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**THERAPEUTIC FOCUS ON CLIENT NONVERBAL EXPRESSIONS:**

An Investigation Of Individual Therapy

Within A Gestalt Framework

by

Sharon Francis Harrison

Thesis submitted to the  
School of Graduate Studies and Research  
of the University of Ottawa  
in partial fulfillment of the requirements  
of the degree Doctor of Philosophy in  
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1

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2



UNIVERSITÉ D'OTTAWA  
UNIVERSITY OF OTTAWA

## CURRICULUM STUDIORUM

Sharon Francis Harrison was born in Ottawa, Ontario. She began her university education at the University of Ottawa in 1975. In 1979, after three years on the Dean's Honor List, she received her Bachelor of Arts (Honors in Psychology).

## TABLE OF CONTENTS

Chapter	Page
	ACKNOWLEDGEMENTS.....vi
	LIST OF TABLES.....vii
	LIST OF FIGURES.....viii
	ABSTRACT.....x
	Introduction.....xii
I	-REVIEW OF THE LITERATURE
	Introduction.....1
	The Significance of the Client's Nonverbal Expressions
	(i) The Rationale From The Gestalt Approach.....2
	(ii) The Empirical Study of The Client's Nonverbal Behaviour in Psychotherapy.....6
	Therapeutic Focus On Client Nonverbal Expressions: The Intervention Under Investigation.....10
	The Therapeutic Context for Interventions Focusing On The Client's Nonverbal Expressions.....17
	The Therapeutic Goals of Interventions Focusing On The Client's Nonverbal Expression
	(i) Theory Based Therapeutic Goals.....19
	(ii) Related Client In-Therapy Changes.....25
	Summary and Statement of The Problem.....28
II	METHOD
	Introduction.....33

Participants	
(i) Therapists.....	34
(ii) Clients.....	36
Measures.....	39
(i) Target Complaint Discomfort Box Scale.....	39
(ii) Client Change of Awareness Measure.....	40
(iii) Experiencing Scale.....	40
(iv) Client Vocal Quality.....	44
(v) Clinical Rating of The Client's Awareness..	45
(vi) Counselor Verbal Response Category System..	49
(vii) Incongruence Rating.....	50
Treatments.....	50
(i) Target Interventions.....	53
(ii) Control Interventions.....	53
Apparatus and Setting.....	54
Procedure	
(i) Preliminary Steps.....	55
(ii) Conduct of the Sessions.....	57
(iii) Video Recording of Sessions.....	58
(iv) Pre- and Post-Session Client Report Forms..	58
(v) Verification of Therapist Behaviour and Client Marker.....	58
(vi) Rating Client Behaviour.....	60
Method of Analysis.....	61
III RESULTS	
Introduction.....	63

Verification of Therapist Behaviour and Client Marker.....	64
Depth of Experiencing (Hypothesis 1).....	71
Client Vocal Quality (Hypothesis 2).....	76
Client Change Of Awareness Measure And The Target Complaint Discomfort Box Scale (Hypothesis 3).....	80
Clinical Rating Of The Client's Awareness (Hypothesis 4).....	88
Summary.....	93

IV

DISCUSSION

Introduction.....	97
Implications Related To The Gestalt Conceptual Rationale.....	97
Implications For Research.....	105
Implications For Clinical Practice.....	110
Considerations Related To Research Design.....	111
Summary.....	113

REFERENCES.....	115
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APPENDICES.....	120
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LIST OF TABLES

Table		Page
3.1	Number of treatment or control interventions per session, for the two therapists and four clients.....	68
3.2	Mean level of incongruence preceding treatment /control interventions.....	70
3.3a	Client self-reported change in awareness data as reported after each session for the clients seen by therapist A.....	82
3.3b	Client self-reported change in awareness data as reported after each session for the clients seen by therapist B.....	83

## LIST OF FIGURES

Figure		Page
2.1	Client change in awareness measure.....	41
2.2	Percentage of responses for each type of intervention in the Hill Category System for an interview with Perls (from Hill, Thames and Rardin, 1979).....	52
3.1a	Distribution of verbal response categories (Hill Verbal Response Category System) employed by therapist A, expressed as proportions.....	66
3.1b	Distribution of verbal response categories (Hill Verbal Response Category System) employed by therapist B, expressed as proportions.....	66
3.2a	Distribution of client statements according to level of experiencing (Klein et al., 1969) for the two clients seen by therapist A, expressed as proportions.....	73
3.2b	Distribution of client statements according to level of experiencing (Klein et al., 1969) for the two clients seen by therapist B, expressed as proportions.....	73
3.3a	Average level of experiencing (Klein et al., 1969) per session for the two clients seen by therapist A.....	74
3.3b	Average level of experiencing (Klein et al., 1969) per session for the two clients seen by therapist B.....	74
3.4a	Distribution of client statements according to voice quality ratings (Rice et al., 1979), expressed as proportions.....	77
3.4b	Distribution of client statements according to voice quality ratings (Rice et al., 1979), expressed as proportions.....	77
3.5a	Proportion of segments rated as focused in each session for the two clients seen by therapist A.....	79

3.5b	Proportion of segments rated as focused in each session for the two clients seen by therapist B.....	79
3.6a	Client self reported level of discomfort pre- and post-session for the two clients seen by therapist A.....	85
3.6b	Client self reported level of discomfort pre- and post-session for the two clients seen by therapist B.....	85
3.7a	Change in the client's level of discomfort across the series of three sessions for the two clients seen by therapist A.....	87
3.7b	Change in the client's level of discomfort across the series of three session for the two clients seen by therapist B.....	87
3.8a	Distribution of segments of client behaviour rated according to level of awareness for the two clients seen by therapist A, expressed as proportions.....	90
3.8b	Distribution of segments of client behaviour rated according to level of awareness for the two clients seen by therapist B, expressed as proportions.....	90
3.9a	Proportion of segments of client behaviour in each session rated as either level 2, shifting awareness, or level 3, high awareness, for the two clients seen by therapist A.....	91
3.9b	Proportion of segments of client behaviour in each session rated as either level 2, shifting awareness, or level 3, high awareness, for the two clients seen by therapist B.....	91

## ABSTRACT

This study examines the therapeutic use of gestalt-based interventions which attempt to increase the client's awareness through direct reference to his/her nonverbal expressions whenever there is incongruence between these and the content of his/her verbalizations. To this end, two experienced therapists employed the interventions in treatment sessions, and "reflection" in control sessions. Each therapist saw one treatment client and one control client for three sessions of individual therapy.

The videotapes of the sessions were rated for the following in-therapy client behaviours, Level of Experiencing, Vocal Quality, and a clinical rating of the client's awareness level. Two client self report measures were also employed, the Target Complaint Discomfort Box Scale and Client Change Of Awareness Measure.

The key results were; the clients in the treatment condition exhibited significantly more frequent instances of focused voice ( $p = .05$ ); the treatment clients displayed lesser discomfort associated with the presenting problem following the last session; and although the results are not consistent, one treatment client exhibited higher levels of self-awareness. The results for the client's experiencing level and self reported change in awareness did

not consistently differentiate between the clients in the two conditions. The results are discussed in the context of the gestalt conceptual literature, research, and clinical practice.

## Introduction

The notion that the client's nonverbal expressions in therapy are both important and meaningful has been supported by many authors within the gestalt approach (Baumgardner, 1975; Enright, 1975; Kepner and Brien, 1970; Levitsky and Perls, 1970; Perls, 1959; Simkin, 1975; Van De Riet, Korb and Gorrell, 1980; Yontef, 1975). The client's nonverbal expressions are not only important on the theoretical level but are also an integral part of many gestalt interventions (Enright, 1970, Naranjo, 1980; Perls, 1959; Van De Riet et al., 1980; Yontef, 1975).

The purpose of this study is to examine those therapeutic interventions employed by gestalt trained therapists which directly refer to the present nonverbal expressions of the client. This type of intervention is advocated in the clinical and theoretical writings within the gestalt approach. However, there is no empirical evidence as to the consequences of their use for the client. It is also important to note that although the clinical and theoretical literature encourages therapists to employ this type of intervention, little practical guidance is provided. It would be useful for the therapist to have information regarding the circumstances under which the intervention might be most therapeutic.

In keeping with the state of the research and clinical literature, this study aims to i) describe these interventions to provide information about their practical application, and ii) examine the relationship between the use of these interventions and related client behaviour. The relationship between the use of these interventions and client behaviour will be examined from the perspective that positive change in client behaviour ought to be associated with their use within a gestalt framework.

To fulfill these goals, video recordings of individual psychotherapy sessions will be studied from four therapeutic dyads, two therapists and four clients. The therapists will be instructed to employ interventions that focus on the client's nonverbal expression at appropriate client markers. The resulting video recordings will be studied to assess the influence of the intervention on the client. Ratings of the client's in-therapy behaviour and self report measures of client change will be employed in descriptive and graphic data analyses.

Towards these proposed goals, various types of literature and information will be reviewed. In the first chapter, relevant literature within gestalt therapy will be reviewed to lay the conceptual foundation for the therapeutic significance of the client's nonverbal expressions and the therapeutic interventions. Although there is a paucity of research in this area, related

empirical research on client nonverbal behaviour in therapy, and on the process of gestalt therapy will be reviewed. Finally, the problem for the study will be stated at the conclusion of the first chapter. The second chapter will include an indepth description of the methodology and data analyses for the proposed study. The results of the data analyses will be presented in the third chapter. Finally, chapter four will discuss and interpret the results of the study.

## CHAPTER I

### REVIEW OF THE LITERATURE

#### Introduction

The purpose of this chapter is to review literature relevant to the proposed study. The intent of this chapter is not to provide a general overview of gestalt therapy, as there are many well written reviews available (for example Enright (1970), Simkin (1976), and Van De Riet et al., (1980)). The literature presented in this chapter has been taken from three major sources: conceptual literature from the gestalt approach to psychotherapy, empirical research literature on client nonverbal behaviour, and research literature examining the process of gestalt therapy.

This chapter is divided into five sections. The first section deals with the importance of the client's nonverbal behaviour from both the conceptual and empirical perspectives. Secondly, the therapeutic interventions which focus on the nonverbal behaviour of the client are described according to the gestalt approach to therapy. In the third and fourth sections, the therapeutic context and goals of the interventions are examined. Finally, the last section serves to summarize major aspects of the literature previously reviewed. In addition, the problem and hypotheses for the study are presented.

## The Significance Of The Client's Nonverbal Expression

### (i) The Rationale From The Gestalt Approach

Within the gestalt approach to psychotherapy, the client's nonverbal expressions are viewed as important. Their prominence is related to the gestalt belief that the human organism functions as a whole (Latner, 1973; Perls, 1959, 1969, 1973; Perls, Hefferline and Goodman, 1951; Van De Riet, Korb and Gorrell, 1980). The assumption of holism renders all forms of self expression meaningful. Thus, the total communication of the client, including both the verbal and nonverbal modes, is attended to in the therapy session (Enright, 1975; Kepner and Brien, 1970; Yontef 1975).

Although gestalt authors do not specify their definition, the term nonverbal expression is employed in a broad sense. Gestalt therapists observe and feed back many aspects of the client's behaviour. Perls (1959) notes that the total personality of the client expresses itself in many ways, through bodily movements, posture, voice, and psychosomatic language. Verbal communication relates only to the content of the client's verbalizations. The client's rate of speech, tone of voice, and other nonlexical aspects of speech are part of the nonverbal realm. Other nonverbal expressions which arise in the therapeutic context are sighs, tears, and laughter.

The client's nonverbal expressions are believed to be directly related to the present experiencing of the client. Levitsky and Perls (1970) believe that the firmest ground for experience lies in the client's awareness of bodily sensations. Baumgardner (1975) also states that bodily awareness is probably the client's primary means of discovering him/her self in relation to his/her environment. The client's external behaviour is seen as an indication of what is going on internally (Van De Riet et al., 1980).

