full compliance were lower in category 9 than in the overall findings. However, given the low frequency of statements in category 9 (N=13), it was not possible to ascertain whether these differences between category 9 and the overall findings in the distribution of client responses were statistically significant.

Chi square analyses indicated that there were no significant differences between the general findings and the findings for category 2 ($\underline{X}^2$=3.17, df=2, .20<$\underline{p}$<.30), category 3 ($\underline{X}^2$=5.55, df=2, .05<$\underline{p}$<.10), and category 4 ($\underline{X}^2$= 4.77, df=2, .05<$\underline{p}$<.10) in the overall distribution of opposition, partial conformity and full compliance. However, these categories were somewhat different from the overall findings in the pattern of client responses across sessions. (Statistical significance was not ascertained.) In category 2 there was a lower level of full compliance in the initial and middle sessions of therapy. Therefore, compared to the overall findings, there appears to be an upward trend in the level of full compliance in category 2 (see Figure 6). Compared to the overall findings, there was a greater difference between the levels of partial conformity and full compliance in the middle sessions in categories 3 and 4 (see Tables 15 and 16, Figures 7 and 8). In category 3, there was a higher

level of partial conformity and a lower level of full compliance in the middle sessions. In category 4, there was a higher level of full compliance and a lower level of partial conformity in the middle sessions. Categories 3 and 4 also differed slightly from the overall findings with regard to the level of passive avoidance in the six sessions. In category 3, there was a higher level of passive avoidance in the first and sixth sessions. Category 4 did not have elevated levels of passive avoidance in the first and third sessions. The level of passive avoidance was low throughout the six sessions in category 4. Thus, when the degree of conformity in each session was examined, there were some (relatively minor) differences between the overall findings and categories 2, 3, and 4 in the pattern (levels) of client response across sessions. Despite these differences, the overall levels of nonconformity, partial conformity, and full compliance in these categories still resembled the general, overall findings for this therapy case.

In summary, in Maloney's case the level of client conformity to the therapist's requests did vary, depending on the kinds of verbal behaviour that the therapist was inviting. Some categories did not differ significantly from the overall pattern that was found in this therapy case. The overall findings indicated that the client generally responded to the therapist's antecedent requests with

moderately high levels of partial and full conformity and a moderate level of passive avoidance. The client's responses in categories 2, 3, and 4 resembled this general pattern (i.e., differences were not statistically significant). On the other hand, the client's responses in categories 1, 5, 6, 7, and 8 were significantly different from this general, overall pattern.

In category 1, the client responded to requests to acknowledge, confirm, or agree with the antecedent therapist statement by manifesting a significantly higher level of partial conformity and less passive avoidance. The client responded to requests to speak directly to the other person (category 5) and to speak as another person or some aspect of self (category 6) with significantly higher levels of passive avoidance. (This was true for category 9 as well but frequencies were too low to determine statistical significance.) The client responded to requests for simple repetition/clarification (category 7) and requests to repeat/modify specific sentences and sounds (category 8) with much higher levels of full compliance and much lower levels of partial conformity. Thus, in Maloney's case the pattern of client response is not the same for all categories of requested verbal behaviour. The levels of client conformity and opposition differ depending on the type of verbal behaviour that is requested.

Conformity in Barry's Categories of Requested Verbal Behaviour. The session by session findings for each of the five categories of requested verbal behaviour by Barry are presented in Tables 22 to 26 and Figures 14 to 18. The tables report the number and percentage of client statements in each session rated as passive avoidance, partial conformity, and full compliance. The figures are a graphic representation of the client's pattern of responses over the sessions. They depict the increases and decreases across therapy in the percentage of client statements that fell in each applicable response classification. (The stage by stage findings for each of Barry's categories are given in Appendix I in Tables I.1 to I.4 and Figures I.1 to I.4.)

In Barry's case, the overall level of client conformity was similar in each category of requested verbal behaviour. There were no significant differences between categories in the overall levels of passive avoidance and partial conformity versus full compliance (χ^2=4.41, df=3, p<.30). (The chi square analysis compared the combined frequency across sessions in the first four categories. The frequency of statements in category 5 was too low. Due to the low frequency of indirect opposition, passive avoidance and partial conformity were treated as one response classification.) Thus, in Barry's case, the level of client conformity to the therapist's requests does not vary depending on the kinds of verbal behaviour that the therapist is inviting. The client's responses to antecedent

Table 22

Distribution of Client Responses Across Sessions for Category 1 in Barry's Case

	Session [a]													
	1 (1)		2 (3)		3 (10)		4 (11)		5 (17)		6 (18)		Total	
Client Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Passive Avoidance	0	0	1	2.7	2	5.8	0	0	0	0	0	0	3	1.3
Partial Conformity	23	46.9	15	40.5	11	32.4	18	52.9	23	45.1	6	24.0	96	41.7
Full Compliance	26	53.1	21	56.8	21	61.8	16	47.1	28	54.9	19	76.0	131	57.0
Total	49		37		34		34		51		25		230	

[a] Numbers in parentheses represent actual session numbers.

Table 23

Distribution of Client Responses Across Sessions for Category 2 in Barry's Case

	Session [a]													
	1 (1)		2 (3)		3 (10)		4 (11)		5 (17)		6 (18)		Total	
Client Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Passive Avoidance	1	7.7	0	0	0	0	0	0	0	0	0	0	1	1.0
Partial Conformity	7	53.8	4	33.3	7	35.0	4	16.6	5	41.7	7	31.8	34	33.0
Full Compliance	5	38.5	8	66.7	13	65.0	20	83.3	7	58.3	15	68.2	68	66.0
Total	13		12		20		24		12		22		103	

[a] Numbers in parentheses represent actual session numbers.

Figure 14
Pattern of Client Responses Across
Sessions in Category 1 – Barry

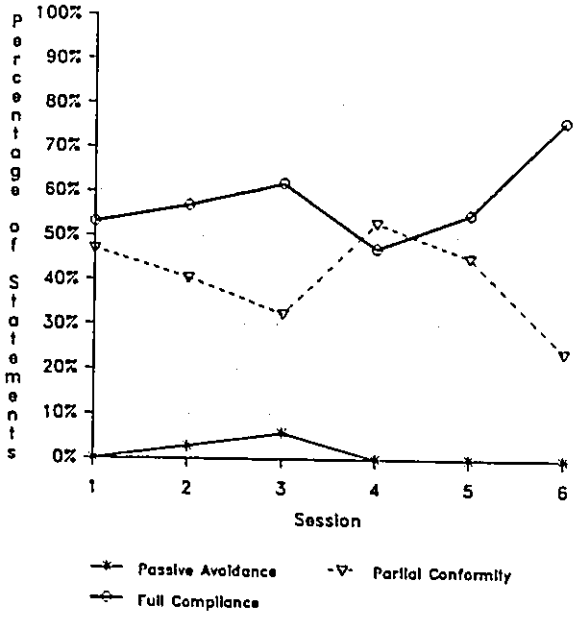


Figure 15
Pattern of Client Responses Across
Sessions in Category 2 – Barry

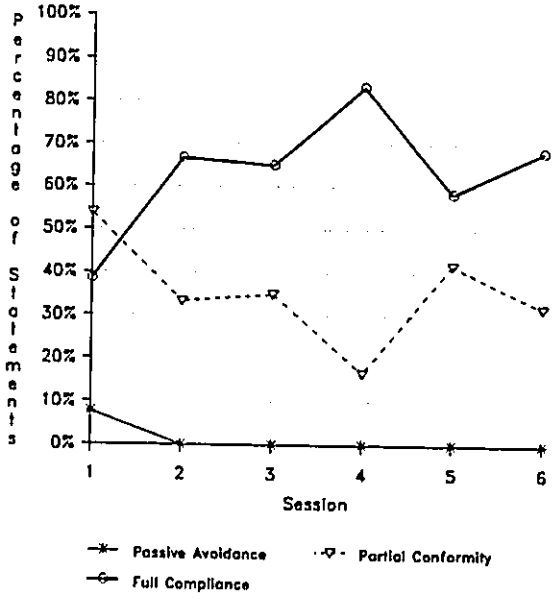


Table 24

Distribution of Client Responses Across Sessions for Category 3 in Barry's Case

	Session [a]													
	1 (1)		2 (3)		3 (10)		4 (11)		5 (17)		6 (18)		Total	
Client Response	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Passive Avoidance	0	0	1	25.0	0	0	0	0	1	12.5	1	25.0	3	8.8
Partial Conformity	1	25.0	1	25.0	1	20.0	3	33.3	1	12.5	1	25.0	8	23.5
Full Compliance	3	75.0	2	50.0	4	80.0	6	66.7	6	75.0	2	50.0	23	67.6
Total	4		4		5		9		8		4		34	

[a] Numbers in parentheses represent actual session numbers.

Table 25

Distribution of Client Responses Across Sessions for Category 4 in Barry's Case

	Session [a]													
	1 (1)		2 (3)		3 (10)		4 (11)		5 (17)		6 (18)		Total	
Client Response [b]	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Partial Conformity	0	0	1	33.3	2	33.3	5	41.7	0	0	4	36.4	12	30.8
Full Compliance	1	100.0	2	66.7	4	66.7	7	58.3	6	100.0	7	63.6	27	69.2
Total	1		3		6		12		6		11		39	

[a] Numbers in parentheses represent actual session numbers.

[b] There were no instances of passive avoidance in Category 4.

Figure 16
Pattern of Client Responses Across
Sessions in Category 3 – Barry

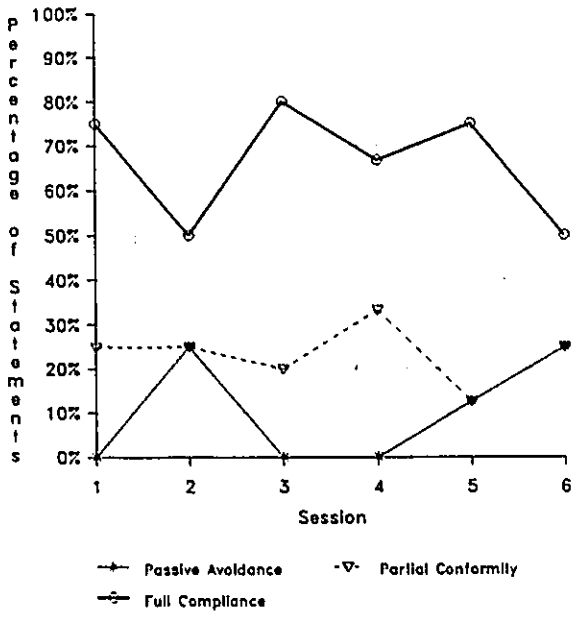
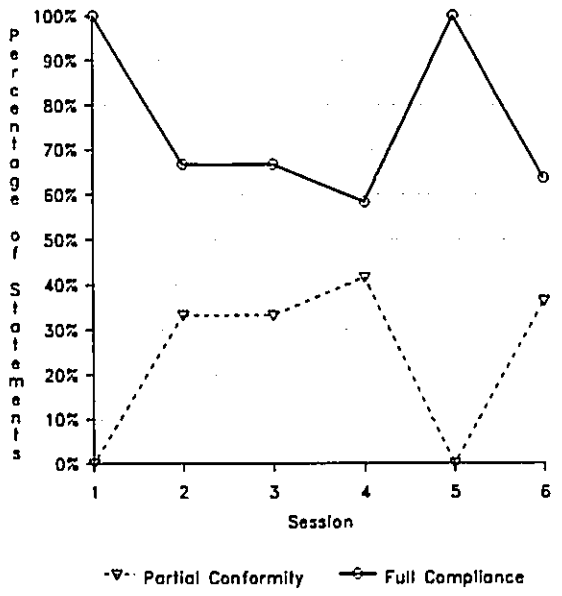


Figure 17
Pattern of Client Responses Across
Sessions in Category 4 – Barry



Note: Percentages in session 1 are based on an N of 1.

Table 26

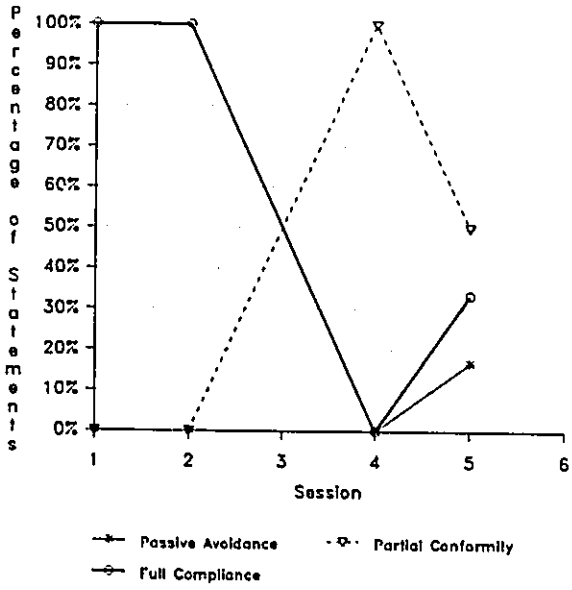
Distribution of Client Responses Across Sessions for Category 5 in Barry's Case

	Session [a]									
	1 (1)		2 (3)		4 (11)		5 (17)		Total	
Client Response	N	%	N	%	N	%	N	%	N	%
Passive Avoidance	0	0	0	0	0	0	1	16.7	1	10.0
Partial Conformity	0	0	0	0	1	100.0	3	50.0	4	40.0
Full Compliance	2	100.0	1	100.0	0	0	2	33.3	5	50.0
Total	2		1		1		6		10	

Note: Category 5 did not occur in sessions 3 (10) and 6 (18).

[a] Numbers in parentheses represent actual session numbers.

Figure 18
Pattern of Client Responses Across Sessions in Category 5 – Barry



Note: Category 5 did not occur in sessions 3 & 6. Percentages are based on very low frequencies.

requests are similar in all categories of requested verbal behaviour.

The distribution of passive avoidance, partial conformity, and full compliance in each category of requested verbal behaviour resembled the general, overall pattern found in Barry's case. As presented earlier in this chapter, the general pattern of client response in Barry's case was (1) a high degree of full compliance (61.1%), (2) a moderately high degree of partial compliance (37%), and (3) a very low degree of passive avoidance (1.9%). There were no significant differences between this general pattern and the overall findings for category 1 ($\underline{X}^2$=1.03, df=1, .30<$\underline{p}$<.50), category 2 ($\underline{X}^2$=.86, df=1, .30<$\underline{p}$<.50), category 3 ($\underline{X}^2$=.58, df=1, .30<$\underline{p}$<.50), and category 4 ($\underline{X}^2$=1.01, df=1, .30<$\underline{p}$<.50). Barry's client responded to each category of requests with a high degree of full compliance and a moderately high degree of partial conformity. With the exception of category 4, in which there were no instances of passive avoidance, the client manifested a low level of passive avoidance in each category of requested behaviour.

There were only slight differences between each category and the overall findings in the pattern of client responses across sessions. In category 1, the levels of full compliance and partial conformity converge in sessions 4 and 5 (see Figure 14). Therefore, compared to the overall findings, there was a smaller difference in category

1 between the levels of full compliance and partial conformity in these two sessions. Compared to the overall findings, in category 2 there was a larger difference between the levels of full compliance and partial conformity in the fourth session of therapy (see Figure 15). In Category 3, the level of partial conformity is slightly but consistently lower throughout the six sessions (see Figure 16). The client's responses in some of the sessions in in categories 3, 4, and 5 (see Figures 16, 17, and 18) appear to be different from the overall findings (see Figure 2). However, these categories occurred with relatively low frequencies per session and, therefore, some of the percentage levels are inflated (see Tables 24, 25, and 26). When the low frequencies are taken into consideration, the pattern of client responses across sessions in these categories is similar to the overall findings. On the whole, each category of requested verbal behaviour resembled the overall findings in the pattern of client responses across the six sessions.

In summary, the general findings in Barry's case are also applicable to each category of requested verbal behaviour. The overall level of client conformity to the therapist's requests did not differ, depending on the type of verbal behaviour that was requested. The categories had similar patterns of client response across sessions. In each category of requested verbal behaviour, and in almost

every session, Barry's client manifested a high level of full compliance, moderate to moderately high levels of partial conformity, and low (or very low) levels of passive avoidance.

CHAPTER IV

DISCUSSION

The purpose of this chapter is to discuss the findings, especially with regard to the implications for practitioners and for psychotherapy research. The discussion will include some methodological and procedural issues pertaining to the examination of therapist statements as behavioural requests, and of client statements as responses to these requests. A summary of the main findings and conclusions is provided at the end of the chapter.

Therapist Statements as Behavioural Requests

A large proportion of the therapists' statements in both therapy cases was found to contain requests for verbal behaviour (66.3%). The results of this research are highly consistent with previous indications regarding the prevalence of behavioural requests in therapist statements. Mahrer and colleagues (in press) found that 70% of therapist statements in three sessions by Joan Fagan contained behavioural requests. Though Friedlander (1982) did not examine therapist statements as behavioural requests, she did find that the majority of the therapist statements in selected segments of initial (67%) and second (65%) interviews had either a high or moderate degree of structure. As is the case in the present research, her

findings indicated that a large percentage of therapist statements structure what is to follow by circumscribing the form and content of the client's response.

Given the large proportion of therapist statements that was found to contain behavioural requests, this research serves to highlight a useful perspective on therapists' communication. It is possible to view therapist statements in terms of the behavioural requests that they contain. The findings of this research indicated that a significant proportion of therapists' statements may be regarded as communication acts that instruct, direct, or invite the client to respond in a particular manner and to carry out given behaviours (cf. Labov & Fanshel, 1977; Searle, 1969, 1976; Shapiro, 1979; Strong & Claiborn, 1982; Watzlawick, 1978). By designating the kinds of verbal behaviour that clients are to manifest in their subsequent statements, therapists' statements serve to guide the client in the therapeutic process (subtly or overtly, explicitly or implicitly, intentionally or unintentionally).

Some of the recent research on influence in psychotherapy focuses on the extent to which each participant initiates and determines the topics that are discussed within the session (e.g., Tracey, 1985; Tracey & Ray, 1984). The results of the present investigation suggest that, regardless of who initiates the topic under discussion, therapists have a strong influence on clients' in-therapy behaviour because many of their statements contain requests that channel and steer the clients' subsequent behaviour (cf. Labov & Fanshel, 1977; Strong & Claiborn, 1982; Watzlawick, 1978). Stating that a large proportion of therapist statements contains behavioural requests does not necessarily mean that the therapist initiated the topic under discussion (cf. Friedlander & Phillips, 1984; Tracey & Ray, 1984). For example, the client may introduce his relationship with his wife as an issue he wishes to address. The therapist may follow the topic that the client initiated. Nevertheless, the therapist may still steer the discourse in a certain

direction by asking the client for general information about his wife (category 4), or inviting the client to describe his feelings about the relationship (category 3), or instructing the client to talk directly to his wife in fantasy in the session (category 5), or by communicating his own impressions of the relationship and (directly or indirectly) inviting the client to confirm and agree with those impressions. Thus, even when therapists do not initiate and determine the topic that will be discussed, much of their communication may well serve to direct the client's immediately subsequent verbal behaviour and, thereby, to guide and influence the therapeutic process.

The proportion of therapist statements that would contain behavioural requests was not presented as a main hypothesis in the present study. This was only put forth as an interesting research question in the first chapter. However, the findings may be of interest to researchers and practitioners. Given that a large proportion of therapist statements seem to contain behavioural requests, it may be important for practitioners to be aware of this component of their statements and to be careful with the wording of their statements (cf. Wachtel, 1980). Moreover, given the frequent occurrence of behavioural requests, it may be useful for therapists to recognize the presence of client statements as responses to the therapist's antecedent requests (at least in part).

Variability across therapists in the proportion of statements containing behavioural requests. The findings showed that within each therapy case the proportion of therapist statements containing behavioural requests was similar (i.e., relatively stable) across sessions. The percentage of statements containing requests ranged from 49% to 64% in Maloney's sessions, and from 86% to 93% in Barry's sessions. On the other hand, there was a significant difference between the two therapists. The overall proportion of therapist statements that contained behavioural requests was consistently higher in Barry's sessions (88.8%) than in Maloney's sessions (56.6%). Thus, while the proportion of therapist statements containing behavioural requests is generally high, this finding suggests that there may be significant differences between therapists in the extent to which their communication guides and directs the client's subsequent response.

Categories of Requested Verbal Behaviour.

The requests for verbal behaviour were organized into nine categories in Maloney's case and five categories in Barry's case. Some categories of requested verbal behaviour were found to occur in both therapy cases. Other categories were found in one therapy case but not the other. While some categories of requested verbal behaviour occurred with high frequency, others occurred with relatively low frequency. The therapists' statements contained both

direct, explicit requests for verbal behaviour and indirect and implicit requests. These observations regarding the categories of requested verbal behaviour will be discussed in the following sections.

Commonalities and differences in the types of requests that therapists make. Some categories of requested verbal behaviour occurred in both therapy cases. These categories include requests to (a) acknowledge, confirm or agree with the therapist statement (category 1), (b) answer yes or no to the therapists' direct and indirect questions (category 2), (c) provide psychological descriptions, assessments, and explanations of oneself, other people, and events (category 3), and (d) provide general, factual information about oneself, other people, and situations (category 4).

It is not surprising to find that, at the level of general categories, there are commonalities in the types of requests that therapists make. Intuitively, it makes sense that in both cases the therapists' statements contained requests to describe feelings and thoughts, to assess and explain the client's own behaviour or other people's actions, to understand and explain situations psychologically (category 3). It also makes sense that both these therapist asked for general, factual information about the client, or about people and events in the client's life (category 4). Similarly, it is not surprising to find that both therapists asked closed questions that invited a yes or

no response from the client (category 2). It is also not unexpected to find that both therapists shared their own understanding (impressions, views, observations, descriptions, assessments, etc.) of the client, or of people and events in the client's life, and that the client is (implicitly or explicitly) invited to agree or confirm (category 1). At the general level, these are not categories of requested verbal behaviour that one would expect to apply only to specific therapeutic approaches.

It must be noted, however, that this commonality applies only at the level of general categories. A common category of requested verbal behaviour does not mean that the statements made by these two therapists contained the same specific requests. For example, while category 1 was found in both therapy cases, the clients were not invited to confirm or agree with the same things. Therapists' understanding of their clients (i.e., their descriptions, observations, impressions, interpretations, assessments, etc.) differ from one case to another, one therapist to another and one therapeutic approach to another. Similarly, there were differences in the specific types of information (factual and psychological) that the clients were requested to provide. The actual content of therapist statements and the specific requests for verbal behaviour (within common categories) are likely to vary across clients, therapists, and therapeutic approaches.

In addition, some general categories were found in one therapy case but not the other. The categories in Maloney's case included requests (1) to speak directly to the other person (category 5), (2) to play the role of and speak as another person or part of self (category 6), (3) for simple repetition (category 7), (4) to repeat/modify specific words and sounds (category 8), and (5) to state a decision, choice or preference (category 9). These categories of requested verbal behaviour were not found in Barry's case. Given that Maloney's approach to psychotherapy is primarily Gestalt, the presence of categories 5, 6, and 8 in his case makes sense. These categories of requested verbal behaviour reflect techniques (e.g., Gestalt two-chair) that are commonly used by Gestalt therapists. These findings suggest that at least some of the requests contained in therapist statements will reflect specific approaches to psychotherapy.

The findings suggest a method that can be used to identify commonalities and differences across therapeutic approaches. The study of therapist statements as behavioural requests can be used to identify therapist interventions that are common to different psychotherapeutic orientations. It can also be used to identify unique features that distinguish one approach to psychotherapy from another. This line of inquiry might be of interest to researchers and practitioners who are concerned with issues

of integration in psychotherapy. The present investigation examined one therapist whose primary orientation was Gestalt and another therapist whose approach was psychodynamic (object relations). Future research on therapist statements as behavioural requests may be extended to other approaches to psychotherapy (e.g., cognitive and behavioural). This avenue of research may lead to a taxonomy of behavioural requests that reflect commonalities and differences across therapeutic approaches. There is also a need to study a number of therapy cases (and/or different therapists) that use the same approach in order to see if there are behavioural requests that are consistently unique to a particular school of psychotherapy (i.e., that consistently distinguish one approach to from another).

High frequency versus low frequency categories of requested verbal behaviour. Some categories of requested verbal behaviour were found in every session. These included categories 1 through 4 in both therapy cases, as well as categories 7 and 8 in Maloney's case. Other categories occurred in only some sessions. These included categories 5, 6, and 9 in Maloney's case and category 5 in Barry's case.

Some categories of requested verbal behaviour occurred with greater frequency than others. The category of requested verbal behaviour that occurred with the greatest frequency in both of the two therapy cases was category 1.

Requests for acknowledgement, confirmation, or agreement accounted for 36% of Maloney's and 55% of Barry's behavioural requests. At the other extreme, requests to state a decision (category 9 - Maloney) or to clarify the meaning of one's words (category 5 - Barry) occurred very infrequently. Thus, both therapists tended to invite (request) certain types of verbal behaviour more often than other kinds of verbal behaviour.

Though it appears that certain categories of requested verbal behaviour may emerge more often than others, the frequency with which a request occurs should not be confused with its clinical value. Certain types of behavioural requests may be rare, yet still be of high clinical significance. It is important to emphasize that high frequency categories of requested verbal behaviour are not necessarily more important to the process of therapy than low frequency categories.

Still, this may be a useful way of examining the process of therapy over a series of sessions. It may be interesting to study a number of therapists and a variety of therapeutic approaches. Do certain types of requests consistently occur with high frequency? Are there certain types of verbal behaviour that are rarely invited by therapists? Future research can determine how often therapists request, or invite, different kinds of client behaviour.

Explicit and implicit requests for verbal behaviour. Some of the requests for verbal behaviour were stated explicitly and directly as requests (cf. Strong & Claiborn, 1982). Such requests fall into the class of statements that Searle (1976, 1979) calls "directives" and that Labov and Fanshel (1977) have called "requests for action". These statements included, for example, straightforward requests to describe or explain feelings, thoughts and behaviour (category 3), requests for general, factual information (category 4), explicit instructions to speak directly to the other person (category 5) or speak in the role of the other person (category 6), and directions to repeat, modify, or clarify specific words (category 5 - Barry; categories 7 and 8 - Maloney).

Other therapist statements contained indirect, implicit requests for verbal behaviour (cf. Strong & Claiborn, 1982). These requests usually corresponded to the class of statements that Searle (1976) calls "representatives" and Labov and Fanshel (1977) call "representations of disputable events". Many of the therapist statements in category 1 and some in category 2 contained such implicit requests for verbal behaviour. The requests were implicit and indirect when the statements (in these categories) were phrased in the declarative, rather than interrogative form. Such statements were not explicit and direct in soliciting acknowledgement, confirmation, agreement, or a yes/no

response from the client. The therapists did not necessarily ask the clients: "Do you agree with me?" "Is that the way you see it?" "Is that correct?" "Does that make sense to you?" Quite often, the therapists made declarative statements that gently suggested or strongly asserted some truth (i.e., observation, description, impression, view, belief, assessment, interpretation, etc.) about the client or about other people, situations, and events.

Not only did category 1 occur with the highest frequency, but it is a good example of a category that contains a high proportion of implicit requests. The declarative statements in Category 1 encompass a variety of therapeutic techniques. Traditionally these statements would be classified as, for example, interpretations, reflections, confrontations, or advisements. The request to acknowledge, confirm, or agree refers to only one aspect of these therapist statements and one aspect of the client's subsequent response. In addition to having the effect of the traditional category of therapist statement (e.g., insight and exploration following interpretations), another aspect of these statements may be that the client is indirectly invited to consider what the therapist is saying and to acknowledge, verify, confirm and agree. It is by virtue of such factors as the wording and structure of the therapist statement (i.e., declarative) that the response

likely to be elicited in human discourse is a yes or no answer, acknowledgement, confirmation, agreement, or disagreement. That will not necessarily be all of the response, but it will likely be included in the immediate response. The client may go on and do other things, such as explore their feelings, elaborate on the topic, or express a new found understanding and perspective on some issue.

Behavioural requests and therapist intentions. The behavioural requests found in therapists' statements may or may not reflect the therapists' "intentions" (as defined, for example, in Elliott, 1979, 1985; Elliott et al., 1982; Hill et al., 1983; Hill & O'Grady, 1985; Martin et al., 1986, 1987, 1989). In comparison to implicit requests, explicit requests are more likely to correspond to therapist intentions, at least to some extent. For example, the therapist's immediate intention and the behavioural request would probably be similar when the therapist asks the client: "How did you feel when your brother said that?" The client is requested and intended to be aware of and describe/explore his feelings. However, even when the therapist statement is explicit in what the client is to do next, it may not necessarily reflect the intention behind the request. There may be other intentions and goals underlying requests to talk directly to the other person, to describe feelings or to assess behaviour.

The difference between therapist intentions and

behavioural requests is highlighted with regard to implicit, indirect requests. It is unlikely that the therapists' intentions correspond to the behavioural requests in category 1. The therapists' intention in making statements in this category is not simply for the client to confirm or agree with their words. It is clear that this category of therapist statements, as techniques and operations, are intended to achieve other things. For example, these therapist statements may be intended to stimulate further exploration or promote insight and awareness of feelings, thoughts, and behaviours (e.g., Hill & O'Grady, 1985).

The high level of full compliance (i.e., 57% of client responses) in category 1 (requests for confirmation or agreement) in Barry's case shows that the therapist statements in this category often do succeed in getting a full response from the client. These findings indicate that the client not only acknowledges, confirms, or agrees with the therapist, but proceeds to continue with the topic, to elaborate and explore further. Researchers may study the client's responses to therapist statements as intentions, and to therapist statements as behavioural requests. The findings in Barry's case suggest that there may be some overlap between these two ways of looking at therapist statements in consequent client responses.

On the other hand, there may be some interesting differences between these two ways of looking at therapist

statements and consequent client responses. In some cases the client may give a minimal response which complies with the request, but does not fulfill the therapist's intentions. For example, the purpose of a reflection may be for the client to explore his/her feelings. However, instead of saying, "tell me how you felt when she did that" (category 3), the therapist says, "it sounds like she made you feel guilty for simply existing every time she did that" (category 1). Thus the therapist's intention is not expressed explicitly as a request. Instead, one ends up with an indirect, implicit request to confirm and agree. In Maloney's case there was a high level of partial conformity (52% of client responses) in category 1. The client confirmed, acknowledged, agreed, or disagreed, but did not explore or elaborate any further. In this case, the client was complying with the behavioural request, but the intention or purpose underlying the therapist's statements was probably not fulfilled. The client's responses were, nevertheless, quite in line with the nature (i.e., the implicit rules, see Labov & Fanshel 1977) of human discourse.

It seems that some therapist statements may contain requests for verbal behaviour that do not correspond to the therapist's intentions. Moreover, it seems that in some cases the client's response may conform to the request for verbal behaviour, but fail to fulfill the therapist's

intentions. These findings have implications for psychotherapeutic practice. They suggest that therapists need to pay attention to the extent to which the requests contained in their statements serve to accomplish the clinical intent or purpose of their interventions. In addition to being aware of the techniques that they use (e.g., reflections, interpretations, etc.), and their goals and intentions in choosing particular interventions, therapists should also be attuned to the specific type of client response (verbal behaviour) that their words invite.

More specifically, therapists may find that clients respond to given statements by conforming to the implicit request, but without doing what the therapist intends them to do. In these cases, therapists may choose to word their statements in such a way that will communicate their intentions more clearly. For example, what can therapists do if their use of reflections, interpretations, and confrontations (worded as declarative statements) result only in simple acknowledgement, confirmation, and agreement (i.e., minimal client responses)? The therapist's intention in choosing these interventions may be for the client to consider the therapist's perspective and to use the therapist's words as a springboard for further discussion of the topic (e.g., to explore feelings, cognitions, and behaviours; to examine an alternative perspective on some

situation). Depending on what it is that the therapist wants the client to do and say next, therapists might consider being more explicit in communicating their intentions to the client. Another option may be to couple their declarative statements (e.g., reflections, interpretations, etc.) with explicit requests and directives (e.g., to "explore that", "talk more about that", "tell me how that makes sense to you", etc.).

It may be useful for future process research to compare therapists' intentions (at the level of specific statements) with the behavioural requests contained in their statements. It may be important to discover those instances in which therapists' intentions correspond to the behavioural requests embedded in their statements, and those instances in which the behavioural requests differ from the therapist's intentions. Future research might well examine subsequent client statements to see if (and when) clients respond by manifesting the requested verbal behaviour, and if (and when) clients do what their therapists intend them to do as well. There may be occasions when clients do not do what they are intended to do, but their responses may be understood as conforming to the behavioural request contained in the therapist's antecedent statements. How do these instances affect the client's progress in therapy, or therapist and client satisfaction with a session?

Client Responses to Therapist Statements as Behavioural Requests.

The overall pattern of client response. The findings in both of the therapy cases indicated that the level of client conformity to the therapist's requests was generally high. Overall, Maloney's client manifested (1) nearly equal and moderately high levels of full compliance (41.4%) and partial conformity (40.4%), (2) a moderate level of passive avoidance (17.8%), and (3) a very low level of active refusal (0.3%). In this case, the client manifested the requested verbal behaviour, either partly or fully, significantly more often than he refused to conform or avoided the request.