The gestalt therapeutic focus on the client's nonverbal expressions is intrinsic to the aim of facilitating the development of the client's awareness. Perls (1959) believes that awareness develops in three zones. He further states that we are too often aware of our intermediate zone of fantasy and unaware of our self and our world. The client's verbalizations are frequently seen as part of his/her "thinking about" zone of awareness (Simkin, 1975) or his/her "rational faculties" (Yontef, 1975). The aim of gestalt therapy is for the client to be more aware in two other zones, awareness of the self and the world (Perls, 1959). The zone of awareness of the self has been referred to as the interior zone. This zone includes all of the organism's experiences of itself, of which awareness of bodily states is an important aspect (Van De Riet et al., 1980). The zone of awareness of the world has been called the exterior zone. It includes the immediate awareness of

the environment gained through the senses (Van De Riet et al., 1980). The client's awareness of nonverbal aspects of his/her behaviour has a role in the development of awareness in these two zones of experience. Simkin (1976) states that experimenting with nonverbal behaviour will help the client become aware of important aspects of self.

Another important aspect of the client's nonverbal expressions is that they are believed to reveal "unfinished business" or reflect aspects of the client's personality which are out of awareness. The expression "unfinished business" is employed in gestalt writings to denote unexpressed or unsatisfied needs or situations, often from the individual's past. Perls (1959) believes that it is not possible to repress a need. Often one avenue of expression is repressed and "the self expression comes out somewhere else, in our movements, in our posture, and most of all in our voice" (Perls, 1959 p. 57). Baumgardner (1975) states that the gestalt emphasis on bodily awareness provides a method for discovering feelings which are held beyond awareness. She also notes that bodily awareness is the key to the client's difficulties, in that unfinished situations and unexpressed feelings are revealed through bodily tensions. Van De Riet, Korb and Gorrell (1980) also note that the personal experiences of which the client may be unaware are indicated by every aspect of the person, such as

bodily feelings and movements, voice, tone, posture, images and even dreams.

Within the gestalt approach, nonverbal expressions are often viewed as the more accurate form of self expression. The client's verbalizations are frequently viewed as misleading and less reliable. Perls (1959) states that the therapist should not listen to the content of the client's verbalizations. His belief is that "real communication is beyond words" (Perls, 1959 p. 57). Thus, according to Perls (1959), the therapist should listen to the client's voice, movement, posture, facial expression and psychosomatic language.

Simkin (1975, 1976) has labelled the body language of the client 'truth buttons'. He believes it communicates how the client really feels. Consequently, he takes the client's symptoms seriously as he feels they will not misdirect in the same manner as verbalizations. He further notes that the neurotic is generally not consciously aware of what is wrong, and verbal reports are inaccurate. Van De Riet, Korb, and Gorrell (1980) note that a therapist will rarely err by attending to the client's body language. They state that the language of the body is obvious, clear, and presents concise data for use in therapy.

In summary, the client's nonverbal expressions are seen as an important avenue of communication which ought to be observed by the gestalt therapist. Yontef (1976) notes that

Perls' unique contribution to the method of therapy was in replacing interpretation with behavioural observation and experimentation. The gestalt therapist's attention to the nonverbal expression of the client provides a new therapeutic tool and a new way of understanding and communicating with his/her client (Yontef, 1976).

(ii) The Empirical Study Of The Client's Nonverbal Behaviour In Psychotherapy

Most of the existing research in this area has examined the nonverbal expression of the client with emphasis on personality factors or psychopathology rather than therapeutic process (Ekman and Friesen, 1968; Fairbanks, McGuire and Harris, 1982; Rice and Gaylin, 1973; Steere, 1982). There have been some studies on client nonverbal behaviour and psychotherapeutic process (Hill et al., 1981; Rice and Wagstaff, 1967), but these are rare. There are no empirical studies of therapeutic interventions which explicitly respond to the client's nonverbal expressions. Nevertheless, the existing research will be reviewed as a source of information regarding the significance of the client's nonverbal expressions in psychotherapy.

To demonstrate the importance and utility of including nonverbal behaviours in psychotherapy research, Ekman and Friesen (1968) reviewed literature examining a wide variety of client nonverbal behaviours. These behaviours include

noncontent aspects of speech, eye contact, body acts, body position, facial expression, head orientation, and movement of head, hands, and feet.— These authors concluded that nonverbal behaviour is sensitive to individual differences, that information communicated nonverbally does not duplicate the verbal channel and thus may be used as an additional source of information about the client.

In a detailed examination of the nonverbal behaviour of patients and therapists, Fairbanks, McGuire and Harris (1982) concluded that patients can be distinguished from controls on the basis of nonverbal behaviour. This study included a broad range of nonverbal behaviours; body lean, head position, leg position, arm position, hand and foot movements, posture shifts, and facial expression. Overall, they found that patients were more constrained in their posture, had more extraneous movements, less eye contact, and less smiles. In addition, therapists differed in their nonverbal responses to patients as opposed to control subjects. Consequently, the therapist's and client's nonverbal behaviour in therapy is seen as interactive.

Although the research is still in its infancy, there is evidence to suggest that specific nonverbal acts have specific psychological meaning for the client (Ekman and Friesen, 1968; Fairbanks, et al., 1982; Steere, 1982). Steere (1982) demonstrated that the client's ego states and the shift from one ego state to another in therapy can be

distinguished in the nonverbal behaviour of the client. In the theory of Transactional Analysis, Berne (1957) describes three distinct types of ego states (parent, adult, and child) each with its own voice, vocabulary, postures, mannerisms and gestures. Using ratings of audio and visual recordings, Steere (1982) isolated characteristic ego states and demonstrated change related to the sample's involvement in therapy. More specifically, he found that a trunk shift that alters the client's basic posture goes along with each change in ego state. There was also a pattern of movements within each ego state. Changes related to therapeutic involvement were associated with a change in the total number of identified movements in each ego state. The total number of movements was assumed to be related to the amount of psychic energy invested in the particular ego state. Steere (1982) also reported that the client may demonstrate a conflict through a bodily split. The bodily behaviours of the client may show a marked split between the left and right, or upper and lower quadrants. The differences in portions of the client's bodily expression are seen as corresponding to the different ego states involved in the conflict. Steere (1982) draws implications for the clinical practice of therapy and the use of bodily expressions as a source of information about the client in psychotherapy.

In his 1974 review of the literature, Gladstein concluded that the client's paralanguage and kinetics

reflect his/her emotional condition during therapy, and that changes in the client's nonverbal behaviour post therapy would be evidence of therapeutic effectiveness.

Other authors have also studied the nonlexical aspects of the client's speech. Rice and co-workers (Rice and Gaylin, 1973; Rice, Koke, Greenberg and Wagstaff, 1979; Rice and Wagstaff, 1967) have devised a measure called Client Vocal Quality. This measure was originally developed to describe moment-by-moment process in therapy. It has also been employed as a measure of individual client differences and, as such, a correlate of therapy outcome. This measure has been used in research studies examining the process of gestalt therapy (e.g. Greenberg, 1980; Greenberg and Rice, 1981; Greenberg and Webster, 1982). These studies will be reviewed in a later section. In therapy process studies, client voice quality has been employed as an index of productive therapeutic process (Greenberg, 1980; Orlinsky and Howard, 1978).

Hill and co-workers (1981) explored client congruence through studying the congruence between verbal and nonverbal expressions. This measure had previously been used only as a measure of the therapist's congruence. Rather than having the client's nonverbal behaviour rated by judges, they asked the client what feelings he/she expressed, i) through words, ii) through voice tone, and iii) through movements, facial expressions, and gestures. The results indicated that the

client's own ratings of congruence were related to his/her own ratings of outcome. Clients who viewed themselves as more consistent in their portrayal of feelings felt better about the session.

Overall, the research indicates that the nonverbal behaviour of the client can be viewed as an additional source of information about the client (Ekman and Friesen, 1968). In fact, certain nonverbal behaviours may have specific psychological meaning for the client (Ekman and Friesen, 1968; Fairbanks et al., 1982; Steere, 1982). In addition, the nonverbal behaviours may be related to the client's progress in the therapy (Hill et al., 1981; Rice et al., 1979). In summary, although the specifics remain unclear, the existing research does indicate that the nonverbal expression of the client is important and thereby worthy of the therapist's attention.

Therapeutic Focus On Client Nonverbal Expression: The  
Intervention Under Investigation

This study is aimed at the examination of a specific type of therapeutic intervention within the gestalt approach. The interventions to be investigated are those which explicitly focus on aspects of the nonverbal expression of the client. This type of intervention is advocated by many authors within the gestalt approach (Enright, 1970; Naranjo, 1980; Perls, 1959; Van De Riet et

al., 1980; Yontef, 1975). The purpose of this section is to describe these target interventions.

Many gestalt authors discuss generally the importance of observing and feeding back the client's nonverbal expressions. In addition, clinical examples of how to employ these interventions are available in the literature (for example Enright, 1975; Naranjo, 1976). However, there is little available in the existing literature that explicitly spells out the form and content of these interventions.

The best source of guidance is provided by Enright (1975). He describes these interventions as intrinsic to the therapeutic aim of reintegrating attention and awareness. He further describes the task of the therapist as helping the client overcome barriers that block awareness. In practice, the therapist watches for splits in the client's attention and awareness. Enright (1975) describes the typical situation in which the client is talking about a problem while sensorily registering and motorically doing many other things. Generally, the client's awareness is concentrated on the content of his/her verbalizations. The key factor for the therapist is the congruence between the content of the client's verbalizations and his/her nonverbal expressions (Brown, 1973; Enright, 1970; 1975; Perls, 1959; Yontef, 1975). The therapist's task begins when there is incongruence between

these two modes of self expression. The therapist will then ask the client to devote some attention to what he/she is doing, sensing, or feeling. Brown (1973) describes the technique as asking the client to turn his/her foreground awareness upon the bodily expression.

Enright (1975) delineates four important characteristics of these interventions. First, the intervention must build on actual present behaviour. The nonverbal behaviour is seen as related to a present concern of the client. The exact nature of the client's concern is not known by the client or therapist. Secondly, the intervention is non-interpretive. Generally, the therapist asks what is going on or what the client is doing. The therapist does not push for a response from the client in the belief that if the behaviour is important, it will reoccur. Thirdly, the style of the intervention should be such that it enhances the client's sense of responsibility for his/her own behaviour. Responsibility in gestalt therapy is seen as a feeling that "I, here and now, am aware of doing thus and so". Finally, the questions which initiate these interventions are generally "what" and "how" questions. It is seen as an important therapeutic contribution if the client can achieve awareness of his/her moment-to-moment behaviour and surroundings. The why of behaviour is not an important aspect of gestalt therapy (Perls, 1959; Enright, 1975).

The interventions which focus on the client's nonverbal expression may be viewed as experiments in directed awareness. Experiments are techniques aimed at focusing attention on particular themes in the client's behaviours (Polster, 1975). This approach aims to facilitate the client's learning by doing rather than talking about. The experiments always return to the primary sensory data of experience (Yontef, 1975).

In the above description, Enright (1975) describes interventions aimed at the client's nonverbal expression as mainly "what" and "how" questions. However, the gestalt therapist may also mirror or reflect the client's behaviour or invite the client to repeat or exaggerate his/her nonverbal behaviour (Naranjo, 1980; Van De Riet et al., 1980; Yontef, 1975). Repetition of the behaviour is aimed at intensifying awareness of an act, and is seen as a step beyond simple mirroring or reflecting. Exaggeration and development may occur spontaneously with repetition, but they are seen as a step beyond (Naranjo, 1980). Naranjo (1980) describes two more techniques in this group aimed at the completion of action or expression, explication and identification. Explication or translation urges the client to translate into words a piece of nonverbal expression, the purpose being to make the content more explicit. Identification and acting require the client to give

movement to thought, thus encouraging the client to experience the actions.

In his system for classifying gestalt expressive techniques, Naranjo (1980) describes two other groups of techniques. The first group of techniques consists of those techniques aimed at initiating action or expressing the unexpressed. These techniques generally invite the client to try certain behaviours in order to increase his/her awareness of certain aspects of his/her self. The second group of techniques is defined by the principle of making expression direct. The aim of these techniques is to increase the directness of the client's expression by eliminating unessential aspects of the communication and highlighting the main message. To the extent that these interventions are tied to the present nonverbal behaviour of the client, they form part of the target group of interventions.