In Barry's case, the client responded to the antecedent requests for verbal behaviour with (1) a high level of full compliance (61.1%), (2) a moderately high level of partial conformity (37%), and (3) a very low level of passive avoidance (1.9%). In this case, as in Maloney's, the level of passive avoidance was significantly lower than the level of partial or full conformity. In addition, the number of instances in which Barry's client manifested the requested verbal behaviour to a full extent was significantly higher than the number of times in which the client conformed partially.

The findings in these two cases suggest that, in general, clients may respond to the behavioural requests contained in therapist statements by manifesting the

requested verbal behaviour, either to some extent or fully. The high levels of overall conformity to the therapists' requests suggest that clients' statements in therapy may be heavily influenced by the behavioural requests in therapist statements. The therapist's behavioural requests can be regarded as playing a significant role in guiding, shaping and channeling subsequent client responses. The high degree of correspondence between the clients' responses and the therapists' antecedent requests for verbal behaviour suggests that the behavioural request that is communicated to the client in the wording of statements is a meaningful ingredient in therapist statements. Accordingly, as indicated throughout the literature on therapy interaction as communication (e.g., Strong & Claiborn, 1982; Watzlawick, 1978; Watzlawick et al., 1967; Watzlawick & Weakland, 1977), the findings lend further weight to the importance of both the explicit and implicit wording (viz., the behavioural request) in therapist statements. Further exploration of linguistic and psycholinguistic aspects of therapist statements as behavioural requests (e.g., syntax, grammar), and the impact of these aspects on subsequent client responses may be useful.

Traditionally, therapist statements have been described as techniques, such as the Gestalt two-chair, reflections, interpretations, confrontation, reframing, self-disclosure, or as response modes, such as, closed and open questions,

direct guidance, and information seeking (e.g., Hill, 1978). The findings of this investigation have implications for future research on these traditional categories of therapist statements. If further research confirms that a large proportion of therapist statements contain requests for verbal behaviour, and that clients manifest a high level of conformity to these requests, then future research can identify the (traditional) categories of therapist statements that contain requests for verbal behaviour. It can identify the behavioural requests that are contained in these traditional categories of therapist statements. It can explore the extent to which the behavioural requests account for the effectiveness, or ineffectiveness, of these interventions. In addition to other aspects of therapist technique, such as depth of interpretations (Auld & White, 1956; Dittman, 1952; Kanfer et al., 1960; Speisman, 1959), degree of directiveness (Pope, 1977, 1979), or level of communicated empathy (Truax & Mitchell, 1971; Orlinsky & Howard, 1978), the behavioural requests contained in therapist statements may be another ingredient that accounts for the effectiveness of these interventions.

It should be noted that the present study examines the therapeutic process from a unidirectional perspective, i.e., client statements as responses to the therapist's behavioural requests. The high level of conformity to antecedent requests indicates that therapists may have a

strong influence on their clients' in-therapy behaviours, because the requests contained with in their statements serve to successfully channel and steer the clients' subsequent verbal behaviour (cf. Haley, 1963). Recent literature suggests that research should focus on reciprocal influences in psychotherapy (e.g., Friedlander, 1984; Friedlander & Phillips, 1984; Haley, 1963; Strong & Claiborn, 1982; Tracey & Ray, 1984; Watzlawick et al., 1967; Watzlawick & Weakland, 1977). This type of research highlights the interaction between the participants, the mutual impact that each person's behaviour and communication has on the other person. It would be very interesting to see if the influence is mutual and reciprocal when statements are understood as containing behavioural requests. Future research could not only study therapist statements as behavioural requests, but extend the scope of the investigation to client statements as behavioural requests. It would be interesting to discover what proportion of client statements can be clearly understood as inviting or requesting a particular verbal response from the therapist. It may be useful to identify the kinds of requests for verbal behaviour that client statements contain. In addition to examining the client's responses to the therapist's antecedent behavioural requests, future research could examine the therapist's statements as responses to the client's antecedent behavioural requests.

It would be interesting to see to what extent the therapist conforms to the client's antecedent requests for verbal behaviour. This would provide one indication of the degree to which clients have a reciprocal influence on the therapist's in-therapy behaviour.

Differences between cases in the overall pattern of client response. While the level of client conformity to antecedent requests was generally high in both therapy cases, they did differ in that there was a higher level of full compliance in Barry's case than in Maloney's case, and a higher level of passive avoidance (nonconformity) in Maloney's case than in Barry's sessions.

While these differences were tangential to the main findings, nevertheless it is difficult to explain why these differences occurred. It is only possible to speculate on some factors that may have influenced the overall patterns of client response in these two cases. The content of the sessions suggests that Barry's client had more experience as a client in psychotherapy. Judging from the length of client statements, Barry's client also appears to be more active and verbal than Maloney's client. (This impression is based on informal examination. Client and therapist activity levels were not assessed systematically.) These factors may have contributed to the higher level of full compliance and lower level of passive avoidance in Barry's case. In addition, Maloney tended to interrupt the client

more often. This may have resulted in increased ratings of client responses as partially conforming to the therapist's requests in this case.

The pattern of conformity to behavioural requests over the course of therapy. It had been hypothesized that over the series of six sessions, there would be increasing occurrence of the requested verbal behaviours (Hypothesis 1). The findings indicate that both clients responded to the therapists' antecedent requests for verbal behaviour with a high level of conformity throughout the course of therapy. If (a) the initial sessions of therapy are a "hooking" stage in which a working alliance is negotiated (Cashdan, 1973; Friedlander & Phillips, 1984), and if (b) clients are gradually inducted into psychotherapy, such that they gradually assume the therapist's frame of reference, the client role and its accompanying appropriate behaviours and attitudes (Frank, 1959, 1975; Haley, 1963; Lennard & Bernstein, 1960), then, at least in these two cases, this was not reflected in markedly lower levels of conformity to the therapist's antecedent requests for verbal behaviour in the initial sessions of therapy. While the findings in Maloney's case were not as clear cut as those for Barry's client, both clients began the sessions with generally high levels of conformity to the antecedent therapist requests, and generally sustained this high level of conformity in a stable and rather consistent manner across the sessions.

In Barry's case, hypothesis 1 was rejected. Instead of increasing over the course of therapy, the level of conformity was consistently very high in each session and each stage of therapy. The level of conformity was also generally high throughout the six sessions examined in Maloney's case. However, in Maloney's case, the findings provided some mild support for the first hypothesis. In this case there was a significant increase in the level of conformity in the last stage of therapy. Thus, the findings in Maloney's case, but not Barry's, reflected (albeit weakly) the progressive increase in client conformity observed by Mahrer and colleagues (in press) in one of their categories of requested verbal behaviour.

It must be noted, however, that this increase in Maloney's case was not very large. The proportion of conforming client responses in the final stage of therapy was only 10% higher than in the initial stage and 14% higher than in the middle stage. Moreover, the degree of acquiescence in the final two sessions was negligibly higher than in sessions 2 and 4. Thus, while these particular findings were statistically significant, they did not provide strong support for the first hypothesis. They only slightly weaken the overall finding of a generally stable and consistent high degree of client conformity from the outset and across the sessions.

In addition to this slight increase in the level of

conformity in the final stage of therapy for Maloney's client, the findings in this case showed that there were statistically significant fluctuations in the level of conformity from session to session, particularly in the early and middle sessions. These findings suggest that, while the level of conformity to antecedent requests is generally high over the course of therapy, the degree to which the client manifests the requested verbal behaviours may vary somewhat from one session to the next.

The findings of the present study are based on the examination of only two therapy cases. Future research should examine the degree to which these two cases are representative of other clients. Is a high level of conformity to the therapist's antecedent behavioural requests a common occurrence? Do many clients begin therapy with a relatively high degree of conformity to the therapist's requests, and sustain this level of acquiescence in a stable and consistent fashion over the course of therapy? The generally high level of conformity to the therapists' requests in these two therapy cases suggests that these clients were cooperative with the therapist. It would be interesting to study the client's responses to antecedent behavioural requests in therapy cases with "difficult" clients. Higher levels of opposition to the therapist's requests may occur when clients are noncooperative, not motivated, resistant or hostile towards

therapy. Successful and unsuccessful therapy cases with "difficult" clients may be compared in future research to see if and how the level of conformity changes over the course of therapy.

It may also be worthwhile to study therapy cases with clients whose interpersonal communication skills are underdeveloped or disturbed. For example, incoherence or poverty of speech is a feature that is frequently associated with schizophrenic disorders (American Psychiatric Association, 1980). It would be interesting to see how these problems at the level of communication manifest themselves when the client's statements are examined as responses to the therapist's requests for verbal behaviour. Future research can examine the extent to which the flow of communication, as conformity to antecedent requests, changes and improves over the course of therapy in such cases.

The clients' high level of conformity to antecedent requests throughout the course of therapy suggests that there is a good working relationship in both the initial and subsequent sessions in these two therapy cases (cf. Cashdan, 1973; Dietzel & Abeles, 1975; Friedlander & Phillips, 1984; Lichtenberg & Barke, 1981; Tracey & Ray, 1984). Though the assessment of conformity to antecedent requests is not a measure of therapeutic alliance per se, it may be viewed as tapping into one specific aspect of the working alliance. If the negotiation of the working alliance takes place

through the medium of language and is reflected in the flow of communication (Friedlander & Phillips, 1984), then the client's responses to the therapist's antecedent requests may provide one indication of the developing state of this alliance. Opposition to and avoidance of antecedent requests for verbal behaviour create a discontinuity in the flow of the dialogue; conformity reflects a degree of continuity in discourse. Discontinuities are thought to reflect conflict or negotiation about who controls the interaction; continuity is viewed as reflecting agreement between the participants regarding their respective roles and responsibilities (Friedlander & Phillips, 1984). Given the findings of the present study, it would be interesting to compare client conformity to the therapist's antecedent requests with other indicators of what may be regarded as client cooperation, motivation, alliance, and fulfillment of the client role. For example, future research might examine how conformity to antecedent requests for verbal behaviour is related to process measures of the therapeutic alliance.

Client opposition to the therapist's requests for verbal behaviour. The findings in these two cases revealed a surprisingly low level of opposition to antecedent requests for verbal behaviour. Overall, there was a very low level of opposition in Barry's case and only a moderate level of opposition in Maloney's case. In light of the research indicating that clients oppose and resist therapist

expectations and demands, especially with regard to active, directive interventions (e.g., Ashby et al., 1957; Bergman, 1951; Carnes & Robinson, 1948; Frank, 1964; Gillespie, 1953; Patterson & Forgatch, 1985; Rottschaffer & Renzaglia, 1962; Snyder, 1945; Tourney et al., 1966), the findings of the present study were quite unexpected. Traditional classification of therapist statements as directive (e.g., advisement) versus nondirective (e.g., acknowledgements, reflections) does not focus on the same aspect of therapist statements as this study does. Still, in the sense that they structure the subsequent client statement by inviting a particular response, be it explicitly or implicitly, intentionally or unintentionally, the therapist statements that contain behavioural requests may be viewed as directive. The generally low level of opposition to these therapist "directions", and the generally high level of conformity, runs contrary to expectations based on the above literature. If future research supports the findings of the present study, then it would appear that client resistance and defensiveness may not emerge in the form of opposition and avodiance of the therapist's antecedent requests for verbal behaviour.

Moreover, the judges' ratings indicated that there were almost no instances of outright, direct refusal to comply with a behavioural request. Tracey and Ray (1984) had also included outright denial to pursue a previous topic as a

response category, but found that this kind of response never occurred in rating. Thus, when the clients did not manifest the requested verbal behaviour, they did not literally oppose the therapists' requests. They changed the subject, responded with silence, were noncommittal, pleaded ignorance, or expressed an inability (as opposed to unwillingness) to comply with the request. Since the bottom line in each of these cases is that the client does not manifest the requested verbal behaviour, these responses may be viewed as indirectly, or passively, avoiding the therapist's request. The findings suggest that the level of resistance may be relatively low when client statements are viewed as responses to the therapist's antecedent behavioural requests. Moreover, the findings suggest that when resistance does occur, it will be in the form of subtle, indirect avoidance rather than open, direct, and outright opposition. If further research supports these findings, such results may indicate the substantial power and "demand characteristics" of therapist statements when they are understood as behavioural requests.

Client opposition to antecedent requests over the course of therapy. Clinical literature (e.g., Cashdan, 1973) and recent research (e.g., Dietzel & Abeles, 1975; Tracey & Ray, 1984) indicates that there is a middle phase of therapy that is characterized by an upsurge of conflict between therapist and client. In Tracey and Ray's

(1984) study, topics that were initiated by one of the participants in the middle sessions were less likely to get a "topic following" response. On the basis of this literature, it was assumed (in the present investigation) that conflict between therapist and client in a symmetrical relationship would show up as avoidance of and opposition to antecedent requests for verbal behaviour. Accordingly, it was hypothesized that, compared to the initial and final stages, there would be heightened opposition to the antecedent requests for verbal behaviour in the middle stage of therapy (Hypothesis 2).

Examination of the clients' responses to the therapists' requests in this research did not provide strong evidence of stages and phases in the degree of opposition to requests for verbal behaviour. The second hypothesis was rejected in Barry's case. Instead of increasing in the middle sessions of therapy, the level of nonconformity was consistently very low throughout the six sessions and three stages. The findings in this case indicate that therapists do not necessarily have to expect an upsurge in resistance at some point in therapy. If the client manifests the requested verbal behaviours often in the beginning of therapy, the client may continue to do so throughout the course of therapy. In some therapy cases, the level of opposition to therapist's requests may remain consistently low.

The findings provided only weak support for the second hypothesis in Maloney's case. Although there was a significantly higher level of opposition in the middle stage of therapy, once again the findings may be statistically but not clinically significant (as was the case with the first hypothesis). The increase in the level of nonconformity in the middle stage of therapy was not a very large one. There was only a 4.5% increase in the proportion of nonconforming client responses from the initial to the middle stage of therapy, and the proportion of nonconforming client responses in the middle stage was only 13.8% higher than in the final stage of therapy. Moreover, the increase in the level of nonconformity was only found in one of the two middle sessions (session 3). Taking into account that the level of opposition fluctuated significantly from session to session, particularly in the initial and middle sessions, these findings suggest there may be session to session variations in the level of opposition, but not necessarily any clear, consistent trends linking opposition to specific phases of therapy.

The results of the present investigation do not correspond to expectations based on the literature (e.g., Cashdan, 1973; Dietzel & Abeles, 1975; Tracey & Ray, 1984). Though the level of nonconformity was somewhat higher in one of the two middle sessions in Maloney's case, the general findings in the two therapy cases did not reveal a strong

upsurge in client avoidance and opposition in the middle stage of therapy. The level of conflict in these two cases, in terms of nonconformity to antecedent requests for verbal behaviour, does not seem to correspond to their phases and stages of therapy.

In their studies, Dietzel and Abeles (1975) and Tracey and Ray (1984) compared successful and unsuccessful therapy cases. Their findings of increased conflict in the middle stage of therapy applied only to the successful therapy cases. There were no outcome measures in the present investigation. Therefore it is not known whether these two therapy cases were successful. In future research on therapist statements as behavioural requests, it would be useful to get outcome measures on the therapy cases and to compare the pattern of client opposition across therapy in successful versus unsuccessful cases.

However, if future studies also indicate that an upsurge in interpersonal conflict and client opposition is not a consistent phenomenon in the middle stage of therapy, then this may have implications for the clinical utility of identifying initial and middle stages of therapy in terms of an expected upsurge in client opposition. The concept of phases and stages of therapy is used often in psychotherapy research (e.g., Tracey & Ray, 1984) and clinical theory (e.g., Cashdan, 1973). The findings of this study suggest that an expected upsurge of client opposition (i.e., a

conformity/ nonconformity dimension) may not be a useful component in the identification and construction of phases and stages of therapy. Other components and dimensions may be more useful and prominent.

The findings may also have implications for the actual conduct of therapy in initial and middle stages. Some therapist procedures in the initial stage of therapy are commonly aimed at the expected upsurge of opposition in the middle phase. If client opposition is not a consistent phenomenon in the middle stage of therapy, it may not be therapeutically useful to carry out operations that are designed to soften and ameliorate the expected upsurge of opposition in this phase. If therapists want to deal with client opposition, whether they regard it as therapeutically valuable or as a confound, the methods that they employ may be used throughout therapy under the appropriate conditions, rather than based on expectations of an upsurge in opposition in the middle stage of therapy.

The quality of client responses over the course of therapy. Based on clinical theory and indirectly related research (e.g., Bergin, 1971; Bergin & Lambert, 1978; Cashdan, 1973; Marmar et al., 1984), it was predicted that there would be progressive developments in the quality of client responses over the course of the sessions (Hypothesis 3). Specific types of client response (i.e., partial versus full compliance, direct versus indirect opposition) were

expected to correspond to particular stages of therapy. Passive avoidance and partial conformity were expected to dominate the initial sessions, whereas the full compliance with antecedent requests was to characterize the final stage of therapy.

This hypothesis was not supported in either of the therapy cases. Instead of progressive developments in the quality of the client's responses in Barry's case, there were no (significant) changes from session to session. The findings show that in each session the level of passive avoidance was low, the level of partial conformity was moderately high, and the level of full compliance was high. Thus, for each type of client response, the level that was manifested in the beginning sessions was generally sustained throughout the course of therapy.

There were no progressive devlopments in the extent of conformity or opposition in Maloney's case either. The level of partial conformity was relatively stable and moderately high throughout the six sessions. The levels of passive avoidance and full compliance fluctuated significantly from session to session, but there were no clear upward or downward trends. When the final sessions were compared to the initial sessions, there were no significant (and consistent) decreases or increases in the levels of partial conformity and full compliance. Thus, specific types of client response were not found to

correspond to particular stages of therapy in either of the two cases.

Client responses to different types of requests for verbal behaviour. The overall findings in both therapy cases showed that the clients generally responded to the therapists' requests for verbal behaviour with a high level of conformity (i.e., either partial or full compliance). When the clients responses in each category of requested verbal behaviour were examined, the findings indicated that this general trend was applicable for all the categories in Barry's case and for most of the categories in Maloney's case.

In Barry's case, there were similar levels of client conformity, regardless of the type of verbal behaviour that the therapist requested. Overall, Barry's client manifested a very low level of passive avoidance, a moderately high level of partial conformity, and a high level of full compliance. This general pattern of client response was reflected in each category of requested verbal behaviour in Barry's case.

In Maloney's case, the distribution of client responses did vary depending on the category of verbal behaviour that the therapist requested. There were significant differences between the categories in the levels of opposition, partial conformity, and full compliance that the client manifested. In general (i.e., in the overall findings), Maloney's client

manifested a moderate level of passive avoidance, and moderately high levels of partial and full conformity to the therapist's requests. The distribution of client responses in categories 2, 3, and 4 did not differ significantly from this general pattern. However, this general pattern of client response was not reflected in categories 1, 5, 6, 7, and 8, which were significantly different from the overall pattern. The findings in Maloney's case suggest that there may be a relationship between the nature of the requested verbal behaviour and the degree of client conformity to antecedent requests. These findings highlight the importance of not aggregating client process in psychotherapy research (cf. Rice & Greenberg, 1984b).

The general trend towards conformity still applied in categories 1, 7, and 8. The client generally responded to Maloney's requests in these categories with a high level of conformity (i.e., either partial or full compliance). However, in category 1, the client responded to the therapist's requests (for agreement, acknowledgement, confirmation) with a higher level of partial conformity and less passive avoidance. The client responded to requests in category 7 (simple repetition/clarification) and category 8 (repetition/ modification of specific sentences and sounds), with a much higher level of full compliance.

The high levels of full compliance in some of the categories in Maloney's case makes sense when one considers

the type of verbal behaviour that the therapist requested. The requests are relatively innocuous, especially in category 7, which called for simple repetition or clarification of words that the therapist did not hear, recall, or understand. The requests to repeat and/or modify specific words and sounds in category 8 are employed as a (Gestalt) therapeutic technique. Though there is a higher level of client opposition in category 8 than in category 7, the client responds to the requests in both categories with a very high level of full compliance. In general, both of these categories contain relatively simple, straightforward requests. One would expect to get high levels of full compliance in response to such requests.

In three of Maloney's categories of requested verbal behaviour, the general tendency to respond with a high level of conformity did not apply. The client responded to requests in category 5 (to communicate directly to the other person) and in category 6 (to speak as another person or aspect of self) with significantly higher levels of passive avoidance. (The level of passive avoidance was also higher when the client was requested to make/state decisions and preferences, but there was insufficient data in category 9 to test for significant differences.)

The findings in this study indicate that clients may oppose, or resist, certain types of requests more often than others. In general, Maloney's client manifested a moderate

level of resistance. However, closer examination of the specific categories of requested verbal behaviour showed that there was less opposition in some categories and more nonconformity in others. Compared to the overall level of nonconformity (18%), there was less opposition in categories 1 (7%), 4 (8%), and 7 (0%). There was more opposition in categories 5 (64%), 6 (35%), and 9 (69%). Thus, this client was not moderately resistant in general. When the therapist statements are examined as containing behavioural requests and the client's responses are viewed as responses to these requests, the findings show that the client tends to avoid or resist only with regard to specific types of requests. These findings suggest that resistance can be understood as a specific phenomenon related to particular categories of therapist intervention.

It is interesting that of all the categories of requested verbal behaviour, Maloney's client manifested the highest level of opposition to those which called for him to carry out some action, to experience and express himself directly in the present, rather than to "talk about" (i.e., categories 5, 6, and 9). Compared to the other categories of requested verbal behaviour these categories are relatively more "experiential". Instead of "talking about" his thoughts, feelings, and reactions towards the other person, the client is requested to express himself directly to the other person, right here and now in the session

(category 5). Instead of "talking about" the other person or some aspect of himself, the client is requested to be that other person or part of self, to speak as if he were that other person or part of self (category 6). The client is not invited to "talk about" his options, or his wants and needs. Instead, the client is requested to choose right now, to make an immediate decision based on those desires and needs (category 9).

Categories 5 and 6 in Maloney's case reflect the types of requests that therapists would make when implementing the Gestalt two-chair technique. It may be that the emphasis on direct, immediate expression and action in these categories of requested verbal behaviour leads to greater avoidance of the therapist's requests. Within a context of psychotherapy, the issues that clients introduce are likely to be somewhat sensitive, areas that entail a certain degree of emotional and psychological threat to the client. It may be more difficult, or riskier, for the client to deal with these issues from a position of relative proximity (i.e., enacting and expressing something in the immediate present), rather than from a relatively safer distance (i.e., "talking about" something or someone). Certainly the requests in categories 5 and 6 are atypical in ordinary human conversation. In the course of every day life, people do not ask each other to speak directly to an "empty chair", or to play the role of and speak as another person or part of

self.

The findings in Maloney's case indicate that there are differences in the overall pattern (level) of conformity to various categories of requested verbal behaviour. These findings suggest that it is worthwhile to identify classes of behavioural requests and to examine clients' responses to different categories of requested verbal behaviour. There seem to be verbal behaviours that clients may manifest readily and with relative ease. There seem to be other types of behavioural requests that clients may avoid consistently. Unfortunately, the data was insufficient to come to any sound conclusions regarding differences between categories in the pattern of conformity over the course of sessions. This may be a topic for exploration in future research.

Methodological Considerations

The purpose is to discuss some methodological issues related to the present investigation, some interesting advantages and singular features of the methodology, limitations and shortcomings of the study, and alternative methodologies that may be used in future research on client responses to therapist statements as behavioural requests.

Some Advantages and Singular Features

In general, the present methodology seems to generate ample data, viz. behavioural requests. Given a sufficient number of sessions, the method should be applicable to a

variety of therapists, clients, and therapeutic approaches. It is feasible to identify the behavioural requests that are contained in therapist statements. It is possible to organize these requests into clusters or categories.

The method is singular in the manner in which it identifies what the client is to do in therapy. It gets at what may be regarded as "therapeutic process goals" in a distinctive fashion, by examining what is manifestly indicated in the therapist's words. Frequently, in psychotherapy process research, there is one category system to describe the therapist statements and a separate system to describe client statements (e.g., Hill et al., 1983; Hill & O'Grady, 1985; Martin et al., 1987, 1989). In this study, each category of "requested verbal behaviour" defines what the therapist is doing in the therapist statement. At the same time, it also defines the subsequent client statement, specifically, how the client is to respond, what the client is to say/do in the next statement. Thus, this method of examining therapist statements operationally relates the client's subsequent response with the therapist's antecedent statement (or client consequences with antecedent therapist operations). Accordingly, this procedure is recommended to researchers who wish to study an interesting proces dimension of therapist-client interaction and change.

Videotapes as an Alternative Form of Data Presentation

The present investigation was limited to requests for

verbal behaviour. It might be interesting to use videotapes in future studies and to examine requests for nonverbal behaviour as well. Such requests did occur in some of Maloney's sessions as part of his "experiential" techniques. For example, in the fourth session the client was instructed to close his fists and "get rid of" the wall. The use of videotapes may also provide data on voice quality and nonverbals that could be helpful in rating further dimensions of clients' responses to therapists' antecedent requests.

However, there would be some limitations that accompany the use of videeotapes (or audiotapes). In the fourth phase of the present study, statements were randomized so that the judges would not know in what part of the session, or in which session, the client statement occurred. It would be much more difficult to follow this procedure with videotapes. It would be technically cumbersome to randomize excerpts using videotapes (or audiotapes). Nevertheless, given this limitation, the use of videotapes in the examination of client responses to behavioural requests contained in antecedent therapist statements is strongly recommended.

Order of Presentation and Practice Effects

In each phase of this research, the level of inter-rater agreement was higher for Barry's case than for Maloney's case. This difference in inter-rater agreement

was only slight, but the consistency with which it occurred suggests that there may have been a practice effect. Throughout the study, the statements in Maloney's case were rated first, and Barry's case was rated last. Therefore, the judges had greater experience by the time they examined the data in Barry's case. A different design is recommended for future research on therapist statements as behavioural requests. Counterbalancing techniques may be used to minimize "order" and "carry-over" effects (cf. D'Amato, 1970). For example, given two therapy cases, the data can be presented in an "abab" sequence to half the judges, and in a "baba" sequence to the other half. That is, half the judges begin with one therapy case while the other half start with the other case, and then proceed to rate T1, T2, T1, T2, and so forth (or T2, T1, T2, T1). Depending on the phase of the research, T1 and T2 would refer to a complete session from each case (Phase 1), or a category of requested verbal behaviour in each case with its corresponding therapist statements (Phase 3) or client statements (Phase 4).

Constructing Categories of Requested Verbal Behaviour

In this study the researcher organized the individual requests for verbal behaviour into a set of categories for each therapy case. It is important to note that alternative categories could probably have been generated from the same set of data. For example, emphasis on the temporal frame of

the requests would have resulted in categories that referred specifically to past events (e.g., the client's early childhood, adolescence, early adult life, etc.), to current circumstances, or to situations in the future. It was also possible to construct categories that would distinguish between requests that refer to the client and those that focus more on other people or specific situations. The fact that someone else could organize the requests for verbal behaviour differently, and come up with a different category system, may be regarded as a problem and limitation calling for resolution in the design of subsequent studies.

Alternative procedures. It was not the purpose of this study to develop an explicit category system of requested verbal behaviours for use in other studies. However, if subsequent studies confirm the utility of examining therapist statements as behavioural requests, then an explicit, standardized category system of requested verbal behaviours may be a useful instrument for researchers to develop. The category system may be based on the behavioural requests made by a large number of therapists representing a variety of therapeutic approaches. It would probably be helpful to examine a number of sessions for each therapist. If the same procedure is used as in the present investigation (i.e., the researcher organizes the requests into categories), then steps have to be taken to insure that the procedure is rigorously systematic. An alternative

procedure would be to have a number of judges independently organize the requests into a set of categories, although such a procedure is likely to be lengthy, and quite difficult and complex. It is highly probable that there would be substantial disagreement among judges regarding the number of categories, the nature of the categories, and the therapist statements included in each category. Nevertheless, the careful development of a method using several judges seems useful and warranted.

Specificity of categories. Some of the categories of requested verbal behaviour are more specific than others. For example, category 5 in Maloney's case is very specific in its requests for the client to speak directly to the other person. On the other hand, categories 3 and 4 (in both cases) distinguish more generally between requests for "psychological" and "factual" information. These two categories could be regarded as encompassing a variety of specific requests. For example, category 3 includes requests for description, assessment, or explanation of problems, feelings, thoughts, or behaviour. An attempt was made to reflect the richness and diversity of the individual requests in the description of each category. Given sufficient data, the researcher would have preferred to have only specific categories of requested verbal behaviour. This may be possible in subsequent studies, if more sessions are examined and there is a much greater pool of individual

requests with which to work. Another option would be to identify subcategories within larger, more general categories. For example, it may be useful to take a closer look at category 1 (requests to confirm and agree). This is a very large category that includes many of the therapist statements. It may be interesting to study this class of requests and identify subcategories.

Mutually exclusive categories. One of the problems with general categories is that the specific instance, such as the individual therapist statement or behavioural requests, may be understood as fitting more than one category. For example, the client may be asked to describe the other person's physical appearance (category 4), or to describe how he or she is feeling (category 3), or to repeat something (category 8) directly to the other person (category 5), while in the role of another person, or a younger self (category 6). In the present study, the judges found it difficult to discern between statements that fit category 1 and those that fit category 2. In some cases it was clear that the client was being invited to agree with the therapist's statement. In some cases it was clear that a yes or no response was being invited. However, in many cases it was not clear whether the therapist statement invited agreement or a yes/no response.

It is the researcher's impression that the categories of requested verbal behaviour in this study are not mutually

exclusive. Though they occurred very rarely, there were instances when the judges "incorrectly included" a therapist statement in a category to which it had not been assigned (phase 3 of this study). These instances suggest that some therapist statements could be understood as fitting more than one category of requested verbal behaviour. To deal with this issue, three options can be suggested for future research. One is to try to come up with mutually exclusive categories. However, given the complexity of therapist statements, this may not be feasible. A second option is to explicitly weight the categories, such that certain categories are consistently given greater priority than others. When the therapist statement can be understood as fitting more than one category, it would be classified in the category that was given a greater weighting. The idea is to provide clear guidelines that will facilitate consistency in the ratings and minimize judges' individual biases towards certain categories. This solution was adopted for some of the categories in the present study, but could be carried out more systematically in future research. A third alternative would be to allow for multiple requests within a given therapist statements. Where necessary and appropriate, a therapist statement could be assigned to more than one category.

Methods of Classifying Therapist Statements into Categories of Requested Verbal Behaviour

In the third phase of this study, the judges were given a sample of the therapist statements and asked to assess whether or not particular statements fit particular categories of requested verbal behaviour. The purpose of this phase was to check whether the therapist statements that were assigned by the researcher to the various categories could be understood by others as fitting (or not fitting) those categories. Moreover, if the judges could discriminate between statements that belonged to a particular category and those that did not, then this would indicate that the category system was useful and workable.

The findings showed that the goodness-of-fit between the categories and the individual therapist statements was satisfactory but not perfect. Given the findings, two options are suggested for future research. The same procedure may be employed as in the present investigation. However, rather than examining a sample of the therapist statements, the judges might well assess the goodness-of-fit for all the statements assigned to the categories of requested verbal behaviour. In addition, if a statement is judged as not fitting a particular category, the rater should identify the category to which the statement belongs.

An alternative method would be to ask the judges to categorize all the therapist statements that contain behavioural requests. Instead of deciding whether or not the therapist statement fits a particular category (i.e

answering "yes, it fits" or "no, it does not fit"), the judges select the category to which the therapist statement belongs. Since the judges have more options, the likelihood of disagreement is higher and the potential loss of data is greater. Therefore, it is recommended that the original pool of therapist statements as behavioural requests be large when this alternative method is employed.

The Client Response Rating Scale

If the client response rating scale is to be used in future research on therapist statements as behavioural requests, some avenues of improvement are in order. Client responses may be complex, especially in lengthier statements. The client can begin by avoiding the therapist's antecedent request, but then proceed to manifest the requested verbal behaviour. For example, the client may respond to a request for agreement (category 1) with a "yes, but..." and then proceed to clarify and explore the issue and topic that is being discussed. It may not be clear to judges whether the client is avoiding the request or not. While the client is not agreeing with the therapist completely and wholeheartedly, the client's response may clearly indicate that the therapist's previous statement is being considered and addressed.

It is especially difficult to distinguish between degrees of conformity and compliance. There are some categories of requested verbal behaviour where degrees of

conformity do not apply. In these categories the client can only comply or not comply with the antecedent request for verbal behaviour. For example, with requests for simple repetition (category 7, Maloney), it is virtually assured that the client will simply either do it or not; the client either repeats the words/sentences or does not do so. The same is true for some requests for factual information (category 4). Suppose the therapist asks: "How old are you?" "What was his name?" "Where did you meet her?" If the client answers the question, the client is complying fully with the request. There really is very little room to manifest partial conformity to these requests.

Each point on the client response rating scale could profit from more careful definition and description to enable judges to distinguish easily between nonconformity and conformity, and between a minimal/partial response to antecedent requests and a full response. Finally, based on the experience with the judges in the present study, a somewhat more extensive training period is recommended for more effective use of the scale.

The Problem of Low Frequencies

Low frequencies presented a problem in that some categories of requested verbal behaviour included too few therapist statements to enable adequate statistical analysis; there were categories that did not emerge in all the sessions and/or occurred with low frequency within

some sessions. Moreover, when the data on client responses was distributed across categories and sessions, as well as over the four client response options, there were many empty cells and cells with very low Ns. As a result, it was not possible to analyze the patterns of client response across sessions on a category by category basis. Given insufficient data, it was not possible to draw sound conclusions regarding the pattern of conformity across sessions in each category of requested verbal behaviour.