As indicated in the above description, interventions which focus on the client's nonverbal expression may take a variety of forms. To further clarify the types of interventions included in the target group, three examples from the literature are provided below.

Example 1:

Therapist: What do you experience now ?

Patient: Nothing special.

Therapist: You shrugged your shoulders.

Patient: I guess so.

Therapist: There you did it again (shrugs shoulders).

Patient: I guess it is a habit.

Therapist: Please do it again.

Patient: (Complies).

Therapist: Now exaggerate that gesture.

Patient: (Shrugs, grimaces, and makes a rejecting gesture with elbows and hands.) I guess I am saying "don't bug me." - Yeah, leave me alone. (Naranjo, 1974; p.292.)

Example 2:

Therapist: What are you feeling now?

Patient: I feel restless. I am impatient at myself for not coming up with anything important. And I'm very aware of the group as a captive audience.

Therapist: I see that you're stamping your left foot.

Patient: (Exaggerates movement.) Yes.

Therapist: Now do with your whole body what your foot is doing (patient gradually develops movement until he is stomping forcefully with both feet while he slaps his thighs with his palms and bares his teeth).

Therapist: Make some sounds, too.

Patient: Ah! Ah! Ahh!! (forceful exhalations proceeded by glottal stops which turn more and more into laughter).

Therapist: Now do something in the same attitude.

Patient: (uncrosses somebody's arms and straightens out his posture) Wake up, man! (Walks around stomping his feet and motions with arms and hands as if to indicate standing up) Wake up everybody ! Let us get out of this sick, dark place ! (opens the door and pushes somebody out of the room) Or you get out. I'll clean up this house and throw away all your shit. (drags somebody by the arm) Be clean and joyful or get out of here! (Naranjo, 1976; p:297).

Example 3:

A woman in individual therapy is going over, in a very complaining voice, some examples of how she was recently mistreated by her mother-in-law. I am impressed in her account by her lack of awareness of how much she invites this, and how she underperceives her capacity to interrupt this behavior, but say nothing. My attention is caught by a rapid repetitive movement of her hand against her other arm, though I can't make out the movement.

T: What are you doing with your hand?

P: (slightly startled) Uh, making a cross.

T: A cross?

P: Yes. (pause)

T: What might you do with a cross?

P: Well, I certainly hung myself on one this weekend,

didn't I ?

She returns to her account, with more awareness of her martyr attitude and its contribution to events (Enright, 1975; p.16).

In summary, the therapeutic interventions focusing on the client's nonverbal expressions have as an essential feature their direct relationship to the client's present nonverbal behaviour. In addition, the interventions are generally non-interpretive and operate to enhance the client's sense of responsibility (Enright, 1975). In terms of the form of the intervention, they are varied and include simple reflection of the client's behaviour ("what" and "how" questions and nonverbal mirroring), and invitations to the client to repeat or exaggerate the behaviour, or to give words to the nonverbal expression.

#### The Therapeutic Context For Interventions Focusing On The Client's Nonverbal Expression

Given the general rationale that the client's nonverbal expressions are important in therapy, the therapist must determine when to employ techniques aimed at aspects of the client's nonverbal expression. Within the gestalt approach, the therapist is given a great deal of latitude to determine which aspect of the client's total communication is significant at a particular moment in therapy and what

intervention to employ. The experience of the client is signaled in every aspect of his/her person and the gestalt therapist may devise an intervention which focuses on any observable part of the client's self expression (Van De Riet et al., 1980).

Some guidance as to when the therapist ought to focus on the client's nonverbal expressions is provided in the literature. As mentioned in the previous section, many authors point to the congruence between the client's verbalizations and his/her nonverbal expressions as the key factor (Brown, 1973; Enright, 1970, 1975; Perls, 1959; Yontef, 1975). When there is congruence and the patient is communicating well, the therapist does not intervene. It is only when there is incongruence between these two modes of expression that the therapist intervenes to draw the client's attention to the nonverbal expression (Enright, 1975). Thus, the gestalt therapist is actively observing his/her client and watching for splits in the client's awareness (Enright, 1975; Van De Riet et al., 1980). These splits are frequently displayed in a lack of match between the verbal and nonverbal expressions and in unconscious activities arising in the client's nonverbal behaviour (Van De Riet et al., 1980).

The Therapeutic Goal Of Interventions Focusing On The  
Client's Nonverbal Expressions

(i) Theory Based Therapeutic Goals

The goal of any specific therapeutic technique within the gestalt approach must be related to the overall aims of therapy. In the gestalt approach, the therapeutic goals are two-fold (Van De Riet et al., 1980), first to facilitate the client's awareness, and secondly to encourage the development of responsibility in the client. These two goals are interconnected and are often seen as sequential, with awareness preceding responsibility (Van De Riet et al., 1980).

In a frequently quoted statement, Perls (1959) announced that "awareness per se - by and of itself - can be curative" (p. 17). In addition, Enright (1975) refers to awareness as the theoretical and therapeutic core of gestalt therapy. The concept of awareness has been described in many ways by different authors. Perls, Hefferline and Goodman (1951) state that "Awareness is the spontaneous sensing of what arises in you - of what you are doing, feeling, planning" (p.88). Enright (1975) notes that awareness refers to a particular kind of immediate experience and is always based on current perception of the current situation. Other authors also describe awareness as being absorbed in the present situation (Latner, 1973; Perls, 1973; Polster,

1975b; Polster & Polster, 1973). These descriptions - immediate, present, spontaneous - lead to the conclusion that awareness, in gestalt terminology, refers to the here and now or present experiencing of the organism.

In the context of gestalt therapy, the focus is on nonintellectual awareness. Thus, therapists emphasize sensory data, feelings and emotional reactions to inner experiences, and environmental contact (Greenwald, 1975). In the gestalt view, awareness refers to the discovery of "what" we experience and "how" we do it. This is in contrast to other approaches, such as introspection, which examine the "why" of behaviour (Latner, 1973). Introspection has also been described as effortful and detached concentration of one part of the organism observing another part. Whereas awareness is described as the self spontaneously concentrating on that aspect of the environment which is exciting and of organismic interest (Enright, 1975). In addition, heightened awareness is encouraged in all areas of experience, physical or mental, sensory, emotional or verbal. On the other hand, free-association generally restricts itself to thoughts and ideas (Perls et al., 1951). Polster and Polster (1973) further describe awareness as an ongoing process which is available to the individual in any situation, thus differing from insight which occurs only at special moments under special conditions. Finally, awareness is tied to actual

present experience which may not be the case with insight (Enright, 1975).

What then is the organism aware of? Perls (1959) describes awareness as developing in three layers or zones, 1) awareness of the self, 2) awareness of the world, and 3) awareness of the intermediate zone of fantasy. The first zone, awareness of the self, has been referred to as the interior zone and includes all of the organism's experiences of itself. Perls, Hefferline and Goodman (1951) note that gestalt therapy emphasizes self awareness because this is where most people are handicapped. The person's awareness of body states is an important aspect of this zone (Van De Riet et al., 1980). The second zone, awareness of the world, has been referred to as exterior experience and includes the immediate experience of the environment which is gained through the senses (Van De Riet et al., 1980). The third zone is the area of psychological contact between the external and internal zones and has been referred to as the middle zone of experience. In this middle zone, thought is the controlling function in the form of memories, fantasy, imagery, and dreams (Van De Riet et al., 1980).

The importance of awareness, within the gestalt approach, is that with awareness the individual can become aware of the organismic self-regulation process. The principle of organismic self-regulation implies that the organism will do its best to regulate itself, given its

capabilities and the resources of the environment (Latner, 1973). When the organism regulates itself, there is no effort in planning or doing. Behavior is spontaneous and natural (Van De Reit et al., 1980).

The aim of therapy is to give the client the means to solve his/her own problems. This tool is self-support and arises from the ability to be truly aware of him/her self and his/her actions on many levels (Perls, 1973). Perls, Hefferline and Goodman (1951) describe the process of gaining both acceptance and control of your self as arising from expanding what you accept as your self to include all organic activities. The inner support system is based on an awareness of what he/she does and how he/she does it. In this way, the individual is able to take responsibility for his/her own behaviour and may choose to change aspects of that behaviour (Van De Riet et al., 1980).

In summary, within the gestalt approach, awareness refers to the present moment-to-moment experiencing of the organism and includes awareness of the self, the world, and fantasy. In this context, it is an important therapeutic aim to facilitate the individual's movement toward greater awareness in these three zones, thereby facilitating his/her ability to be self supportive and responsible for his/her own behaviour. In therapy, the focus is often on nonintellectual awareness, and the emphasis is on sensory data, feelings, and emotional experiences.

Interventions which focus on the client's nonverbal expressions aim also to help the client to discover how his/her awareness is blocked (Perls, 1973; Yontef, 1975). Brown (1973) notes that the therapist helps the client to reclaim his/her desensitized sensori-motor-affective modalities by making the client actively attend to them. According to Perls (1973), the gestalt technique involves the client experiencing as much of him/herself as possible, including his/her breathing, emotions, voice, facial expressions, and thoughts, so that he/she may learn about him/herself and how he/she interrupts his/her awareness. Perls (1973) further notes that the procedure is to re-establish the client's self through integrating the dissociated parts of the personality.

In keeping with the goals of gestalt therapy, Van De Riet, Korb and Gorrell (1980) propose that the therapeutic process be divided into four steps: 1) Expression, 2) Differentiation, 3) Affirmation, and 4) Choice and Integration. In the first step, expression, the aim is for the inner experience of the client to be expressed overtly. It is important to remember that personal experience is portrayed in every aspect of the individual's being, including words, tone of voice, images, body movements, muscles and organs of the body (Van De Riet et al., 1980). In the second stage, differentiation, the assumption is made that an inner battle is going on. The two aspects of the

conflict must first be differentiated and separated so that the process may be recognized. The goal of this step is to facilitate the client's recognition of alienated aspects of self (Van De Riet et al., 1980). In the affirmation stage, the therapist encourages the client to own both parts and to accept them as aspects of self. With ownership comes responsibility and the ability to choose one's reactions (Van De Riet et al., 1980). In the final stage, choice and integration, the client is able to choose behaviour belonging to either side of the conflict. The choice is made with awareness and acceptance. In this stage, Van De Riet, Korb, and Gorrell (1980) hypothesize an internal integration at a preconscious level which releases tension.

According to the process described by Van De Riet, Korb and Gorrell (1980), techniques which focus on the client's nonverbal expression would fit largely within the first two steps. The therapist must first help the client to express him/herself overtly before any therapeutic interaction can take place (Van De Riet et al., 1980). Thus in the first step, expression, the therapist may decide to employ an intervention which highlights a nonverbal aspect of the client's behaviour. In the second step, differentiation, awareness is needed to facilitate the client in separating the different aspects of his/her self which are involved in an inner battle (Van De Riet et al., 1980). In this stage, the primary tool used by the therapist is experimentation.

The interventions are aimed at helping the client to become more aware of self through concrete experience (Van De Riet, et al., 1980). The client's nonverbal expressions play a lesser role in the latter two steps. Once the parts of the client's self have been differentiated, the aim is for each aspect to be accepted by the individual (Van De Riet, et al., 1980). Thus, he/she will acknowledge ownership and responsibility for each part, including those parts initially signaled through nonverbal expressions.

#### (ii) Related Client In-Therapy Changes

The previous section outlined the global theoretical goals of gestalt therapy. However, it remains unclear how the changes in the client can be observed or measured. How does the therapist gauge if the client has gained awareness or increased responsibility? Intuitively therapists do make judgements regarding the success of interventions and client change. However, the conceptual literature offers little explicit information regarding specific client behaviours indicative of positive therapeutic change.

One term which does arise in the literature is congruence. In defining the therapeutic context for interventions which focus on the client's nonverbal behaviour, many authors point to the significance of congruence between the client's verbalizations and his/her nonverbal expressions (Brown, 1973; Enright, 1970, 1975;

Perls, 1959; Yontef, 1975). Lack of congruence is seen as indicative of blocked awareness and/or incomplete gestalten.