A partial solution to this problem may be to include a larger number of sessions. The frequencies would still be too low within each session, especially in low frequency categories. However, if many sessions are examined, it may be possible to collapse the data from a number of adjacent sessions (e.g., according to stages). This solution might only be useful if the sessions that were collapsed had similar proportions of client responses rated as passive avoidance, partial conformity, etc. Collapsing data when there are session to session differences (as in Maloney's case) would be misleading.

Other Suggestions For Future Research

Unfortunately, there were no outcome measures for the two cases that were examined in this study. This makes it difficult to compare the findings of the present investigation with some of the findings in previous studies (e.g., Tracey & Ray, 1984). It would be useful to have some

indications of outcome in order to compare the therapist statements as behavioural requests, the level of conformity to these antecedent requests, and the pattern of client responses across sessions in successful and unsuccessful cases.

This study examined the pattern of conformity to behavioural requests across sessions. It may be interesting to take a closer look within sessions, for example, (1) at how the therapist statements as behavioural requests are distributed (patterned) over the course of a session, or (2) at the patterning of client responses to these requests across a session. Are there common sequences of behavioural requests? Do certain kinds of behavioural requests tend to precede or follow one another? Are there categories of requested verbal behaviour that tend to occur throughout a session, or mainly in the beginning, middle, or end of a session? Does the level of conformity to antecedent requests for verbal behaviour increase over the course of a session, or is it relatively stable and consistent throughout? Research can take a closer look within sessions at the client's response to the therapist's requests in general. Given sufficient data, it can examine the pattern of conformity to specific kinds (categories) of requested verbal behaviour over the course of a session. Finally, it may also be interesting to compare the therapist's behavioural requests, and the pattern of conformity to these

requests, over the course of "good" therapy sessions versus "bad" therapy sessions.

Conclusions

Based on the study of two sessions from the beginning, middle, and end of two therapy cases - one Gestalt, the other psychodynamic - where each client was seen for 18 sessions, these are the main conclusions that were drawn:

1. A large proportion of therapist statements contained behavioural requests.

(a) Some of these requests were stated explicitly and directly as such. Some therapist statements contained indirect, implicit requests for client verbal behaviour.

(b) Some categories of requested verbal behaviour were common to both therapists and therapeutic approaches. Other categories of behavioural requests were unique to a particular therapist and therapeutic approach.

(c) Therapists invited certain categories of verbal behaviour more often than other kinds of verbal behaviour.

2. The clients responded to the therapists' requests for verbal behaviour with an overall high level of conformity and a relatively low level of avoidance. There was virtually no direct opposition to the therapists' antecedent requests.

3. The level of conformity was high in the beginning of therapy, and that level was generally sustained throughout the course of therapy. However, the findings in one case

provided some weak evidence suggesting the presence of a slight increase in the level of conformity in the final stage of therapy.

4. In terms of specific types of client response (i.e., passive avoidance, partial conformity, and full compliance), the findings indicated two patterns. One pattern was that of stability and consistency across sessions for each type of client response. The other pattern was one of fluctuations from session to session. For both cases there was no clear upward or downward trend in these specific forms of client conformity and nonconformity.

5. There was no substantial support for the presence of a middle phase of therapy characterized by a high level of opposition. Instead, the findings indicated two patterns. One pattern was a consistently low level of opposition across sessions. The second pattern was that of session to session fluctuations in the level of opposition, suggestive of an upsurge of opposition in some sessions, but not necessarily in the middle stage of therapy.

6. The clients' responses to the specific categories of requested verbal behaviour resembled, for the most part, the clients' general, overall pattern of response.

(a) The overall findings showed a high level of conformity to the therapists' antecedent requests. A closer look at the specific categories of requested verbal behaviour revealed that this pattern of client response was

also reflected in all the categories used by one therapist (Barry), and in most of the categories used by the other therapist (Maloney).

(b) The overall findings showed that a generally high level of conformity was a relatively stable and consistent characteristic throughout therapy. Unfortunately, the data was insufficient to draw conclusions regarding the pattern of conformity across sessions for each category of requested verbal behaviour.

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APPENDIX A

Instructions to Raters in Phase 1: Determining Behavioural Requests

In the following meetings you will be given verbatim transcripts of complete psychotherapy sessions. You will be examining the therapist statements in these sessions.

"Therapist statement" includes all the words spoken by the therapist, preceded and followed by the client. Each "therapist statement" in a session will be numbered consecutively. You are asked to study each therapist statement independently, examining the first therapist statement, then the next, and so forth.

There are two steps to follow in studying each therapist statement. First, you must decide whether or not a particular therapist statement does contain a behavioural request. Second, for those therapist statements that you judge to contain behavioural requests, you must identify and write down the particular behavioural request contained in that particular therapist statement.

STEP 1 How to Identify Statements as Containing or not Containing Behavioural Requests

The first step is to examine the individual therapist statement and decide whether or not it contains a behavioural request.

Examine the therapist statement answering the following question: Does this statement generate a specific picture of how the client is to respond in the next statement?

It may be helpful to pretend that you were the client. If you were the client, would you have a good idea of what you are invited or requested to do?

(1A) Statements that Contain Behavioural Requests

A therapist statement contains a behavioural request if it provides a clear, specific and concrete indication of what the client's subsequent verbal behaviour (verbal response) is to be. On the basis of these statements, you have a clear picture of what the client is to say next, what the subsequent verbal response should be.

Here are some examples of therapist statements that contain behavioural requests, that provide a clear, specific and concrete indication of how the client is to respond in the next statement:

1. T: Say it louder. Really scream it out.

2. T: Tell me more about what happened in your meeting with her.

3. T: Share those feelings with your mom, now, here. Tell her directly.

These therapist statements give the client directions, instructions on how to proceed in the client's next response. The client has a clear, specific and concrete indication of what the therapist expects him or her to do. If you were the client, you would know how to respond. You would know that you are to really scream it out or to provide more information about what happened in the meeting with the other person or to directly tell your mother, in the session, how you feel.

4. T: How did you feel when he said that to you?

5. T: "I should be more assertive". Who is saying that to you?

6. T: Do you remember that day when they let you down? What's the situation?

These therapist statements, phrased as questions, interrogatives, specifically indicate how the client is to respond. On the basis of each statement, the client should have a clear sense of what the therapist is requesting. If you were the client, you would know what your next response should contain. You would know to describe your feelings or to identify and name the person who is saying "You should be more assertive", or to describe the specific situation in which you were let down.

7. T: So you got upset when he put you down for associating with the wrong people?

8. T: Was it after you told him that you were feeling kinda low, that he started lecturing you on your faults?

These therapist statements may be considered to contain behavioural requests because they contain clear invitations for a "yes or no" response from the client. They would generally be presented by the therapist as questions and clarificative statements. The client would have a sense that a "yes or no" response is requested.

9. T: It's very important for you not to get back into stealing hubcaps. You know that's a dangerous

trap for you to fall back into.

10. T: You tend to react by withdrawing because you don't want to hurt them. But being the good guy can get in your way, stop you from expressing yourself.

These therapist statements fall into the genre of therapist statements that put forth or assert some hypothesis or truth about the client, therapy, the client's environment, the nature of reality, etc. They may be considered to contain behavioural requests, but they are somewhat different from the previous examples cited. The request is still specific, clear and concrete but may be seen as more subtle, more indirect. You may ask yourself: If I were the client, would there be a likely response on my part? What would the likely response be? For example, one way to regard these statements is as invitations for an "agreement or disagreement" response from the client.

(1B) Inert Therapist Statements: Statements That Do Not Contain Behavioural Requests

In this first step you are identifying and differentiating between therapist statements that are relatively inert in terms of behavioural requests and those that clearly, specifically, and concretely indicate how the client is to respond in the next therapist statement. While you could probably make sense of every therapist statement in terms of what the therapist meant and what the client is to do, in this study we prefer that you identify those inert statements that do not contain a clear and specific indication of what the client is to do next (i.e., the subsequent verbal response).

Inert statements, at the most, contain very vague hintings of what the client might do next. They do not have high informational value as to how the client is to respond. It would require guesswork on your part (and on the client's part) to figure out what the client's response should be.

Generally, inert statements will consist of simple acknowledgments, simple repetition, or restatements of previous client statements. (In the course of studying the therapist statements, you may find that other therapist statements also do not contain clear, specific and concrete behavioural requests).

Here are some examples of therapist statements that we consider to be inert. To get a sense of the difference between inert therapist statements and those that contain behavioural requests, contrast the following statements with those provided in the previous section.

1. T: Uh-huh. Uh-hmm.

2. T: Yeah. Yeah. Right. Right.

3. T: Ah, yes ... I see.

These are simple acknowledgments of what the client has said. The client is not requested to do anything. There is virtually nothing in the therapist statement to guide the subsequent client response in one way or another.

4. T: We'll meet next week at the same time.

This is part of the therapy arrangements. The client is not requested to do anything in the next statement. These interchanges are not really part of the therapeutic work.

5. Cl: I look forward to the meeting with a bit of mixed feelings.
   T: Uh-huh...mixed feelings.

6. Cl: Ah. I get to work.
   T: Okay, you're arriving at work.

7. Cl: I should be more assertive. I should tell them how I feel.
   T: I should be more assertive. I should tell them how I feel.

8. T: There's so much pain there. That's okay. I understand.

These therapist statements are simple repetitions and restatements of what the client is saying. They convey the therapist's understanding, empathy, sympathy, but they do not request anything from the client. There is nothing in these therapist statements that suggests or indicates how the client is to respond, what the client is to say next.

9. T: I've been thorough that myself.

10. T: I feel very close to you right now.

These therapist statements are self disclosures that do not contain indication of how the client is to respond. The client is not requested to do anything. There is no clear, specific, concrete behavioural request that could guide the client in responding to the therapist statement.

(1C) <u>Equivical Therapist Statements</u>

There will be therapist statements that are equivocal. They really do not contain behavioural requests unless you get

too loose. At the same time, they are not as clearly inert as the examples of therapist statements given in the previous section.

Here are some examples of equivocal statements:

1. T: Is the washroom up there?

2. T: Do you put your shoes on at the office?

These therapist statements may appear to request a "yes or no" response from the client. However, when they are part of the general chitchat that sometimes take place at the beginning and/or end of therapy sessions, and are not part of the actual therapeutic work, we do not consider them to contain behavioural requests.

3. Cl: ...I'm trying to get my life in order and I think these meetings and going over the problems are getting rid of some of the mist that has been holding me up...
   T: Well...what is...you mentioned the mist, clearing some of that so you could sort through problems...

This is a tricky example of incomplete therapist statements. In these statements the therapist may be merely repeating or restating the client's previous statement, or part of the client's previous statement. If you get loose, you might see that the therapist is getting at something, such as a request for the client to go on and talk more about a specific subject or topic. Because the sentence is incomplete, the behavioural request is really not clear. Since the behavioural request is not clear, this statement would not be considered to contain a behavioural request.

4. Cl: I have tried to tell them. Just recently.
   T: You have?! (said in delighted, pleased voice).

In this statement, the therapist is not really asking the client if he or she actually did that, but is expressing delightful acknowledgment and approval. At best the statement is equivocal. It may contain a behavioural request but it is not clear that it does. So this statement would not be considered to contain a behavioural request.

(1D) <u>What to do once you have decided whether or not the therapist statement contains a behavioural request</u>

Once you have examined the individual therapist statement, write down the therapist statement number and, next to it, yes -- if you judge the statement to contain a behavioural request, or no -- if you judge the statement to contain no such behavioural request.

STEP 2 Identifying the Behavioural Request Contained in the Therapist Statement

For those therapist statements that you judge as containing a behavioural request, you are to describe what the requested behaviour is.

Examine the therapist statement and try to frame an answer to the following question: On the basis of this individual therapist statement, what is the client to do now? How is the client to respond in the next statement? What is the client's verbal behaviour to be?

Here are some guidelines for you to follow in describing the behavioural requests contained in therapist statements.

1. Imagine you were the client

Ask yourself: Given the therapist's actual words, what immediately subsequent verbal response is invited, suggested, directed, instructed by the therapist's communication?

If you were the client, would you have a good idea of what you are invited or requested to do? If you were the client, listening to the therapist, and you were to follow what the therapist was inviting you to do, what would you know to do/say next? What would be the likely response if you were to follow the request, invitation, or direction contained in the therapist's words?

Here are two examples:

(a) Cl: I should be more assertive.
T: Just say that sentence over.

Here are a couple of ways of describing the behavioural request:

(1) The client is to say: "I should be more assertive."
(2) The client is to repeat the sentence.

(b) Cl: I should be more responsible.
T: I should be more responsible. Who is saying that to you?

Here are a couple of ways you might describe the behavioural request:

(1) The client is to (identify and) name the person who says "You should be more responsible," or
(2) The client is to name the person who is the source of

the words "You should be more responsible."

2. Focus on the immediately subsequent client response

In describing what the client is to do, focus on the immediate present. Define what the client is to do now, in therapy, in the immediately subsequent client response. This is as opposed to what the client might or should do in the more remote future, later in therapy or outside the therapy session.

Here are two examples:

(a) Cl: After I re-experience the whole situation with her I feel a great amount of frustration.
T: Okay. Would you share that with her, now.

Here are a couple of ways you might describe the behavioural request:

(1) The client is to express his feelings of frustration directly to the other person, or
(2) The client is to share his feelings with the other person.

(b) Cl: She thinks that I'm really stupid. That she knows more about everything. There are things I know that she knows nothing about.
T: Can you tell her that you're bright, there are some things you know about.

Here are a couple of ways of framing the behavioural request:

(a) The client is to tell the other person directly that she is bright and that there are things she knows about, or
(b) The client is to express herself directly to the other person.

In both the above examples, the immediate request is for the client to say these words directly to the other person, right here and now in therapy, and not in the remote future outside therapy.

Sometimes a therapist statement will actually instruct the client to do something outside of therapy. Your focus must still be on the behavioural request pertaining to the immediately subsequent client response. Ask: What is the client to say next in response to the therapist statement? How is the client to respond?

Here are two examples:

(a) Cl: I don't know how she'd feel about coming into the session with me.
T: Well, I would suggest that you discuss this with her, that you tell her that it may be helpful at some point if she considered coming into a few sessions.

The behavioural request may be framed as follows:

(1) The client is to indicate his willingness or unwillingness to follow the therapist's suggestion for extra-therapy behaviour by saying "yes or no", or
(2) The client is to state whether he is willing to go along or not willing to follow the therapist's recommendation.

(b) T: It's important that you avoid any situation that might tempt you to steal hubcaps again. Maybe it's better that you stay away from that crowd for a while.

Here are a couple of ways of framing the behavioural request:

(1) The client is to indicate, by saying yes or no, her willingness or unwillingness to go along with the therapist's recommendation, or
(2) The client is to agree or disagree with the therapist's assessment of what's important for the client and the therapist's subsequent suggestion.

It is true in both these examples that the therapist is advising particular behaviours outside of therapy. Since we will only be looking at the client's statements in therapy, we want to define what the client is to say next, how the client is likely to respond in the next statement, We want to define what the behavioural request is in terms of the immediately subsequent client response.

3. Formulate specific behavioural requests using simple language

Stay close to the therapist's words and formulate a specific, rather than general, behavioural request. Use simple language, avoid technical vocabulary from one theory or another.

Here is an example to illustrate specific versus general behaviour requests:

T: How are you feeling toward her?

Generally formulated the behavioural request might be: The client is to have insight into, be aware of, or be in touch with her feelings for other people. Don't formulate behavioural requests that are general.

Specifically formulated, the behavioural request might be:

(1) The client is to describe her feelings for the other person, or

(2) The client is to say how she feels towards the other person.

These are good, specific ways to frame the behavioural request.

Here is an example of simple language versus technical vocabulary from some theory:

T: Would you be willing to talk to him now. Would you put him over there and describe him.

The behavioural request in technical vocabulary might be: The client is to use the Gestalt 2-chair technique. Don't do this. It's technical vocabulary. Use simple language.

The behavioural request in simple language might be written as:

(1) The client is to describe the other person, or
(2) The client is to imagine the other person there and describe the person.

4. Try to frame the one main behavioural request for each therapist statement

Typically, a therapist statement will contain only one behavioural request. Sometimes, however, longer therapist statements will contain a number of behavioural requests. When this is the case, use the following guidelines:

(a) Use your judgement to select which one seems most important

Almost always, one behavioural request will seem more important than the others. It is the one that carries more weight, that affects the client's response, that directly suggests what the client is to say next. The main behavioural request will usually be located either at the beginning or the end of long therapist statements.

(b) Select the behavioural request that is most likely

to influence what the client says in the next statement

This point is discussed further in guidelines 5 and 6. The general idea is that you select that behavioural request which is directly aimed at the client's subsequent verbal response. That is, if a judge were to examine the subsequent client statement, which behavioural request would the client most likely be responding to in his or her words.

(c) If two or more behavioural requests still seem equally important, use your judgement to either give preference to the one that occurred last or to combine two behavioural requests.

In most instances, the behavioural requests that occurred last will have the greater effect upon the subsequent client statement. In some instances, it may seem likely that the client will respond to two behavioural requests. The best guide is to put yourself in the client's shoes and ask yourself whether you would be likely to respond to only one behavioural requests or a combination of two requests.

Here are two examples:

(a) T: Be a young woman. Be 22. That day. You're on your way home from work. And what are you feeling? Are you, did you take the bus home from work or the car?

The behavioural request may be framed as follows:

(1) The client is to say whether she took the bus or the car home from work, in the specific earlier situation, or
(2) The client is to say what she is feeling as a 22 year old in a specific situation and to provide information on means of transportation -- car or bus -- from work to her house in the specific earlier situation.

The therapist statement contains a number of behavioural requests. The client is asked to be a certain person, a certain age, in a specific situation. The client is asked to describe her feelings. The client is asked to provide information on how she got home from work that day. Two alternatives are given for framing the behavioural request. In one, the last behavioural request is chosen. In the second alternative, the behavioural request is framed as a combination of two requests -- to describe her feelings and to provide information on how she got home from work that day. This is an acceptable alternative because the request to describe her feelings seems more important therapeutically, and while the client is likely to first

answer the therapist's last question, she might go on to describe her feelings.

(b) T: Do you want to do anything about it or do you prefer not to?
Cl: I don't know.
T: But I want you to make your decision now. See? Maybe you feel pressured. Be aware of that too. Or check more on what you want to do.

The behavioural request may be framed as follows:

(1) The client is to state his decision now, or
(2) The client is to decide now and tell the therapist his decision.

The therapist statement contains a number of behavioural requests. For example, the client is to make a decision, the client is to be aware of any pressure he feels, the client is to check more on what he wants to do. In this case, the decision to focus on the first behavioural request is based on two factors -- (1) the request for the client to decide seems to be more important than the others, more likely to affect the client's subsequent response, (2) it would be relatively difficult to assess whether, in response to the therapist's request, the client is being aware of felt pressure or checking more on what he wants to do. It would be relatively easier to see whether or not the client decides.

5. Refer to verbal behaviour only

In formulating the behavioural request, refer only to what the client is requested to say. In this study we are not including body movements or physical actions, such as hitting the pillow, kicking feet and legs, lifting arms, etc. These are indeed clear and specific behavioural requests but we cannot use them in this study. So the behavioural requests you write down should describe what the client is to say. They may also refer to how the client is to say them. That is, the behavioural requests may refer to sounds that are not language, not words, but may be heard. For example, you may refer to sounds such as screaming, yelling, crying, shouting, laughing, etc.

Here are a few examples:

a) T: It helps when you hit the mattress as hard as you can, and yell as you do it. Make a noise.

The behavioural request might be written as:

(1) The client is to yell, to make a noise while hitting

the mattress, or
(2) The client is to yell, to make some noise while engaged in the next activity (note that hitting the mattress and engaging in the next activity is not included as part of the request. Instead the description refers to the client's verbal response.)

b) T: Say it again, louder, louder and with more feeling.

The behavioural request may be written as:

(1) The client is to say it again, louder and with more feeling, or
(2) The client is to repeat it, but this time say it louder and with more feeling.

c) Cl is crying.
T: It's okay. Just let it out. Just let it out.

The behavioural request may be written as:

(1) The client is to go on crying, to let the feelings out, or
(2) The client is just to let the crying out.

d) T: Come here. Stand up. Give me a hug. Go ahead. Cry if you want.

Though the behavioural request does indeed call for some physical actions, since we are only looking at what the client is to say and how the client is to say it, the behavioural request may be written as follows:

(1) The client is to cry if he wants to, or
(2) The client is to go ahead and cry, if that is what he wants.

6. What to do with behavioural requests that refer to client behaviours that are unspoken, internal processes

There is a problem with therapist statements that ask or invite the client to engage in a task or process that is covert behaviour, done internally, without words. For example, therapist statements may directly request or indirectly invite the client to be aware of something, to think about or consider something. The therapist might say "take your time" or "stay in contact with". The problem with these requests or invitations is that it would be difficult, if not impossible, for an external judge or rater, looking at the next client statement to assess and verify whether indeed the client is being aware, thinking

about, considering, taking his/her time, maintaining contact, etc. These are internal processes, covert behaviours, that are not given to external observation.

In this study, we want to be able to look at a subsequent client statement and to see whether or not the client is evidencing the behaviour that is requested in the previous therapist statement. Try to write down behavioural requests that allow for that. Accordingly, in writing out the behavioural requests, always try to figure out: "What is the client to <u>say</u> next? What sounds is the client to make? What words or sounds are being directly requested or indirectly invited from the client? Wherever possible, write down the request referring to observable, measurable, verbal behaviours, what the client is to say and <u>not</u> to behaviours and processes that are covert, internal, unspoken, not given to observation.

If the therapist's statement is a long, multi-part statement with many behavioural requests, you can use this guideline to select the main request.

When there is a therapist statement with one behavioural request, or there is no way to write down the behavioural request in terms of what the client is to say or how the client is to say it, only then do you leave the behavioural request as is, referring to a requested behaviour that is not given to external verification.

Here are three examples:

(a) T: It's unlikely that you felt that way for the first time at age 12. That experience may have reinforced it, but probably there were situations before that, when you were a child.

The behavioural request may be written as follows:

(1) The client is to agree or disagree with the therapist's statement about when the feelings began, or
(2) The client is to say yes or no, in agreement or disagreement with the therapist's statement about the client.

There are a number of ways to look at therapist statements that posit some truth or hypothesis. They may be seen as invitations to consider or reflect upon the therapist statement. They may be seen as invitations for the client to see himself or herself in a new way. If we are just looking at the client's subsequent statement, there is no way to assess whether the client is really considering or reflecting upon the therapist's words or whether the client is really seeing himself/herself in a new way. From the

client's words, all that we can see is whether the client agrees or disagrees, or whether the client's words follow up on what the therapist has said, adding to and bolstering the therapist's perceptions or discounting them.

(b) T: Just close your eyes now. Hear someone saying to you: "You should be more assertive. You should be more assertive." Hear that being said to you. Take your time about it. Do you see someone yet?

The behavioural request may be written as follows:

(1) The client is to say yes or no to the therapist's question about seeing someone saying those words, or
(2) The client is to say yes, meaning he has a picture of someone, or no, meaning he does not see anyone yet.

There are a number of behavioural requests here. Only the latter is really given to verification by looking at the client's subsequent words.

(c) T: See him. See your husband in that chair. Be a young woman, 22 with your briefcase. See his face, his expressions. And just let your feelings develop.

This is a tough one. None of the therapist's words request the client to say something. They ask the client to see someone, to be someone, to let her feelings develop. This is one of those times I would go with the latter request, framing it in the context of the earlier ones and acknowledge that there is no requested "verbal" behaviour. For example, I might write: The client is to let her feelings develop, while she, a 22 year old woman, is looking at and seeing her husband's face and expressions. I might also write: In the specific situation where she is 22 and seeing her husband, the client is to let her feelings develop (may express or describe feelings).

Training Examples of Therapist Statements and Behavioural Requests

Here is a separate batch of examples of therapist statements and the behavioural requests that they contain.

1) T: So, she's been to grandfather's funeral and she looks sad. How are you feeling toward her?

Behavioural Request: The client is to describe her feelings for the other person in the particular situation.

2) T: Where's your nervousness coming from right now?

Do a check in your body and see if you can find out where it is?

Behavioural Request: The client is to check her body to find out where in the body the feeling is and is invited to report where in the body the feeling is.

3) T: Let me give you a sentence and ask you to try saying it. Would you say this to your mother...

Behavioural Request: The client is to say some words directly to mother.

4) T: Were you feeling a bit nervous?

Behavioural Request: The client is to say "yes or no" in response to the therapist's question about her feelings.

5) T: How did you go about finding an apartment?

Behavioural Request: The client is to describe how he went about finding a new apartment.

6) T: What stops you there? You couldn't tell him how you felt. What stops you from doing that?

Behavioural Request: The client is to explain, describe what it is that stops her from expressing her feelings to the other person.

7) Cl: I want to be more assertive. Yeah.
T: Yeah? Well that's part of it. Now you know how you felt when you let them decide for you. You felt angry, frustrated. Somehow you need to talk to them about that. I feel you need to talk to them about that.

Behavioural Request: The client is to agree or disagree with the therapist's assessment of what he needs to do.

8) Cl: I thought about what I would say to her, but I know what her answer would be.
T: That's another way of stopping yourself. Sort of decide in advance what her response would be, you know?

Behavioural Request:	The client is to say "yes or no", she agrees or disagrees with the therapist's statements about her behaviour that stops her from doing certain things.

APPENDIX B

Instructions to Raters in Phase 3: Assessing the Goodness-of-Fit Between the Therapist Statements and Categories of Requested Verabl Behaviour

You have been given the following materials:

(1) Verbatim transcripts of 12 sessions of psychotherapy (6 sessions for Maloney, 6 for Barry).
(2) A category system for Maloney (9 categories) and a category system for Barry (5 categories). These categories refer to a particular aspect of therapist statements. They refer to what the therapist is asking inviting, instructing, directing, or requesting the client to say next. The therapist statement is viewed as inviting, or requesting, or instructing the client to respond (verbally) in a specific way in the immediately subsequent client statement. Given the therapist's words, the client is likely to respond in a particular way. (see *NOTE 1).
(3) The specific therapist statements that you are to examine are listed following the description of each category.
(4) The response categories from which you are to choose are provided beside each statement number. They are: (1) Yes, it fits, (2) No, it does not fit, and (3) I am not sure.

Your job is to determine whether a particular therapist statement qualifies as fitting or not fitting into a particular category. Here is what you do:

(1) Read the title and description of the category. Start with Maloney Category #1.
(2) Identify the number of the statement that you are to examine (and the Maloney session from which it comes from). You will see that the first statement you are to examine is statement #48 from Maloney session #1.
(3) Get the transcript of the session you are to examine (e.g., Maloney session #1). Read the identified statement (e.g., #48).
(4) Answer the following question:
Given this particular category, does this statement qualify as fitting into this category?

It may be helpful, and sometimes necessary to read the previous client statement and/or previous therapist statement. If it helps, go back 1 or 2 or 3, or more therapist and client statements. But remember that ultimately you are dealing with the verbal behaviour that is being requested in the target statement.

In order to judge whether a statement fits the

category, it may be necessary for you to figure out what verbal behaviour that specific therapist statement is requesting. If you find that you need to do so, answer the following question: On the basis of this statement, how is the client to respond (verbally) in the next statement? What immediately subsequent verbal response is invited, suggested, directed, or requested by the therapist's words? If you were the client, what would you be likely to say next? (If there is more than one behavioural request in the statement, select the one to which the client is most likely to respond. Usually this will be the last request.)

(5) Indicate your answer to the above question by circling number 1, or 2, or 3 to the right of the statement number.
You have a choice of three answers, as follows:
   (1) Yes, it fits. Your judgement is that there is a perfect, or adequate (pretty good, moderately good, sufficient) fit between this statement and this category.
   (2) No, it does not fit. Your judgement is that there is absolutely no fit, or negligible fit, or hardly any fit between this statement and this category.
   (3) I am not sure. This means that you have really thought about it and you simply cannot decide whether the statement fits or does not fit the category. This is a rating of last resort, reserved for those statements of which you are unsure for good reason. Please do your best to be sure.

(6) Identify the next statement you are to examine. (For example, after you have finished with Maloney session #1 statement #48, you are to examine statement #76, also from Maloney session #1.)

(7) Repeat steps 3 to 5 for this statement number.

(8) Repeat steps 2 to 5 for each statement number listed under category #1 for Maloney.

(9) Repeat all the above steps for Maloney Category #2, #3, #4, etc.

(10) Do the same for Barry.

*NOTE 1 - In a previous phase of this study, another group of judges determined that certain statements (including those that you will be examining) contain requests for verbal behaviour. That is, each of these statements generate a specific, clear, concrete picture of how the client is to respond in the next statement. The judges in the previous phase of this study also formulated what the requested verbal behaviour was for those statements they judged to contain a behavioural request. It is on the basis of their work that the present category systems were constructed.

APPENDIX C

RATING SCALE: CLIENT RESPONSES TO REQUESTS FOR VERBAL BEHAVIOUR

1. The client actively refuses to do it.

The client clearly, directly and openly refuses to manifest the requested verbal behaviour. The client clearly, openly and directly objects to, disagrees with, or questions the behavioural request.

The client, in a clear, forthright, direct manner, disagrees with the therapist; objects to or rejects what the therapist is saying. (pertains to category 1, both cases)

The client says (literally or in essence): "I don't want to... do it (...answer your question, ...follow your request or instruction, ...tell you this)", or "I won't... do it (...answer your question, ...follow your request or instruction, ...tell you this)". (pertains to all other categories)

2. The client passively avoids doing it.

Rather than openly refusing to carry out the requested verbal behaviour, the client avoids it in an indirect manner. To be rated as a 2 the client must really not be doing it. If the client does it even a little bit or in an incomplete manner, rate it as a 3.

These are some ways in which the client may ignore, disregard, or avoid the behavioural request:

(a) changing the subject; doing or saying something else.
(b) being silent
(c) responding with "maybe" or "possibly"; giving a "yes, but..." or "no, but..." response. (pertains to category 1 and 2) (Read the whole client statement! These client responses get a 2 rating if the client is being evasive, is not committing himself to a response, or is disqualifying her own response. If your sense is that the client is answering and then specifying, differentiating, elaborating, and exploring further, then the client response is rated as a 3 or 4.)
(e) responding with "I don't know" or "I don't remember". (Read the whole client statement! Rate it as a 2 only when the client says "I don't know" or "I don't remember" and then either changes the

subject or says no more. If the client says "I don't know" or "I don't remember" and then proceeds to manifest the requested verbal behaviour then rate the client response as a 3 or a 4.)

(f) responding to a question with another question.
(g) saying "I can't". (pertains especially to categories 5 & 6, Maloney)
(h) talking to the therapist "about" it, rather than talking directly to the other person or playing the role of younger self, other person, etc. (pertains to categories 5 & 6, Maloney) (clues - uses past tense; uses 3rd person language, such as he, she, they, or them, rather than "you" or "I" language.)

3. <u>The client manifests the requested verbal behaviour to some extent</u>

The client is following the behavioural request to a moderate or weak extent, is slightly or partially evidencing the requested verbal behaviour. The requested verbal behaviour is present but cursory, weak, incomplete or barely present. The client is doing it a little bit, or is doing part of it.

Here are some special guidelines to aid you in detecting client statements that get a "3" rating:

(a) Unelaborated responses - In terms of manifesting the requested verbal behaviour, the client gives the bare minimum, but does not elaborate or explore further.
For example, in Category 1 and 2 - the client says yeah, uh-hmm, yes, or no, and then either changes the subject or simply says nothing more.
(b) Minimum involvement - There is very little investment of self on the part of the client. This indicator may be especially relevant for category 3 (both cases), and categories 5, 6, & 8 (Maloney).
(c) The client gives a "yes, but..." (or "no, but...") response and your sense is that, rather than being evasive, the client is attempting to answer the question, to explore further and to differentiate to some extent. (pertains to category 1 and 2)
(d) The client begins with "I don't know" (or "I don't remember), but then proceeds to follow the behavioural request, to manifest the requested verbal behaviour to some extent.
(e) Maloney Categories 5 & 6 - Doing it a little bit or doing part of it
For example, the client talks in the past tense,

but the client response is not all evasion. The client may be talking in a little kid voice, or in a clearly invested manner, though talking in the past tense. Another example is when the client responds to either the specific therapist request or to the larger category, but not to both concurrently. Ask yourself, is the client doing it a little bit? If yes, rate it as 3.

4. The client is following the behavioural request well, is significantly evidencing the requested verbal behaviour.

A client statement is rated as 4 when the client gives a full response. Your sense when reading the statement is that the client is really doing it; is manifesting the requested verbal behaviour fully and well.

The client shows clear involvement and self-investment. His or her heart is really in it.

With regards to category 1 and 2, the client goes beyond saying yes or no or uh-hmm. The client elaborates, explores further on the subject under discussion. When the client elaborates (expands, explores further), the content must be on topic. That is, the client is continuing with the subject under discussion rather than changing the subject. The client's continued exploration is pertinent to, connected to, and related to the therapist's question or statement.

APPENDIX D

Instructions to Raters in Phase 4: Rating of Clients' Responses to Therapist's Requests for Verbal Behaviour

Background Information

In a previous phase of this study, another group of judges examined a series of sessions conducted by two therapists, Maloney and Barry. The judges determined that certain therapist statements (including those that you will be examining) contain requests for verbal behaviour. That is, each of these statements generate a specific, clear, concrete picture of how the client is to respond (or is likely to respond) in the next statement. These judges also formulated what the requested verbal behaviour was for those statements they judged to contain behavioural requests.