In their study of nonverbal behaviour and outcome, Hill and her co-workers (Hill, Siegleman, Gronsky, Sturniolo, and Fretz, 1981) concluded that congruence within a counselling session is an important factor. Congruence in this study was defined as the consistent portrayal of affect among various channels (verbal, paralinguistic, and kinetic). This study involved counsellors and clients rating their own level of congruence for each one-minute segment of a video recorded therapy session.

Another source of information regarding client behaviours indicative of therapeutic change is empirical research on the process of therapy involving the gestalt approach. However, research in this area is limited. The largest group of studies has been produced by Greenberg and his co-workers (Greenberg, 1979, 1980, 1983; Greenberg and Clarke, 1979; Greenberg and Dompierre, 1981; Greenberg and Higgins, 1980; Greenberg and Rice, 1981; Greenberg and Webster, 1982). Their work has focused on a particular gestalt intervention, the two-chair technique. To judge the success of the intervention, these researchers have employed rating scales which have been demonstrated to rate client behaviour indicative of positive in-therapy process. In these studies, the most frequently used measure of the client's in-therapy behaviour is the Experiencing Scale

(Klein, Mathieu, Gendlin, and Keisler, 1969). The experiencing scale evaluates the quality of the client's self involvement in psychotherapy and is sensitive to changes in the level of his/her involvement. Client vocal quality (Rice, Koke, Greenberg, and Wagstaff, 1979) has also been used (Greenberg, 1980, 1983; Greenberg and Rice, 1981; Greenberg and Webster, 1982). The client vocal quality scale measures the subtle moment-by-moment process of the client's involvement and focus. These measures have proven useful to gauge change in the client's behaviour related to the use of specific therapeutic interventions.

In addition to rating the client's in-therapy behaviour, Greenberg and his co-workers have employed a number of extra-therapy measures to gauge the success of specific interventions and therapy sessions. Frequently, some type of client self-report form is employed to assess the client's perception of the session. These forms include the (i) Change Of Awareness Measure (Greenberg and Dompiere, 1981; Greenberg and Higgins, 1980), (ii) Target Complaint Discomfort Box Scale (Greenberg and Dompiere, 1981; Greenberg and Higgins, 1980; Greenberg and Webster, 1982), and (iii) Client Session Report Form (Greenberg and Rice, 1981). Additional extra-therapy measures are often employed to assess the therapeutic relationship and/or the client's suitability for short term counselling. The Barrett-Lennard Relationship Inventory (Barrett-Lennard,

1962) is frequently used to rate the client's perception of the therapist as empathic (Greenberg and Clarke, 1979; Greenberg and Dompierre, 1981; Greenberg and Webster, 1982).

Consequently, although there is a limited amount of process and/or outcome research on the gestalt approach to therapy, measures of the client's in-therapy behaviour are available. These measures appear compatible with the goals of the gestalt approach.

#### Summary and Statement of the Problem

The aim of this study is to investigate, empirically, interventions which explicitly focus on the client's nonverbal expression within a gestalt approach in order to determine if they give rise to desirable changes in the client's behaviour. The importance of the client's nonverbal expressions within the gestalt approach was outlined in the previous sections. Briefly, nonverbal expressions are seen as related to present experiencing and unfinished business (Baumgardner, 1975; Levitsky and Perls, 1970; Perls, 1959; Van De Riet et al., 1980). Gestalt trained therapists view nonverbal expressions as a more accurate form of self expression and as an important aspect of the client's self awareness (Perls, 1959; Simkin, 1975, 1976; Van De Riet et al., 1980; Yontef, 1975).

Empirical research on nonverbal expression in psychotherapy indicates that it is an important source of

information about the client (Ekman and Friesen, 1968). Furthermore, nonverbal behaviours may have specific psychological meaning to the client and be related to the client's progress in therapy (Ekman and Friesen, 1968; Fairbanks et al., 1982; Steere, 1982). Overall, the research indicates that the client's nonverbal expressions are important and worthy of the therapist's attention.

The specific therapeutic interventions to be examined in this study are those interventions which focus explicitly on the client's present nonverbal expression. These interventions are varied in form and include simple reflection of the nonverbal expression (mirroring, "what" and "how" questions), exaggeration and repetition of the behaviour, and giving words to the behaviour. These interventions are appropriate when some aspect of the client's self expression is incongruent. The therapist's aim is to facilitate the client's awareness of an aspect of his/her self. Generally, the client is aware of the content of his/her verbalizations and not of his/her nonverbal expressions. Thus, these interventions fit within the overall goals of gestalt therapy, which are increased awareness and responsibility.

Research on the process of gestalt therapy provides some guidance as to how to assess the effectiveness of specific interventions. Research instruments designed to rate client behaviour indicative of positive in-therapy

process are frequently employed. In addition, client self report forms for rating in-therapy experience and therapeutic outcome are often included in these studies.

In summary, the clinical and empirical literature agree on the importance of the client's nonverbal expressions in therapy. There is some guidance regarding the appropriate therapeutic context for the use of interventions which focus on the nonverbal expressions of the client. However, there has been no empirical examination of their effectiveness. Consequently, the aim of this study is to examine the relationship between the therapist's use of interventions which attend to the client's nonverbal expression and client behaviour.

The following problem and hypotheses have been formulated to clarify the aims of the study.

Problem: Within the gestalt approach to therapy, the therapist aims to heighten the client's awareness by employing interventions which explicitly attend to aspects of the client's nonverbal expression when the client exhibits incongruence between his/her verbalizations and his/her nonverbal expressions. Incongruence may be between the content or intensity of the client's verbalization as compared to his/her nonverbal expressions. In psychotherapeutic interviews in which the therapist responds to the described client marker with an intervention focused explicitly on the nonverbal expression of the client, the

client's behaviour ought to be rated more frequently as demonstrating greater therapeutic self involvement. The client's in-therapy behaviour will be compared to client behaviour in control sessions, in which the therapist responds to the client marker with the control intervention (reflection). In addition, the client and clinical judges ought to be able to indicate a greater increase in the client's awareness, and greater problem resolution in the treatment sessions.

The following hypotheses are put forth to empirically test the problem defined above.

Preamble to the hypotheses: The treatment sessions are defined by the therapist's use of interventions which respond explicitly to a present nonverbal expression of the client in response to the client marker. In the control sessions, the therapists will respond with the alternate intervention, reflection. Both treatment and control interventions are to be preceded by the client marker, which is an incongruence between the content of the client's verbalizations and the content or intensity of his/her nonverbal expressions.

Hypothesis 1: The client's behaviour, during sessions in which the therapist explicitly responds to nonverbal expressions of the client (treatment sessions), will exhibit higher levels of experiencing than will the client's behavior during control sessions.

Hypothesis 2: The client's vocal quality, during sessions in which the therapist explicitly responds to nonverbal expressions of the client (treatment sessions), will exhibit more frequent instances of focused voice than will the client's vocal quality during control sessions.

Hypothesis 3: The client's self report data, following sessions in which the therapist explicitly responds to nonverbal expressions of the client (treatment sessions), will demonstrate greater awareness and lesser discomfort related to the presenting problem than will the client's self report data following control sessions.

Hypothesis 4: The client's behaviour, as rated by clinical judges, during sessions in which the therapist explicitly responds to nonverbal expressions of the client (treatment sessions), will exhibit greater self-awareness than will the client's behaviour during control sessions.

## CHAPTER II

### METHOD

#### Introduction

The aim of this chapter is to provide a detailed description of the method for the study. The study aims to examine therapeutic interventions within the gestalt approach which focus explicitly on aspects of the client's nonverbal expressions. The relationship between the use of these interventions and changes in the client's in-therapy behaviour and the client's self reported experience will be examined. In this chapter, the strategy of the investigation will be described in detail. Separate sections will present the participants, measures, treatments, apparatus and setting, procedure, and method of analysis.

An important aspect of the study is that it involves experienced gestalt trained therapists working with volunteer clients whose presenting problem is a personally meaningful conflict. Thus, the sessions are as close as possible to authentic therapeutic interviews. The therapists were instructed, in terms of when to use the target and control interventions and the range of possible interventions, to help maintain similarity among the therapeutic dyads.

The study involved the video recording of therapeutic interviews for intensive analysis. Recordings were made of four therapeutic dyads consisting of two therapists, each working with two clients. Each client was seen for a series of three sessions. Two client-therapist dyads comprised the treatment condition and the other two comprised the control condition. The data for the two clients (one treatment and one control) seen by therapist A was examined separately from the data for the two clients (one treatment and one control) seen by therapist B.

The intensive analysis of the sessions requires the client's in-therapy behaviour (level of experiencing, vocal quality, and awareness) to be rated every four minutes throughout each session. The client's self reported level of discomfort was obtained before each session, while both the client's self reported change in awareness and self reported level of discomfort were obtained after each session.

#### Participants

(i) Therapists: Two registered psychologists on staff at the University of Ottawa Centre for Psychological Services were employed as the therapists for the study. Both therapists are experienced in the gestalt approach to psychotherapy.

Therapist A received his training in gestalt therapy through workshops, and a year of gestalt training at the Centre de croissance et d'humanisme applique (C.C.H.A. in Montreal) working under the supervision of Jeanine Corbeil. He has 17 years of experience in psychotherapy.

On a semi-structured questionnaire (see Appendix E), therapist A classified his therapeutic approach as gestalt, and further specified that 75 percent of his therapeutic style is gestalt or compatible with the gestalt approach. In a brief written description of his therapeutic approach, therapist A noted that he works extensively on awareness as a tool of change, he encourages contacting and immediate experiencing, employs reflection as a means of staying with the client phenomenologically, and uses an analytic framework to make sense of the client's world (bio-energetic character armor).

Therapist B received her training in gestalt therapy at the University of British Columbia (Department of Counselling Psychology) and through working with Leslie S. Greenberg. She has 12 years of experience in psychotherapy.

On a semi-structured questionnaire (see Appendix E), therapist B classified her therapeutic approach as both gestalt and Rogerian. She further specified that 70 percent of her therapeutic style was gestalt or compatible with the gestalt approach. In a brief written description of her therapeutic approach, therapist B noted that she focused on

experience, increasing awareness, aspects of experience the client was not attending to, and on creating new meaning from expanded experience.

Both therapists were provided with general information about the project, and specific instructions regarding their role in the therapeutic sessions (see Appendix D). Briefly, the therapists were instructed to carry out a verbal therapy which is consistent with the gestalt approach without being technique bound. In addition, they were provided with a list of possible interventions to be employed in the absence of the client marker, and with definitions of the treatment and control interventions to be employed in response to the client marker. The specifics of the client marker, treatment and control interventions are described in subsequent sections.

(ii) Clients: It was determined that the intensive analysis of a small number of clients over a series of therapeutic sessions would be able to address the aims of the study. In addition, it was deemed important that the clients present with a personally meaningful issue, thereby rendering the sessions as authentic as possible, and that the issue be defined to help focus the sessions. Consequently, four clients were sought, to to be paired with the two therapists.

The four clients were sought through an advertisement in the university newspaper, posters, and visits to various psychology classes. The advertisements invited people to volunteer for a research project examining the process of individual counselling (see appendix A). The volunteers were instructed that they must be prepared to discuss a personally meaningful conflict at each session and be willing to have their therapy sessions video taped. They were also required to agree to a time-limited contract of three sessions. They were informed that the counselling would take place at the University of Ottawa Centre for Psychological Services.

The volunteer clients were screened through an orientation session. At this session, they were asked to specify the personal conflict they wished to discuss in the sessions, and to complete the Target Complaint Discomfort Box Scale (Battle et al., 1966). Only those clients whose rating on the Target Complaint Discomfort Box Scale met a minimum level (pre-set at 9) were selected for the study. Thus, although the specific conflict to be discussed varied from client to client, the issue was concretely stated and a minimum discomfort rating was met. Four volunteers were selected at random from those who met both criteria. They were then assigned to a therapist and treatment condition.

The final client group obtained by the above procedure consisted of one male and three females. Two of these

clients were assigned to the treatment group and two to the control group. The first treatment client was a 24 year old female who was employed full time and attending university part-time, having completed more than half of a political science degree. She had received counselling in her early teen years and had recently thought of seeking additional counselling. She was seen by therapist A. The second treatment client was a 22 year old female who was a full time student completing the second year of a general Arts degree. She had sought career and personal counselling at the University Student Counselling Service. She was seen by therapist B.

The first of the control clients was a 24 year old female with an Engineering degree who was employed full time. She had not actually sought counselling previously but had thought of it many times. She was seen by therapist A. The remaining control client was a 24 year old male who was a part-time student of philosophy and was employed part-time. He had an Engineering degree, and had sought counselling just prior to participating in the project. He was seen by therapist B. Each of these individuals had specified an issue to be discussed in the sessions, and had indicated that the issue was personally meaningful.

### Measures

The following measures were selected as indicators of the client's therapeutic progress. Measures of the client's in-therapy process (Experiencing Scale, Voice Quality Scale, and clinical rating of the client's awareness) were employed to assess relevant aspects of the client's behaviour in the treatment and control sessions. Client self report measures (Target Complaint Discomfort Box Scale, and Change in Awareness measure) were also selected as an indication of the client's perspective on the sessions, and particularly as an indication of changes in his/her awareness, and of the level of discomfort associated with the presenting problem.

(i) Target Complaint Discomfort Box Scale: This client self report form was designed by Battle and co-workers (1966) to determine the degree of discomfort experienced by the client before and after therapy. It was selected as an indicator of the client's perspective regarding his/her progress in the sessions. It has been employed as a rating of therapeutic outcome in other studies examining client process in gestalt therapy (Greenberg and Dompierre, 1981; Greenberg and Higgins, 1980; Greenberg and Webster, 1982).

In the screening session, the clients were asked to write a brief description of the issue they wished to work on during the sessions, and to rate their level of discomfort on the Target Complaint Discomfort Box Scale.

The rating form presents a column of 13 boxes with the words "not at all" beside the bottom box, "a little" beside the seventh box, "very much" beside the tenth box, and "couldn't be worse" beside the top box (see Appendix F). This measure was employed to screen potential volunteer clients, and as an on-going indicator of the client's progress. It was administered before and three hours after each therapy session.

(ii) Client Change Of Awareness Measure: A measure of the client's perception of shifts in awareness employed in previous research on gestalt techniques (Greenberg and Dompierre, 1981; Greenberg and Higgins, 1980) was given to each client after each therapy session. The emphasis on change in awareness is particularly relevant to the gestalt approach. This measure provides the client's assessment of his/her change in the session. The clients were asked to complete the scale three hours after the session and to return it at the next session. The rating scale poses two questions to the client (a) Did you have a shift in awareness?, and (b) Did you increase awareness of yourself? It requires the client to rate his/her response on a five point scale ranging from "not at all" to "very definitely" (see Figure 2.1).

(iii) Experiencing Scale: This scale has been used frequently in previous research into gestalt therapy

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Please answer the following questions by circling the appropriate number.

(1) Did you have a shift in awareness? (Example: Maybe you saw something differently, experienced something freshly, made some discovery?)

1	2	3	4	5
not at all				very definitely

(2) Did you increase awareness of yourself?

1	2	3	4	5
not at all				very definitely

---

Figure 2.1

Client Change In Awareness Measure

(Greenberg, 1980; Greenberg & Clarke, 1979; Greenberg & Dompierre, 1981; Greenberg & Higgins, 1980; Greenberg & Rice, 1981; Greenberg & Webster, 1982). It is believed to be correlated with successful therapeutic outcome (Orlinsky and Howard, 1978).

The scale was designed by Klein and his co-workers to evaluate "the quality of the patient's self involvement in psychotherapy directly from tape recordings or transcripts of the therapy session" (Klein et al., 1969, p. 7). It is also recommended as a measure of the specific effects of particular therapist interventions. The scale attempts to assess the degree to which the client communicates his/her personal, phenomenological perspective and employs it productively in therapy. The ratings were based on four minute segments of therapy.

The scale is a seven-point annotated and anchored rating device. The seven points on the scale are described in detail in Appendix G. The different aspects of the client's process associated with the scale are described below.

At a low level on the continuum of experiencing, discourse is markedly impersonal or superficial. Moving up the scale, there is a progression from simple, limited, or externalized self-references to inwardly elaborated descriptions of feelings. At higher experiencing levels, feelings are elaborated and

emergent levels of experiencing serve as the basic referents for problem-resolution and self-understanding. Independent of specific pathology or problem content, and apart from details of therapists' technique, this scale attempts to assess the degree to which the patient communicates his personal, phenomenological perspective and employs it productively in the therapy session (Klein et al., 1969, p.1).

Inter-rater reliabilities with the experiencing scale have generally been high (Kiesler, 1973). In studies of Gestalt therapy, inter-rater reliabilities range from a Pearson correlation of .71 to .83 with raters agreeing on 51 to 67 percent of the ratings (Greenberg and Clarke, 1979; Greenberg and Dompierre, 1981; Greenberg and Higgins, 1980; Greenberg and Rice, 1981). In this study, two raters rated the complete series of videotapes. Upon completion of the ratings, the raters met to discuss those segments upon which they disagreed. The raters initially agreed on 67.4 percent of the ratings with an additional 24 percent of the ratings being only one point apart. For the mode level of experiencing, the final rating was agreed upon by both raters. The peak level rating was an arithmetic mean of the two ratings.

(iv) Client Vocal Quality: A measure of client voice quality developed by Rice and co-workers (1979) was selected for its ability to differentiate a process related to effective therapeutic process (Butler, Rice, and Wagstaff, 1962; Rice and Wagstaff, 1967; Orlinsky and Howard, 1979). The Vocal Quality scale has also been employed in previous research on gestalt techniques (Greenberg, 1980, 1983; Greenberg and Rice, 1981; Greenberg and Webster, 1982), and has proven useful to gauge client behaviour related to the use of specific therapeutic interventions. It was designed to measure a level of communication which is vocal but not verbal. The ratings are based on the client statement as the scoring unit. However, for this study, ratings were given for four minute segments to facilitate comparison with other measures.

On this scale, the client responses are classified into four mutually exclusive subclasses, externalizing, limited, emotional, and focused voice (see Appendix H for description of the categories). Briefly, each voice quality category is related to a different style as follows: (1) focused voice gives the impression of pondering, of energy turned inward in an exploring fashion, (2) emotional voice gives the general impression of disruption of the usual voice patterns with varying degrees of effort at control, (3) externalizing voice gives the total effect of energy turned outward, a "talking at" quality, and (4) limited voice gives the

impression of limited involvement, of distance from what is being expressed (Rice and Wagstaff, 1967, p.558).

Rice and co-authors (1979) report several different measures of reliability which have been employed with the Client Vocal Quality scale. In each case, the reported inter-rater reliabilities are quite high (for example 69 to 75 percent). In this study, each of the two raters rated two-thirds of the videotapes, leaving a one-third overlap for the calculation of agreement. The raters achieved 90 percent agreement on the overlapping sessions.

(v) Clinical Rating of The Client's Awareness: This measure was designed for this research project. It asks trained raters to complete a rating of the client's behaviour and awareness every four minutes throughout the treatment and control sessions. The raters are asked to rate the client's awareness on a three point rating scale ranging from "low awareness" to "high awareness".

The raters were provided with the following definition of awareness according to the gestalt approach, a list of behaviours indicative of "high awareness", and examples of the three points on the scale.

By definition, gestalt awareness refers to the present experiencing of the individual. It is the spontaneous sensing by the individual of what he/she is doing, feeling, planning. (Awareness is an integral element of the

organism-environment transaction from which it develops. As such, it is always based on the individual's perception of the current situation in the immediate present, and includes perceptions, thoughts, and feelings which the individual senses in the immediate present. From this perspective, awareness may be summarized as the individual being conscious of that to which the organism is attending.

Behaviour indicative of "high awareness" often fits the statement "I, here and now, am aware of doing thus and so". Awareness is always in the present. For example, even while relating a story, the individual may become aware of present sensations and reactions.

Within the context of gestalt therapy, awareness is seen as developing on three levels: (1) awareness of the self or inside world which involves sensory contact with inner events in the present, (2) awareness of the outside world which involves sensory contact with objects and events in the present, and (3) awareness of the intermediate zone of thought and fantasy which includes all mental activity. Frequently, the emphasis in therapy is on self awareness and nonintellectual awareness. Thus, the focus is on sensory data, feelings, and emotional reactions to experiences. In therapy, stress is placed on the use of external senses and the internal proprioceptive system of self awareness.

[ The above definition of awareness according to the gestalt approach is the context employed for the clinical

ratings of the client's awareness during a therapy session. In addition, a number of client behaviours indicative of "high awareness" can be delineated from the gestalt literature. They are as follows;

(i) Use of the present tense (the client may be discussing a personally relevant situation, which although it occurred in the past, has been brought into the present).

(ii) Use of I-language (the client uses I rather than it and relates own experience rather than talking about others).

(iii) Congruence between the client's verbal and nonverbal expressions (no behaviours which are incongruent with the content or intensity of the client's verbalizations).

(iv) Concentration (the client is able to stay with his/her awareness without interruptions or splits in awareness).

(v) Attentional focus on sensory contact with objects, events, and inner events in the present.

The clinical ratings of the client's awareness will be based on the conceptual definition and concrete behaviours described above. The actual numerical ratings will be based on a three-point rating scale on which the client's level of awareness ranges from "high awareness" to "low awareness". Examples of typical client behaviours for the three levels

are given. The raters will indicate their ratings of the client's awareness by the appropriate numbers. The ratings will be performed every four minutes throughout each therapy session. Four minute segments were selected to keep the ratings similar to the other clinical scales employed (ie. Depth of Experiencing). The three point scale provides the raters with a choice of categories without requiring him/her to make minute distinctions between a large number of categories which would likely render the ratings less reliable. For this study, inter-rater reliability was high. Each rater rated two thirds of the videotapes, leaving a one third overlap for the calculation of agreement. The raters achieved 95 percent agreement on the overlapping third.

The following descriptions are provided to further delineate client behaviour typical of each level (further examples are provided in Appendix I).

Level 1: An individual's awareness would be rated level 1, "low awareness", when his/her focus is on the content of his/her verbalizations and he/she relates his/her story with little emotional involvement or responsiveness in the present. He/she shows little understanding or knowledge of the nonverbal aspects of his/her self expression or his/her style of interaction. In addition, he/she may demonstrate difficulty concentrating and staying in the present. Generally, the individual is involved in a flow of

fantasy-imagery and thinking which is not deeply rooted in ongoing organismic activity.

Level 2: An individual's awareness would be rated level 2, "shifting awareness", when he/she displays the ability to focus on his/her present experience but is inconsistent. For example, he/she may be distracted or display incongruence between the content or intensity of his/her verbal and nonverbal expressions. Alternately, the individual might slip away from his/her present awareness of his/her self and world into fantasy or other mental activity.

Level 3: An individual's awareness would be rated level 3 "high awareness" when he/she is focused on the present and is consistent in his/her verbal and nonverbal expressions. He/she generally employs the present tense, relates his/her own experience, and is not troubled by difficulties in concentrating. Overall, she/he is in constant contact with his/her self and world, in the present.

(vi) Counselor Verbal Response Category System: The definitions of various therapeutic interventions provided by Hill and co-authors (1981) were employed to define the therapist's range of behaviour in the sessions, and the control intervention (reflection). This category system was selected because it has been employed in previous research on individual therapy employing gestalt techniques (Hill,

Carter, and O'Farrell, 1983; Hill, Thames and Rardin, 1979). In this study, the verbal response categories were employed in the instructions to the therapists and the verification of the therapists' behaviour (see Appendix D for the list of categories and definitions employed).

(vii) Incongruence Rating: The client marker, which is the precondition for the use of the treatment and control interventions, is defined as an incongruence between the content of the client's verbalizations and the content or intensity of his/her nonverbal expressions. Consequently, a verification of the client's behaviour preceding the treatment and control interventions was devised to ensure the presence of the client marker. To this end, a rater was instructed to review the client's behaviour preceding each treatment and control intervention and to rate the client's level of incongruence. The incongruence ratings were made on a five point scale with 1 labeled "not at all", 3 "somewhat", and 5 "very definitely".