On the basis of their work, two category systems were constructed, one for Maloney and one for Barry. (You will note that some categories occur in both therapy cases.)

An Overview of Your Task

This week I am giving you the title and description of Category 1 for Maloney. Following the description of the category are a number of excerpts taken from Maloney's sessions and presented to you in random order. In the following weeks you will get the other categories. Following the title and description of each category there will be a number of excerpts taken from Maloney's or Barry's sessions. You will examine each therapist's work separately. Depending on the number of excerpts included in each category you will get 1 or 2 or 3 categories per week.

The categories given to you refer to a particular aspect of the therapist's statements. They refer to what the therapist is asking (inviting, instructing, directing, requesting) the client to say (that is, verbal behaviour only) next (that is, in the immediately subsequent client response).

Your job will be to examine each excerpt and determine the extent to which the client manifests (carries out) the verbal behaviour requested by the therapist.

You have an additional task for Category 1 (both cases). This is described in greater detail at a later point in these instructions.

Steps in Rating Client Statements

1. Carefully read the title and description of the category.

2. Go to excerpt #1.

3. Read the excerpt.

4. The target client statement, the one you are to rate, is always the last client statement in the excerpt. Usually an excerpt consists of only the target couplet, that is, one therapist statement and the immediately subsequent client statement. You will note that sometimes one or more previous therapist and client statements have been included. You will also note that in Category 6 (BM only) I have sometimes included part of the therapist statement immediately subsequent to the target client statement. These statements have been included to help you in your ratings. They clarify what it is exactly that the therapist is requesting, or they provide a context to help you better understand the client response. Read these statements. Let them help you, but remember that you are rating only the target client statement.

5. Make sure that you have carefully read the whole (target) client statement. You are rating the whole client statement.

6. You are to answer the following question:
Given (a) this category of requested verbal behaviour, and (b) given the specific request for verbal behaviour that is contained in the antecedent therapist statement (i.e., the specific instance of the larger category)... to what extent is the client manifesting (displaying, carrying out) the requested verbal behaviour?

7. Now refer to the Rating Scale - Client Responses to Requests for Verbal Behaviour. This rating scale gives you a choice of four answers to the question posed above. Rate the client statement by choosing one of the four options given in the rating scale.

8. Remember that you are rating the whole (target) client statement. At times you may find that a client statement fits more than one option. As a general rule, go with the highest rating. For example, if there are elements of a 2 and a 3 in the client response, rate it as 3. If there are elements of a 3 or 4 in the client response, rate it as 4.

9. Repeat steps 3 to 8 for excerpt 2, then 3, then 4, etc., until you have finished rating all the target client statements included in that category.

10. Follow the same procedure (steps 1 to 9) for each subsequent category.

Special Instructions for Category 1

In both therapy cases, Category 1 is subdivided into 1a

& 1b. For this category only I would like you to do one thing in addition to rating the target client statements. For each excerpt, examine the therapist statement that is immediately antecedent to the target client statement and determine whether this particular statement fits into 1a or 1b. Answer the following question: Is the requested verbal behaviour in this specific statement best described in 1a or in 1b? Then indicate your choice (rating, decision) by marking either 1a or 1b.

APPENDIX E

The Categories of Requested Verbal Behaviour

Following is a full description of each category of requested verbal behaviour of therapist statements that were assigned to the respective categories.

Maloney's Categories of Requested Verbal Behaviour

Category 1: The client is to consider the therapist's words and to provide confirmation, acknowledgement, or agreement.

In this category of requested verbal behaviour, the client is to reflect upon what the therapist is saying, to seriously consider and weigh the therapist's words, and to confirm, acknowledge, verify, agree, accept the therapist's words.

The client is to provide confirmation and verification. He is to confirm or verify that the therapist is correct and accurate in his impressions, intuitions, observations, descriptions, understanding, and assessments of the client, or the other person, or the situation. The client is to re-confirm his own previous words, or to confirm that the therapist's understanding of what the client has been saying is correct.

The client is to provide acknowledgement. He is to simply acknowledge the therapist's words. He is to acknowledge that the therapist is right, that there is sense or truth in the therapist statement.

The client is to indicate understanding of the therapist statement. He is to indicate that he sees the therapist's point, or that he sees what the therapist is talking about.

The client is to agree with the therapist. He is to agree with the therapist's impressions, observations, feelings, thoughts, images, views, opinions, descriptions, and assessments of the client, or the other person, or the situation/scene. He is to agree that therapist is correct or right, or accurate. He is to agree that this is what he (the client) means.

The client is to accept the therapist's general knowledge and expertise as true, correct, or accurate. In his response to the therapist, the client is to agree to follow the therapist's suggestions, instructions, or recommendations of in-therapy or extra-therapy behaviour.

Category 2: The client is to provide a yes or no response to the therapist's questions.

In this category of requested verbal behaviour the client is to answer yes or no. He is to say yes or no in

response to the therapist's questions about the client, about other people, or about past, present, and future events.

The client is to answer yes or no to a direct question. The therapist statement may also be indirectly questioning, probing, querying. For example, the therapist says: "You don't smoke, aye?", or "You like science fiction books". The client is to say whether or not he smokes, or likes science fiction books.

Though there are some similarities between Category 1 and Category 2, the difference is that the requested response in Category 1 is clearly confirmation, acknowledgement, or agreement, whereas in Category 2 there is more room for the client to answer no, to disconfirm, to disagree. In category 2, the requested response is clearly either a yes or a no.

Category 3: The client is to understand, to describe, assess, or explain himself, or the other person, or the situation psychologically.

The client is to be aware of and describe aspects of himself, such as: (1) his feelings and experiencing (current, ongoing feelings or feelings in a past situation), (2) his feelings about and reactions to doing or saying something to the other person, (3) his feelings and reactions when he hears the other person say something, (4) his feelings about and reactions to current or past events and situations, (5) his physical self (for example, where in his body he feels something), (6) his thoughts and beliefs, (7) his concerns, difficulties, and fears in a specific situation, or (8) issues that he would like to work on in the session.

The client is to identify the particular individual or past event that is the source of some cognition, feeling, belief, behaviour. The client is to identify aspects of self, the other person, or the situation that make him feel, or react, or behave a certain way.

The client is to understand, to explain and account for: (1) being or not being a certain way, (2) his behaviour, that is, doing or not doing something, (3) wanting or not wanting something, (4) the meaning of his physical gestures (for example, a smile), (5) changes in himself, his life, or the other person, or (6) for the impact the other person has on the client.

The client is to understand and evaluate his past and present relationships. He is to understand, evaluate, and explain the personal significance of specific events and situations, including the therapy session.

Category 4: The client is to provide general demographic and descriptive information about himself, the other person, or situations and events.

In this category of requested verbal behaviour the client is to provide general information about himself and aspects of his day to day life, such as: 1) his age, 2) his job, and 3) his eating habits.

The client is to identify, to name the other person. He is to give general information about the other person. He is to describe, or to continue describing and say more about the other person.

The client is to identify past situations, events, incidents, or scenes that come to his mind when he considers certain words or focuses on a feeling. He is to identify past situations in which a particular thing happened.

The client is to describe, or say more about, earlier life events, recent incidents, or the present scene. He is to provide information about aspects of a situation, such as: (1) the physical setting or surroundings, (2) the client's behaviour, what he said and did, (3) the other people's behaviour, what they said and did. The client is to either recount the past incident or to describe it as if it were taking place in the present.

This category excludes those instances in which the client is to describe the scene or other person while playing the role of younger self or other person. Those instances go in category 6.

Whereas in category 3 the client is to respond with psychological understanding, description, assessment, explanation, or evaluation, category 4 focuses more on "factual" information.

Category 5: The client is to talk directly to the other person.

In this category of requested verbal behaviour the client is to express himself directly to the other person. He is to make contact with and speak directly to the other person. The emphasis is on saying it directly, talking directly, telling it directly.

The client is to share his feelings, experiencings, and reactions directly with the other person. He is to say specific words. The words are either provided by the therapist or previously stated by the client. He is to tell the other person directly whatever comes to mind, whatever he needs or wants to say.

The other person may be someone from the client's past or current environment, or it may be the therapist. The client is to speak directly to the other, whether the other is there in imagination or there in person.

This category includes those instances in which the client is to talk directly to the other person while playing the role of a younger self. It also includes those instances in which the client is to continue talking or say

it again...directly to the other person.

Category 6: The client is to play the role of younger self, part of self, body part, or other person. The client is to speak as that younger self, part of self, body part or other person.

The client is to speak as another person, or a younger self, or a part of self, or a body part. In the role of the other person, or younger self, or part of self, or body part the client is to: (1) describe his feelings, experiencings, and thoughts, (2) state what he believes, (3) describe the other person, (4) describe the scene or situation (that is, the physical setting, what is happening, what is being said and done), (5) say particular words, (6) respond to the other person's words, (7) answer questions, (8) continue speaking or repeat something, or (9) merely speak as the other person, self, or body part.

Category 7: The client is to clarify or repeat his words when the therapist does not hear or understand.

The client is to repeat what he just said in the immediately antecedent client statement. The client is to repeat something that either he or the therapist had said earlier in the session. The client is to repeat all or only some of the previous words, sentence, or statement.

The client is to clarify his words. He is to explain what he means by saying something. He is to be more specific. The client is to clarify or explain all or only some of his previous words, sentence, or statement.

In this category of requested verbal behaviour, it must be clear from the therapist's words that the therapist did not hear the client's words, or that he forgot an earlier statement, or that he does not understand.

Category 8: The client is to say it again or continue saying it, with or without modification.

The client is to say it again, to repeat it, to continue saying it, to just keep saying it over and over. "It" is a specific sentence, or set of words. These specific words may have been spoken by the client in a previous statement. The specific words may be ones provided by the therapist that the client is to try on for size. The client is to simply repeat the sentence(s), or the client is to repeat the sentence(s) with modifications. For example the client is to repeat the sentence, but add certain words, or use the first person (I language) instead of the third person (she, they, one).

The client is to continue making a sound, to do it again, go on doing it. The sound can be a word, but it need not involve language. It can be a yell, or a sob, or a

moan. The client is to simply continue making that sound or the client is to modify it in some way (for example, to say it louder, or substitute one sound for another).

Category 9: The client is to make a decision, indicate his choice or preference, say what he wants or needs to do.

The client is to make and state a decision. He is to make his choices and decisions based on his own wants and needs. While fantasizing or living in a scene with another person (real or fantasized), the client is to decide what he is going to do with the other person. The client is to decide if he wants to do or say something to the other person. The client is to decide what he wants the other person to do, here and now in the session. The client is to see what he wants or needs to do for himself in a situation and then say what he wants or needs to say.

The client is to make decisions and choices relating to therapy and the therapy session. He is to state what he wants to work on in the present session. He is to say whatever it is he needs to say to finish off the session. He is to decide which hand or part of self he wants to be right now in the session.

Barry's Categories of Requested Verbal Behaviour

Category 1: The client is to consider the therapist's words and to provide confirmation, acknowledgement, or agreement.

In this category of requested verbal behaviour the client is to reflect upon what the therapist is saying, to seriously consider and weigh the therapist's words, and to confirm, verify, acknowledge, agree with, or accept the therapist's words.

The client is to provide confirmation and verification. She is to confirm or verify that the therapist is correct and accurate in his impressions, understanding, assessment, descriptions, interpretations, and observations of the client, or the other person, or the situation. She is to re-confirm her own previous words, or to confirm that the therapist's understanding of what she has been saying is correct.

The client is to provide acknowledgement. She is to simply acknowledge the therapist's words. She is to acknowledge that the therapist is right, that there is sense or truth in the therapist statement.

The client is to indicate understanding of the therapist's statement. She is to indicate that she sees the therapist's point, or sees what the therapist is talking about.

The client is to agree with the therapist. She is to agree with the therapist's impressions, observations, thoughts about, views, opinions, descriptions, assessments, interpretations, and explanations of the client, or the other person, or the situation. She is to agree that the therapist is correct, right, or accurate. She is to agree that this is what she means.

The client is to accept the therapist's general knowledge and expertise as correct, true, or accurate. She is to agree with the therapist's suggestions or recommendations regarding extra-therapy behaviour.

Category 2: The client is to provide a yes or no response to the therapist's questions.

The client is to answer yes or no. She is to say yes or no in response to the therapist's questions about the client, about her day to day life, about the other person, or about past, present, and future events and situations.

The client is to answer yes or no to a direct question. The therapist statement may also be indirectly questioning, probing, querying. For example, the therapist says: "You don't smoke, aye?", or "You like science fiction books". The client is to say whether or not she smokes, or likes science fiction books.

Though there are some similarities between categories 1

and 2, the difference is that the requested response in category 1 is clearly confirmation, acknowledgement, or agreement, whereas in category 2 there is much more room for the client to answer no, to disconfirm, to disagree. In category 2 the requested response is clearly either a yes or a no.

Category 3: The client is to understand, describe, assess, or explain herself, or the other person, or the situation psychologically.

The client is to understand and describe, report, evaluate, or explain aspects of herself such as: (1) her general state of mind, (2) her feelings in the present or in a past situation, 3) her feelinged reactions to specific incidents, situations, events, or circumstances, (4) her thoughts, views, and acquired understanding, (5) her actions, her choices and behaviour, or (6) symptomatic, problem-related behaviours and feelings.

The client is to understand, to assess or explain her relationships. She is to assess the relationship's current status. She is to describe or explain her feelings about and reaction to the other person. The client is to understand, to assess or explain the other person. The client is to understand, to assess or explain situations, events, and incidents.

Category 4: The client is to provide general demographic and descriptive information about herself, the other person, or situations and events.

The client is to provide general information about herself and aspects of her day to day life such as: (1) her physical self, (2) her financial situation, (3) her job and working environment, or (4) her material possessions and circumstances (for example, car, apartment, furniture).

The client is to identify and provide general information about people and events. She is to identify the particular person who said or did something. She is to name the person to whom she said or did something. She is to identify who she was with on a specific occasion.

She is to provide general information about past, recent, current and future events and interpersonal situations. She is to supply information as to who, what, when, how often, how much, etc. She is to recollect and describe: (1) some aspect of her past history, such as an event or incident, (2) an interpersonal situation or incident (for example, a conversation), or (3) the course of a relationship.

Whereas category 3 requires some psychological understanding on the part of the client, category 4 focuses more on "factual" information.

Category 5: The client is to clarify, explain, or specify the meaning of her words.

The client is to provide clarification. She is to explain or clarify what she means by saying something. She is to explain a little better or be more specific. She is to specify what she is referring to when she says something, or who she is referring to when she says "he", "she", or "they".

The client is to complete a previous statement. She is to tell the therapist what she was about to say, but did not say. She is to complete her unfinished thoughts, utterances, or sentences.