#### Treatments

Each of the two therapists was paired with two clients, one in the treatment condition and one in the control condition. Each client was seen for a series of three one-hour long therapy sessions. All sessions were

videotaped and conducted at the University of Ottawa Centre for Psychological Services.

The therapists were instructed to conduct the three sessions with each client as much as possible within a gestalt framework. However, to maintain similarity between the therapeutic dyads, the therapists were further instructed to restrict the range of possible interventions. In addition to employing the experimental or control interventions at the appropriate client markers, they were provided with a list of possible interventions to be employed during the sessions. These interventions were to be consistent with the gestalt approach. In addition, to keep the focus on the target interventions, the other possible interventions were to be kept simple. The interventions and their definitions were therefore taken from Hill (1978). In a study by Hill, Thames, and Rardin (1979), it was demonstrated that these interventions were employed by Perls in a therapeutic interview (see Figure 2.2). Specifically, the therapists were instructed to restrict their interventions (see appendix D) to the following (Hill et al., 1978, p.467):

Minimal encourager

Approval-reassurance

Information

Direct guidance

Closed Question

---

<u>Intervention</u>	<u>Percentage</u>
Minimal Encourager	8
Approval-Reassurance	5
Information	12
Direct Guidance	19
Closed Question	6
Open Question	10
Restatement	5
Reflection	1
Nonverbal Referent	5
Interpretation	12
Confrontation	6
Self-Disclosure	1
Silence	1
Other	1

---

Figure 2.2

Percentage of responses for each type of intervention in the Hill Category System for an interview with Perls (from Hill Thames and Rardin, 1979).

Open Question

Restatement

Reflection

(i) Target Interventions: The target interventions include all interventions in which the therapist explicitly refers to the client's present nonverbal expression. The key factor in determining the therapist's use of these interventions is the client marker, which is defined as an incongruence between the content or intensity of the client's verbalizations and his/her nonverbal expressions (Brown, 1973; Enright, 1970, 1975; Perls, 1959; Yontef, 1975). Frequently, the client's awareness is focused on the content of his/her verbalizations. Thus the therapist asks the client to devote some attention to another aspect of his/her behaviour, in this case the nonverbal expression.

The form of these interventions is varied and includes (1) simple reflection of the client's behaviour (for example "what" and "how" questions, and nonverbal mirroring), (2) verbal invitations to the client to repeat or exaggerate the behaviour, and (3) inviting the client to give words to the nonverbal expression. These interventions are generally non-interpretive and operate to enhance the client's sense of responsibility (Enright, 1975).

(ii) Control Interventions: The rationale for specifying control interventions is to provide the therapists with a

defined alternative intervention appropriate within a gestalt framework, to be employed in the control sessions. The alternative intervention was to be employed when the context was similar to the appropriate context for the target interventions, that is when there was incongruence in content or intensity between the client's verbalization and his/her nonverbal expressions.

Specifically, the therapists were instructed to employ reflection as the alternative intervention with the clients in the control condition. The definition of reflection provided by Hill (1978) was employed for this project. However, the therapists were instructed not to refer directly to the nonverbal expression of the client in the reflection.

Reflection: This is a repeating or rephrasing of the client's statement (not necessarily just the immediately preceding statements). It must contain reference to stated or implied feelings. It may be based on previous statements, nonverbal behaviour, or knowledge of the total situation. It may be phrased either tentatively or as a statement (Hill, 1978 p.467).

#### Apparatus and Setting

The therapy room was located at the University of Ottawa Centre for Psychological Services. The room is

approximately 3.7 metres by 3.4 metres. The therapist and client sat in arm chairs approximately 0.9 metres apart with a small table between the chairs. The chairs were angled toward each other. A microphone was placed on the table. On the wall directly across from the therapist and client was a one-way mirror.

The camera was located in the adjacent room behind the one-way mirror. It was on a tripod approximately 4.0 metres from the therapist and client. It was aimed through the mirror to view both the therapist and client in the sitting position from head to foot. The camera was only moved during the session if the participants moved out of view.

The sessions were recorded on a Panasonic VHS (model PV-1275-K) video cassette recorder. The camera was a Sony (model HVC-2800) low light intensity colour camera. A Sony Trinitron (KV-1916) 26 inch colour monitor and a Realistic multidirectional microphone were also employed for the recording.

#### Procedure

(i) Preliminary Steps: The first requirements of the study were to obtain the volunteer clients, instruct the therapists, and assign the therapist-client dyads to treatment conditions. The client volunteers were sought through an advertisement in the university newspaper, posters, and visits to various psychology classes inviting

people to participate in a research project on the counselling process dealing with personal conflicts. The advertisement stipulated that the volunteers must be able to define a personally meaningful conflict and that the counselling would be limited to three sessions and would be videotaped (see appendix A). The volunteer clients were screened through an orientation session. During this session the requirements of the study were again outlined and the volunteers were asked to describe in writing the personal conflict they wished to discuss during the therapy sessions (see appendix B). In addition, they were asked to complete the Target Complaint Discomfort Box Scale. To be selected to participate in the study, it was necessary for an individual to have given the personal conflict a discomfort rating of nine or more, thereby indicating that the issue was important and personally meaningful (Hutchison, 1984). Four individuals were selected at random from the group that met these criteria to participate in the study, and each was randomly assigned to a therapist and treatment condition.

The therapists were instructed as to the explicit description of the target interventions and the appropriate therapeutic context for their use (see Appendix D). The therapists were instructed to use the target interventions with high frequency in all three sessions with one client, and not at all with the second. In the three sessions with

the second client, the therapists were instructed to employ the control interventions at the client marker.

The volunteer clients were required to sign a consent form (see Appendix C) for the therapy sessions to be videotaped and employed for research purposes. In return, the confidentiality and security of the tapes was assured. The clients were blind to the specific purpose of the study.

(ii) Conduct Of The Sessions: As soon as the therapeutic dyads were set up, the therapist and client arranged a schedule for the sessions. Normally, the sessions took place weekly for three consecutive weeks. Following the first session, the appropriateness of each client was assessed. The suitability of the client was based on two criteria. The first criterion was that the client must exhibit incongruence, which was the marker for the use of the experimental intervention, a minimum of five (5) times in the initial session. The frequency was obtained by a trained rater reviewing the video tape. Secondly, the therapist must judge that the client was suited to the therapeutic approach. Judgement of the client's suitability was left up to the experienced therapists and was intended only to select out those clients who would be unsuited to the study due to the severity of their presenting problem. None of the clients who met the selection criteria and followed through to the first session were judged unsuitable. All of the sessions were conducted at the

University of Ottawa Centre for Psychological Services between the months of March and May 1987. Each client completed the series of three sessions in a four to six week period.

(iii) Video Recording of the Sessions: The camera was operated by a graduate psychology student, trained in its use. It was the responsibility of this student to assure accurate labelling of the tapes with the date, therapist number, client number and session number. The student was also responsible for securing the video cassette at the end of each session.

(iv) Pre- and Post-Session Client Report Forms: The camera operator was also trained in the administration of the pre- and post-session client report forms, the Target Complaints Discomfort Box Scale and the Change of Awareness Measure. The Target Complaint Discomfort Box Scale was completed by the client before each therapy session. In addition, a package containing the Change of Awareness Measure and the Target Complaint Discomfort Box Scale was given to the client with instructions to complete the forms 3 hours after the session and return it at the next session.

(v) Verification of Therapist Behaviour and Client Marker: To verify that the therapists employed only the specified interventions and that the client marker was present prior

to each experimental and alternate intervention, one experienced graduate level psychology student trained according to the manual (Hill et al., 1981) and reviewed the video recorded therapy sessions. This rater categorized each therapist intervention according to the list of possible interventions (see section on treatments). In addition, when an experimental or alternate intervention was encountered, the rater reviewed the client behaviour preceding the intervention to ensure that the client marker was present and to rate the client's level of incongruence. Incongruence is observable when there is a lack of match between the verbal and nonverbal expressions of the client either in terms of the content or intensity of the expression. For the treatment interventions, the nonverbal expression had to be 'present', that is, it must have occurred within five minutes of the intervention. The rater then rated the level of incongruence on a five point scale ranging from "not at all" to "very definitely". For the session to be acceptable as part of the research sample, the therapist's interventions must be at least 85 percent categorizable on the list of specified interventions and the appropriate client marker must precede the experimental and alternate interventions (regardless of the rating of incongruence).

A second verification of the therapist's behaviour sought to ascertain if the therapist's overall therapeutic

approach was compatible with the gestalt approach. To this end, the therapists were asked to describe their own approach on a semi-structured questionnaire (see Appendix E).

(vi) Rating Client Behaviour: Each four minute segment of therapy was rated for Depth of Experiencing, Client Vocal Quality, and Client Awareness. For the Depth of Experiencing Scale, two raters were trained according to the manual provided. Each rater then rated all of the videotapes. The final rating of the mode level of experiencing was achieved through comparison and discussion between the two raters. The final rating for the peak level of experiencing was the arithmetic mean of the two ratings.

For the Vocal Quality ratings, the procedure was that two raters each rated two thirds of the segments. The overlapping one third was employed for the calculation of inter-rater reliability. The raters were trained according to the manual and accompanying audio tape (Rice et al., 1979). A rating of voice quality was given to each client statement. For this study, the predominant voice quality for each four minute segment was employed in the analyses and other ratings were omitted.

For the rating of client awareness, two experienced graduate level psychology students were trained on the definition and list of behaviours provided. In addition,

they did practice ratings on one video tape. During the practice rating, it was discovered that quite reliable ratings could be achieved with a three point scale. Consequently, each rater rated two thirds of the videotapes, thereby employing the overlapping third for the calculation of inter-rater reliability. The ratings were based on the predominant awareness level for each four minute segment.

#### Method Of Analysis

The purpose of this section is to describe the data and analyses that result from the design described above. The analysis employs statistical and graphic analyses of the data collected on the four therapeutic dyads, two in the treatment condition and two in the control condition, on five variables.

Due to the small number of clients in the study and the use of repeated measures, graphic data presentations and analyses of variance (Systat Version Three) were employed. Each of the hypotheses stated in chapter one involves the comparison of the treatment and control clients on a particular variable. For each of the process variables (Experiencing Scale, Vocal Quality Scale, and clinical rating of the client's awareness level), the frequencies of occurrence were calculated and the distributions for the treatment and control clients were transformed into proportions and the distributions are presented graphically.

For the distributions, the data for the clients seen by therapist A are treated separately from the data for the clients seen by therapist B. In addition, the data were analyzed according to the appropriate analysis of variance model. Consequently, the comparisons of the treatment and control clients for each therapist are based on the results of the analysis of variance and the graphic presentation of the data.

The client self report data (Change in Awareness Measure and Target Complaint Discomfort Box Scale) are treated somewhat differently. The results of the Change in Awareness Measure are presented in tabular form. For the Target Complaint Discomfort Box Scale, the results are presented graphically, and then transformed into a second graph which displays the magnitude of change for each client from his/her base line level.

The results of the data analyses are the focus of the next chapter. It will present the analyses associated with each hypothesis in detail.

## CHAPTER III

### RESULTS

#### Introduction

This chapter presents the results of the study. The study involves six major variables which are employed either as descriptors of the client's or therapist's behaviour or in testing the hypotheses. These variables are the Hill Counselor Verbal Response Category System (Hill et al., 1981), Depth of Experiencing Scale (Klein et al., 1969), Client Vocal Quality (Rice et al., 1979), Target Complaint Discomfort Box Scale (Battle et al., 1966), Client Change of Awareness Measure (Greenberg and Dompierre, 1981; Greenberg and Higgins, 1980), and a clinical rating of the client's awareness.

The first analysis (Verification of Therapist Behaviour and Client Marker) involves an examination of each therapist's behaviour to verify (a) if she/he employed the treatment or control interventions in sufficient quantity and under the specified conditions, and (b) if she/he employed the range of interventions specified in the instructions to the therapists (see appendix D). The subsequent analyses are intended to test the hypotheses presented in chapter one. Hypothesis one deals with the client's depth of experiencing in the treatment and control sessions, hypothesis two with the client's vocal quality,

hypothesis three with the client's self report measures of change (the Target Complaint Discomfort Box Scale and the Client Change of Awareness Measure), and hypothesis four with the clinical rating of the client's level of awareness in the treatment and control sessions.

#### Verification of Therapist Behaviour and Client Marker

To ensure that the therapists carried out the sessions as instructed, three checks were performed. First, it was verified that the therapists employed the specified list of verbal response categories in the absence of the client marker. Second, the frequencies of occurrence of the treatment and control interventions in each session were tallied. Third, for each treatment and control intervention, the preceding client behaviour was reviewed to ensure that the client marker was present and to rate the level of incongruence.

The first check emanated from the need to maintain similar conditions within the treatment and control sessions. Consequently, the therapists were instructed to follow certain guidelines during the sessions. These guidelines were described in detail in the methodology, and are presented in full in appendix D. To summarize, the therapists were to conduct each session generally within a gestalt approach and, in the absence of the client marker, to restrict their interventions to the following: minimal

encourager, approval-reassurance, information, direct guidance, closed question, open question, restatement, and reflection (as defined by Hill et al., 1981). These interventions are within the range of interventions employed in gestalt therapy (Hill et al., 1979).

The results of the first verification indicate that the therapists utilized the range of interventions described in the instructions. Ninety eight percent (98%) of all interventions employed by therapist A with both clients were within the specified list of verbal response categories. For those interventions employed by therapist B, 96 percent were within the specified list. It had been predetermined that, as an acceptable minimum, 85 percent of interventions should fall within the preselected verbal response categories. Both of these results exceed the predetermined minimum.

Each therapist's use of the various interventions, as defined by the Hill System (Hill et al., 1981), is presented in figures 3.1a and 3.1b. These graphs show the distribution of interventions employed by each therapist with his/her treatment and control clients respectively. Figure 3.1a refers to therapist A and figure 3.1b to therapist B.

The profiles presented in the two bar graphs are visually similar, however, somewhat different patterns of

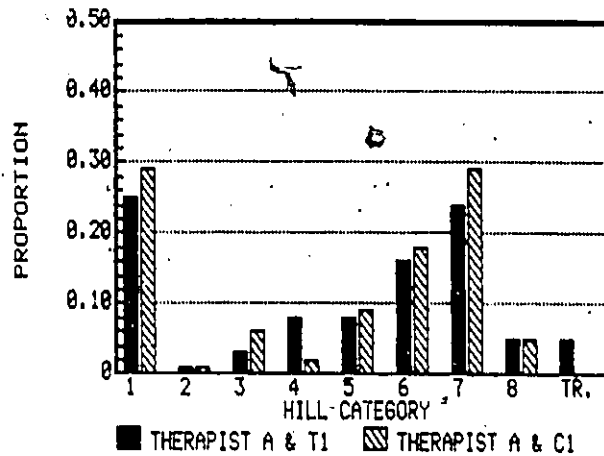


Figure 3.1a

Distribution of verbal response categories employed by therapist A, expressed as proportions.

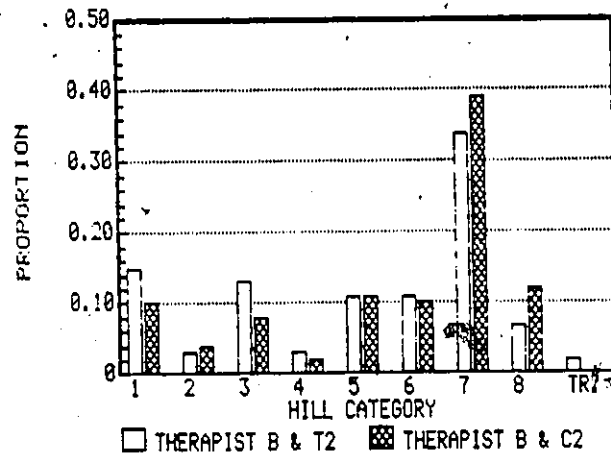


Figure 3.1b

Distribution of verbal response categories employed by therapist B, expressed as proportions.

**Legend:** T = treatment client; C = control client; 1) minimal encourager, 2) approval-reassurance, 3) information, 4) direct guidance, 5) closed question, 6) open question, 7) restatement, and 8) reflection (as defined by Hill et al., 1979).

interventions were used by the therapists with their treatment and control clients.

The second verification concerns the frequency of occurrence of the treatment and control interventions. As one of the selection criteria, it was determined that the treatment or control interventions should occur in the first session, with sufficient frequency to warrant seeing the client for the full series of three sessions. The minimum number of treatment or control interventions for the first session was set at five. The results of the second check are presented in table 3.1. All sessions met or exceeded the stated acceptable minimum.

The third check was to ensure that the treatment and control interventions occurred following a client marker, which was the precondition for both the treatment and control interventions. For this study, the client marker was defined as an incongruence between the content or intensity of the client's nonverbal expression and the content of his/her verbalizations. For example, the client's gestures might indicate that he/she is angry while the verbal content of what he/she is relating to the therapist remains calm. In response to the client marker, the therapist was to employ the treatment intervention with the treatment client and the control intervention with the control client. Consequently, when a treatment or control intervention was identified, the preceding client behaviour

Table 3.1

Number of treatment or control interventions per session,  
for the two therapists and four clients.

Therapist	Client	Session		
		I	II	III
A	T1	18	14	13
B	T2	8	10	6
A	C1	5	6	7
B	C2	6	11	12

Note: T = Treatment client; C = Control client.

was reviewed in order to rate the client's level of incongruence. The level of incongruence was rated on a five point scale with 1 labeled "not at all", 3 "somewhat", and 5 "very definitely". The mean level of incongruence for each client across sessions, and the overall mean, are given in table 3.2. For treatment client T1, 80 percent of the treatment interventions were preceded by client behaviour rated as 3 or greater on the above scale. For treatment client T2, 62.5 percent of treatment interventions were preceded by client behaviour rated as three. For the control clients, C1 and C2, the results were 77.8 percent and 93 percent respectively. Visual examination of table 3.1 indicates that three of the clients (T1, C1, and C2) had similar mean levels of incongruence. The overall mean level of incongruence for client T2 is somewhat lower.

In summary, the above checks verified that the therapists followed the guidelines and instructions provided. Both therapists employed the specified list of interventions. The treatment and control interventions were present in sufficient numbers. The majority of the treatment and control interventions were preceded by the client marker. However, examination of the therapist's use of the various interventions demonstrated that both therapist A and therapist B employed somewhat different patterns of interventions with the treatment and control

Table 3.2

Mean level of incongruence preceding treatment/control interventions.

Therapist	Client	Session			
		I	II	III	Overall
A	T1	3.89	3.50	3.08	3.53
B	T2	2.75	3.40	1.00	2.58
A	C1	4.60	3.00	2.57	3.28
B	C2	3.17	3.64	3.58	3.52

Note: T = Treatment client; C = Control client. Incongruence ratings are based on a 5-point scale.

clients. A certain amount of variability in the therapist's behaviour is to be expected given that individual client behaviours cannot be predicted in therapy and therefore require adjustment by the therapist.

#### Depth of Experiencing (Hypothesis 1)

**Hypothesis 1:** The client's behaviour, during sessions in which the therapist explicitly responds to nonverbal expressions of the client (treatment sessions), will exhibit higher levels of experiencing than will the client's behaviour during control sessions.

The client's depth of experiencing was rated as two distinct but related variables, the mode and peak levels of experiencing. However, according to the analyses, these two ratings relay very similar information. Consequently, only the results for the mode level of experiencing will be reported. The mode was selected because it is a more stable rating, in that it is based on a larger portion of the client's behaviour.

The analyses address hypothesis one in two ways, (1) by comparing the distributions of client statements that correspond to each of the levels of experiencing for each treatment and control client, and (2) by comparing the average levels of experiencing across sessions for each of the treatment and control clients. The results of these analyses are presented below.

For the first group of analyses, the total distribution of client statements according to the level of experiencing (grouped in four-minute segments) was prepared for each client. These distributions are presented in figure 3.2a for the two clients seen by therapist A, and in figure 3.2b for the two clients seen by therapist B. Visual comparison of the frequency distributions in figure 3.2a reveals that the two clients seen by therapist A were rated as exhibiting very similar levels of experiencing. For the two clients seen by therapist B, the graph in figure 3.2b demonstrates that they had somewhat different distributions of experiencing levels. Specifically, therapist B's control client (C2) had a larger proportion of ratings in the upper levels of experiencing than did the treatment client (T2), contrary to hypothesis one.

The second group of analyses addressing hypothesis one compares the treatment and control clients in terms of their average level of experiencing per session. These results are presented graphically in figure 3.3a for the two clients seen by therapist A, and in figure 3.3b for the clients seen by therapist B. Figure 3.3a shows that both of therapist A's clients (T1 and C1) increase their average levels of experiencing across the three sessions, and attain a comparable average level of experiencing in session three. These results concur with the results of the previous analysis. They indicate that clients T1 and C1 are similar

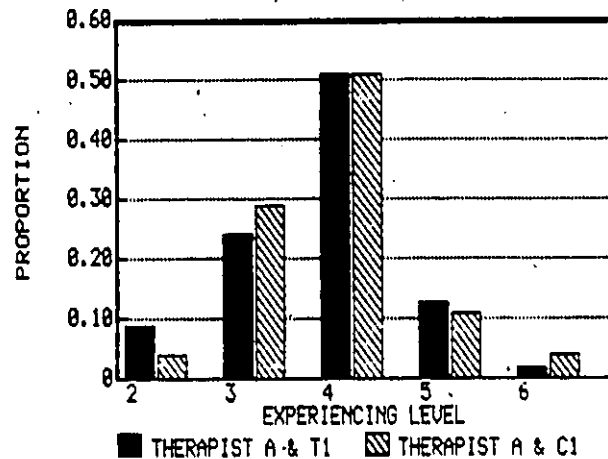


Figure 3.2a

Distribution of client statements according to level of experiencing (Klein et al., 1969) for the two clients seen by therapist A, expressed as proportions.

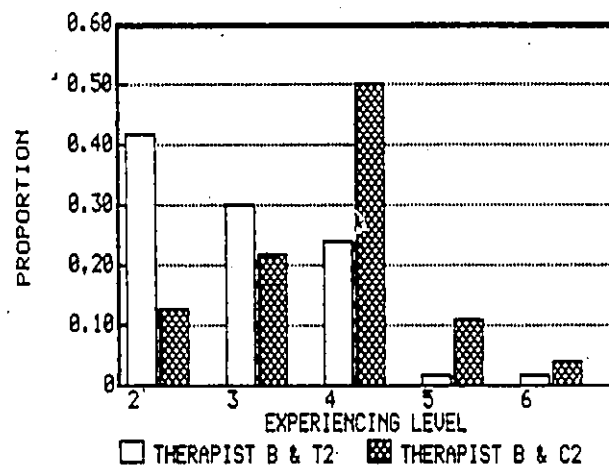


Figure 3.2b

Distribution of client statements according to level of experiencing (Klein et al., 1969) for the two clients seen by therapist B, expressed as proportions.

Legend: T = treatment client; C = control client. The Depth of Experiencing Scale is a 7-point scale with 7 indicating the highest level of experiencing.

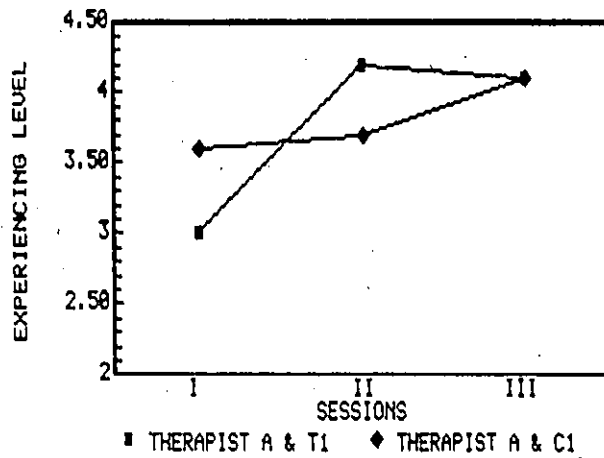


Figure 3.3a

Average level of experiencing (Klein et al., 1969) per session for the two clients seen by therapist A.