APPENDIX F

Table F.1

Level of Agreement on the Degree of Client Conformity to Maloney's Categories of Requested Verbal Behaviour

Category	No. of Statements Rated	Statements Attaining Criterion	
		N	%
1	216	182	84.3
2	72	61	84.7
3	91	75	82.4
4	62	41	66.1
5	48	40	83.3
6	37	24	64.9
7	34	18	52.9
8	31	25	80.6
9	13	10	76.9
Total	604	476	78.8

Table F.2

Level of Agreement on the Degree of Client Conformity to Barry's Categories of Requested Verbal Behaviour

Category	No. of Statements Rated	Statements Attaining Criterion	
		N	%
1	238	194	81.5
2	109	82	75.2
3	38	31	81.6
4	41	32	78.0
5	10	10	100.0
Total	436	349	80.0

APPENDIX G

Table G.1

Number and Percentage of Client Statements in Each of Maloney's Categories Assigned a Rating from the Client Response Scale

	Statements Given a Rating	
Category	N	%[a]
1	208	96.3
2	68	94.4
3	89	97.8
4	61	98.4
5	47	97.9
6	37	100.0
7	31	91.2
8	30	96.8
9	13	100.0
Total	584	96.7

Table G.2

Number and Percentage of Client Statements in Each of Barry's Categories Assigned a Rating from the Client Response Scale

	Statements Given a Rating	
Category	N	%[a]
1	230	96.6
2	103	94.5
3	34	89.5
4	39	95.1
5	10	100.0
Total	416	95.4

[a] Percentages are based on total number of client statements

APPENDIX H

Table H.1

Distribution of Client Responses Across Stages for Category 1 in Maloney's Case

	Stage of Therapy						
	Initial		Middle		Final		Total
Client Response	N	%	N	%	N	%	N
Active Refusal	0	0	1	2.1	0	0	1
Passive Avoidance	4	4.3	5	10.6	5	7.4	14
Partial Conformity	48	51.6	23	48.9	39	57.4	110
Full Compliance	41	44.1	18	38.3	24	35.3	83
Total	93		47		68		208

Table H.2

Distribution of Client Responses Across Stages for Category 2 in Maloney's Case

	Stage of Therapy						
	Initial		Middle		Final		Total
Client Response	N	%	N	%	N	%	N
Active Refusal	0	0	1	3.1	0	0	1
Passive Avoidance	3	25.0	6	18.8	1	4.2	10
Partial Conformity	7	58.3	17	53.1	11	45.8	35
Full Compliance	2	16.7	8	25.0	12	50.0	22
Total	12		32		24		68

Figure H.1
Pattern of Client Responses Across
Stages in Category 1 – Maloney

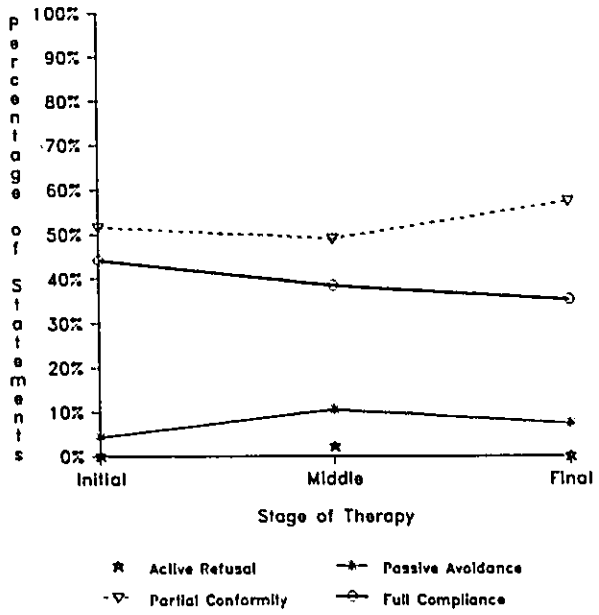


Figure H.2
Pattern of Client Responses Across
Stages in Category 2 – Maloney

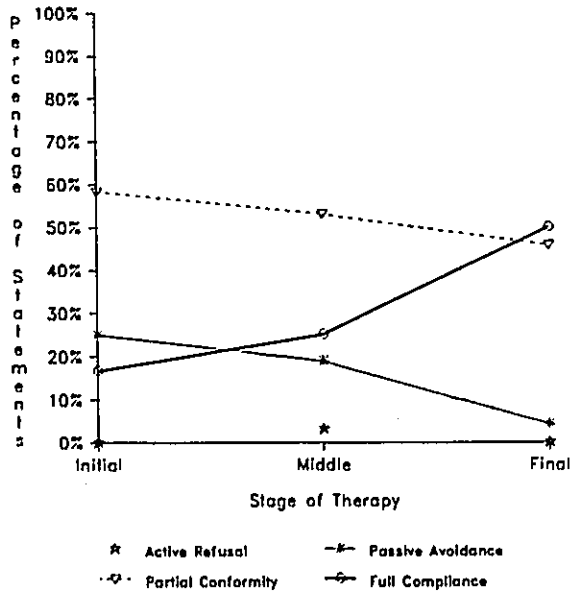


Table H.3

Distribution of Client Responses Across Stages for Category 3 in Maloney's Case

	Stage of Therapy						
	Initial		Middle		Final		Total
Client Response	N	%	N	%	N	%	N
Passive Avoidance	10	27.0	4	14.8	4	16.0	18
Partial Conformity	12	32.4	17	63.0	10	40.0	39
Full Compliance	15	40.5	6	22.2	11	44.0	32
Total	37		27		25		89

Table H.4

Distribution of Client Responses Across Stages for Category 4 in Maloney's Case

	Stage of Therapy						
	Initial		Middle		Final		Total
Client Response	N	%	N	%	N	%	N
Passive Avoidance	2	9.1	2	11.1	1	4.8	5
Partial Conformity	9	40.9	4	22.2	11	52.4	24
Full Compliance	11	50.0	12	66.6	9	42.9	32
Total	22		18		21		61

Figure H.3
Pattern of Client Responses Across
Stages in Category 3 – Maloney

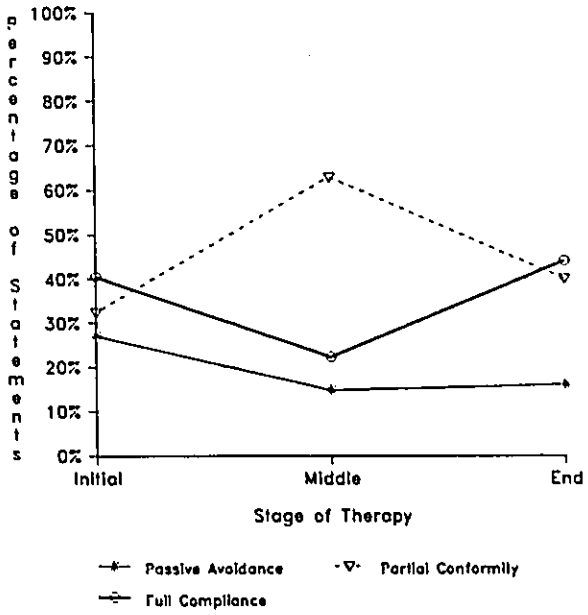


Figure H.4
Pattern of Client Responses Across
Stages in Category 4 – Maloney

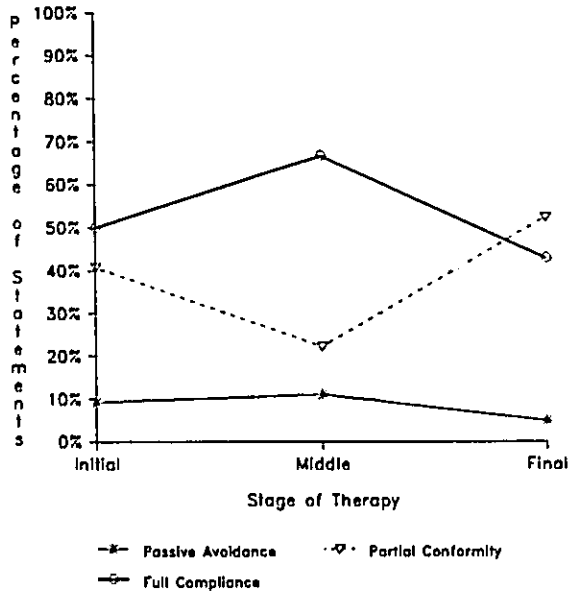


Table H.5

Distribution of Client Responses Across Stages for Category 5 in Maloney's Case

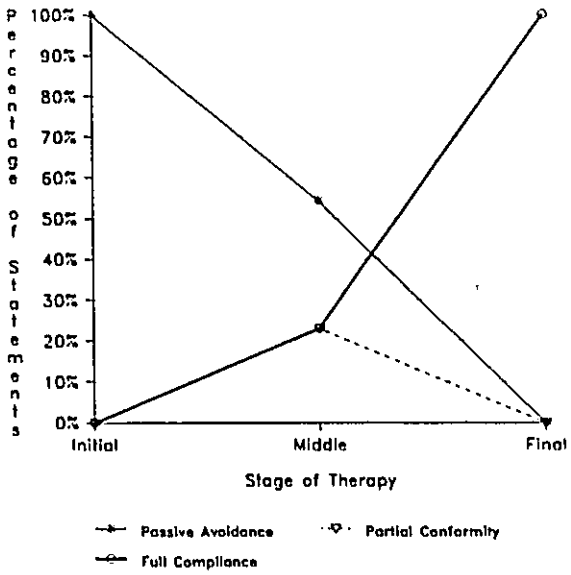
	Stage of Therapy						
	Initial		Middle		Final		Total
Client Response	N	%	N	%	N	%	N
Passive Avoidance	11	100.0	19	54.3	0	0	30
Partial Conformity	0	0	8	22.9	0	0	8
Full Compliance	0	0	8	22.9	1	100.0	9
Total	11		35		1		47

Table H.6

Distribution of Client Responses Across Stages for Category 7 in Maloney's Case

	Stage of Therapy						
	Initial		Middle		Final		Total
Client Response	N	%	N	%	N	%	N
Partial Conformity	0	0	1	9.1	1	10.0	2
Full Compliance	10	100.0	10	90.9	9	90.0	29
Total	10		11		10		31

Figure H.5
Pattern of Client Responses Across
Stages in Category 5 – Maloney



Note: Percentages in final stage of therapy are based on an N of 1.

Figure H.6
Pattern of Client Responses Across
Stages in Category 7 – Maloney

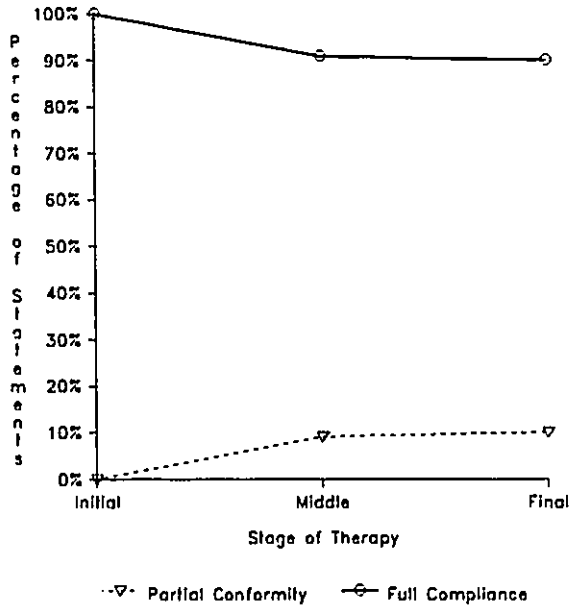
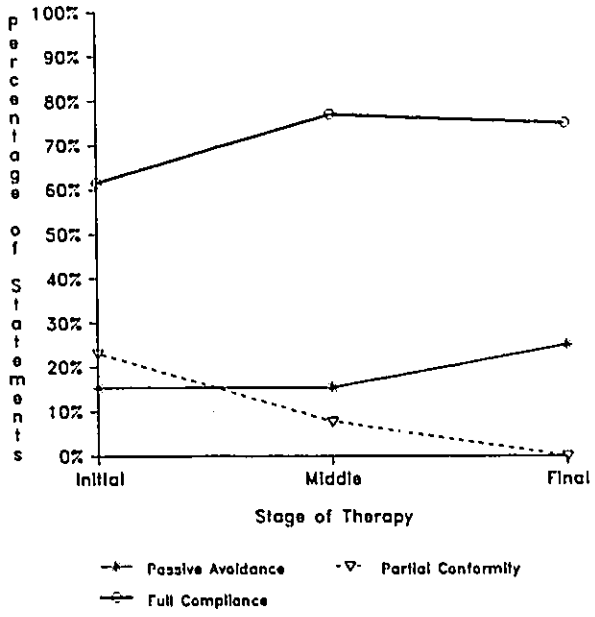


Table H.7

Distribution of Client Responses Across Stages for Category 8 in Maloney's Case

	Stage of Therapy						
	Initial		Middle		Final		Total
Client Response	N	%	N	%	N	%	N
Passive Avoidance	2	15.4	2	15.4	1	25.0	5
Partial Conformity	3	23.1	1	7.7	0	0	4
Full Compliance	8	61.5	10	76.9	3	75.0	21
Total	13		13		4		30

Figure H.7
Pattern of Client Responses Across
Stages in Category 8 – Maloney



APPENDIX I

Table I.1

Distribution of Client Responses Across Stages for Category 1 in Barry's Case

	Stage of Therapy						
	Initial		Middle		Final		Total
Client Response	N	%	N	%	N	%	N
Passive Avoidance	1	1.2	2	2.9	0	0	3
Partial Conformity	38	44.2	29	42.6	29	38.2	96
Full Compliance	47	54.7	37	54.4	47	61.8	131
Total	86		68		76		230

Table I.2

Distribution of Client Responses Across Stages for Category 2 in Barry's Case

	Stage of Therapy						
	Initial		Middle		Final		Total
Client Response	N	%	N	%	N	%	N
Passive Avoidance	1	4.0	0	0	0	0	1
Partial Conformity	11	44.0	11	25.0	12	35.3	34
Full Compliance	13	52.0	33	75.0	22	64.7	68
Total	25		44		34		103

Figure I.1
Pattern of Client Responses Across
Stages in Category 1 – Barry

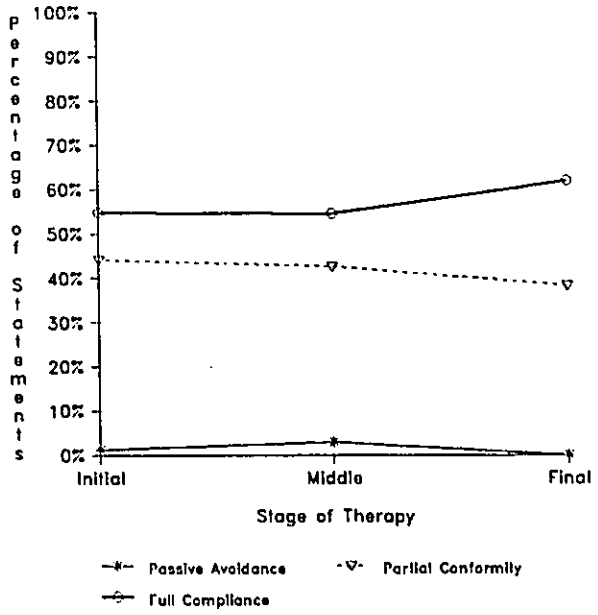


Figure I.2
Pattern of Client Responses Across
Stages in Category 2 – Barry

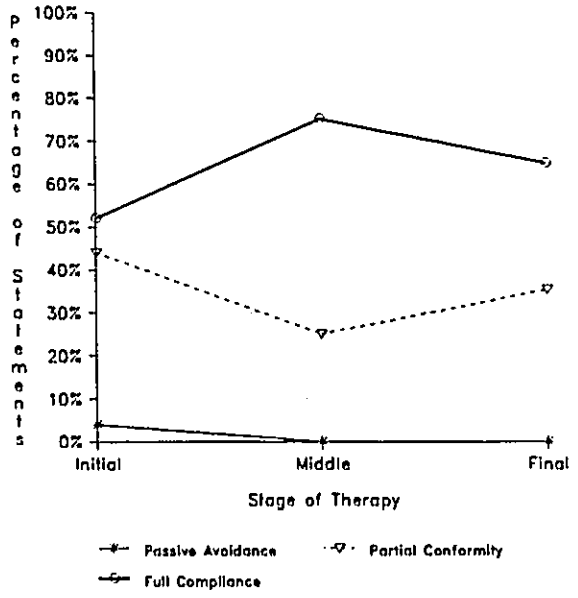


Table I.3

Distribution of Client Responses Across Stages for Category 3 in Barry's Case

	Stage of Therapy						
	Initial		Middle		Final		Total
Client Response	N	%	N	%	N	%	N
Passive Avoidance	1	12.5	0	0	2	16.7	3
Partial Conformity	2	25.0	4	28.6	2	16.7	8
Full Compliance	5	62.5	10	71.4	8	66.7	23
Total	8		14		12		34

Table I.4

Distribution of Client Responses Across Stages for Category 4 in Barry's Case

	Stage of Therapy						
	Initial		Middle		Final		Total
Client Response	N	%	N	%	N	%	N
Partial Conformity	1	25.0	7	38.9	4	23.5	12
Full Compliance	3	75.0	11	61.1	13	76.5	27
Total	4		18		17		39

Figure I.3
Pattern of Client Responses Across
Stages in Category 3 – Barry

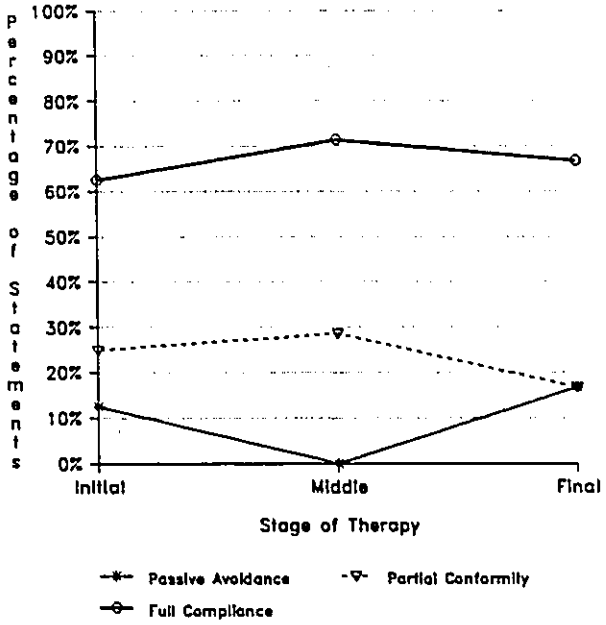


Figure I.4
Pattern of Client Responses Across
Stages in Category 4 – Barry