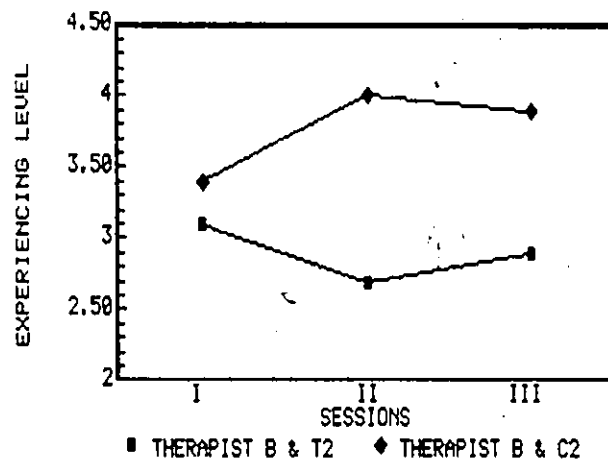


Figure 3.3b

Average level of experiencing (Klein et al., 1969) per session for the two clients seen by therapist B.

Legend: T = treatment client; C = control client. The Depth of Experiencing Scale is a 7-point scale with 7 indicating the highest level of experiencing.

in terms of depth of experiencing. Figure 3.3b shows that control client C2 increased his average level of experiencing across the three sessions in a manner similar to the control client seen by therapist A, C1. However, treatment client T2 maintained a somewhat lower average level of experiencing across sessions. These results agree with the results of the previous analysis. Both methods of analysis indicate that the control client with therapist B exhibited somewhat higher levels of experiencing across the series of three sessions compared to the treatment client, contrary to hypothesis one.

As an adjunct to the second analysis, the clients' average level of experiencing across sessions was compared via a repeated measures analysis of variance. This analysis revealed that the clients' average levels of experiencing are not significantly influenced by the treatment condition ( $p = 0.476$ ), or whether they were seen by therapist A or therapist B ( $p = 0.476$ ). These results agree with the previous analyses and indicate that the clients' levels of experiencing were not influenced by the treatment.

To summarize, the results of the analyses which tested hypothesis one either did not confirm the hypothesis (in the case of the two clients seen by therapist A), or contradicted it (in the case of the clients seen by therapist B). Hypothesis one, therefore, could not be confirmed.

### Client Vocal Quality (Hypothesis 2)

**Hypothesis 2:** The client's vocal quality, during sessions in which the therapist explicitly responds to nonverbal expressions of the client (treatment sessions), will exhibit more frequent instances of focused voice than will the client's vocal quality during control sessions.

The data from the voice quality ratings were analysed in two ways in order to test the second hypothesis. The first analysis compares the distribution of client statements in each voice quality category for each treatment and control client. The second analysis utilizes the proportion of segments rated as focused in each session for each client as a basis of comparison.

For the first analysis, the distribution of client statements (grouped in four minute segments) in the four voice quality categories (focused, externalizing, limited, and emotional) for each client is presented graphically. Figure 3.4a presents the distributions for the two clients seen by therapist A, and in figure 3.4b are the distributions for the clients seen by therapist B. The distributions presented in the bar graphs are expressed as proportions. Visual examination of the distribution in figure 3.4a reveals that the two clients seen by therapist A exhibited different vocal quality. The treatment client received the highest proportion of ratings in the externalizing and focused categories, while the majority of the ratings for the control client (C1) were in the limited

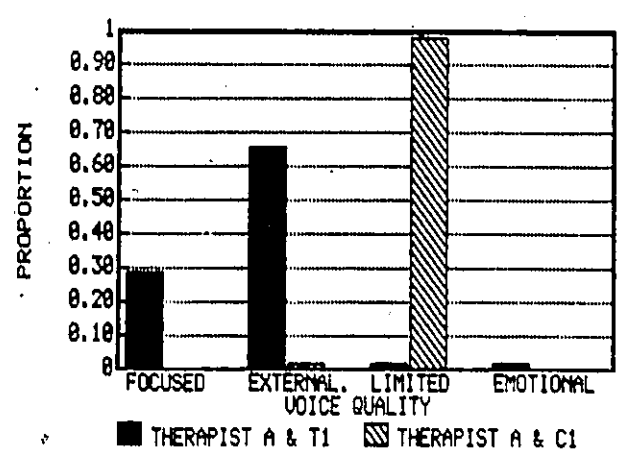


Figure 3.4a

Distribution of client statements according to voice quality ratings (Rice et al., 1979), expressed as proportions.

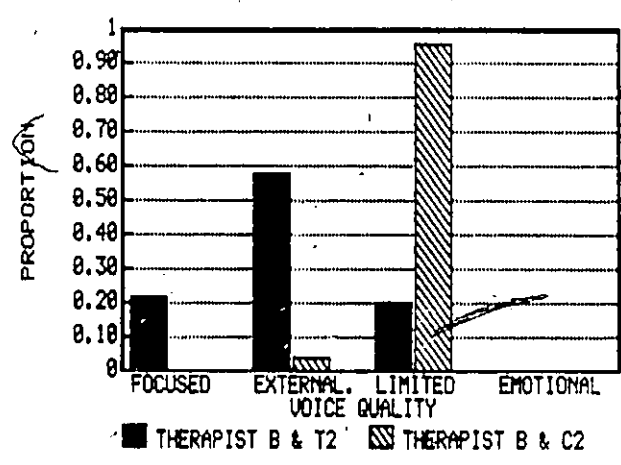


Figure 3.4b

Distribution of client statements according to voice quality ratings (Rice et al., 1979), expressed as proportions.

Legend: T = treatment client; C = control client.

category. Similar results are presented in figure 3.4b for the two clients seen by therapist B. For the treatment client, the ratings were mostly in three categories, externalizing, focused, and limited, while the majority of ratings for the control client were in the limited category.

The second set of analyses which addresses hypothesis two compares the proportion of segments rated as focused in each session for each client. These results are presented graphically in figure 3.5a for the clients seen by therapist A, and in figure 3.5b for the clients seen by therapist B. Figure 3.5a shows that client T1 demonstrated a steady increase in the proportion of segments rated as focused, with session three having 50 percent of segments in the focused category. Client C1 had no segments in any of the three sessions rated as focused. These results concur with the results of the previous analysis and indicate that the client in the treatment condition (T1) exhibited significantly more frequent instances of focused voice. In figure 3.5b, the dichotomy between the treatment and control clients is also clear. Client T2 has a small proportion of segments rated as focused in the first two sessions, and increases markedly to 44 percent of segments rated as focused in the final session. Again, the control client (C2) does not have any segments rated as focused in any of the three sessions. These results agree with the

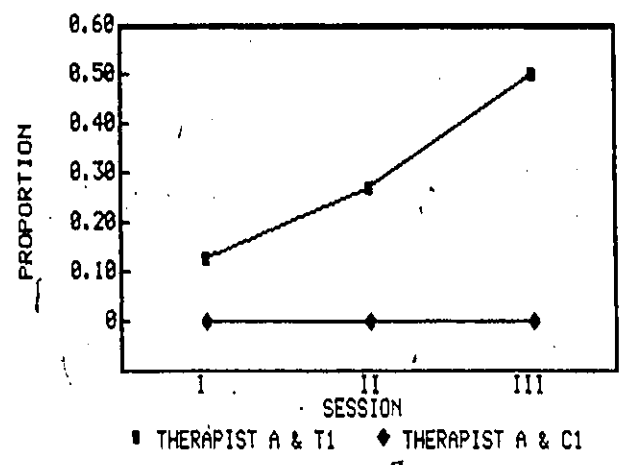


Figure 3.5a

Proportion of segments rated as focused in each session for the two clients seen by therapist A.

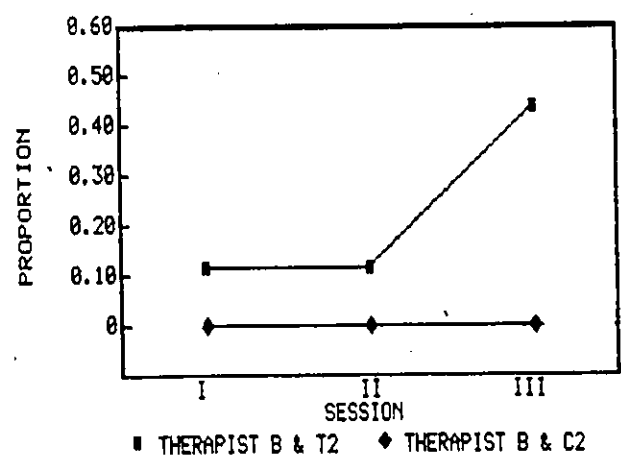


Figure 3.5b

Proportion of segments rated as focused voice per session for the two clients seen by therapist B.

Legend: T = treatment client; C = control client.

previous analysis. They indicate that the treatment client exhibited more frequent instances of focused voice.

As an adjunct to the second analysis, the total frequency of client focused voice was compared across treatments and therapists by a two way analysis of variance. The analysis reveals that the frequency of segments rated as focused was not significantly related to the therapist ( $p=0.5$ ) but was significantly influenced by the client's inclusion in the treatment condition ( $p=0.053$ ). This result coincides with the disparate distributions of proportions presented in figures 3.4a and 3.4b. The treatment clients exhibited significantly more instances of focused voice (for T1 and T2, 13 and 11 respectively) while the control clients had no segments rated as focused.

In summary, the results of both methods of analysis for the voice quality ratings confirm the prediction that the clients in the treatment sessions will exhibit more frequent instances of focused voice. The results both for the clients seen by therapist A and those seen by therapist B confirm hypothesis two.

#### Client Change of Awareness Measure And The Target Complaint

##### Discomfort Box Scale (Hypothesis 3)

Hypothesis 3: The client's self report data, following sessions in which the therapist explicitly responds to nonverbal expressions of the client (treatment sessions), will demonstrate greater awareness and lesser discomfort related to the

presenting problem than will the client's self report data following control sessions.

The third hypothesis involves two separate client self report measures, the Client Change Of Awareness Measure (Greenberg and Dompiere, 1981; Greenberg and Higgins, 1980), and the Target Complaint Discomfort Box Scale (Battle et al., 1966). The analyses address hypothesis three in three ways, (1) the results of the clients' reported change of awareness are presented in tabular form, (2) the client's reported level of discomfort pre- and post-session for each client for the series of three sessions is presented graphically, and (3) the change in the client's level of discomfort across sessions is displayed graphically utilizing the client's reported level of discomfort prior to session one as his/her base line level.

The client's change of awareness measure presented the client with two questions. The first question asked if the client experienced a shift in awareness, and the second if he/she had increased awareness of him/herself. Both questions were answered on a five point scale, with 1 labeled "not at all", 3 "somewhat", and 5 "very definitely". For the first analysis, the data collected on this measure is presented in table 3.3a for the clients seen by therapist A and in table 3.3b for the clients seen by therapist B. These data demonstrate little variability between the treatment and control clients. All clients reported a high

Table 3.3a

Client self-reported change in awareness data as reported after each session for the clients seen by therapist A.

Session	Question 1		Question 2	
	T1	C1	T1	C1
I	5	5	4	5
II	2	4	3	4
III	4	2	3	3
Mean	3.67	3.67	3.33	4.00

Note: T = treatment client; C = control client. The Client Change In Awareness Measure is based on a 5 point scale. The questions were as follows:  
 (1) Did you have a shift in awareness?  
 (2) Did you increase awareness of yourself?

Table 3.3b

Client self-reported change in awareness data as reported after each session for the clients seen by therapist B.

Session	Question 1		Question 2	
	T2	C2	T2	C2
I	5	5	5	5
II	5	5	5	5
III	5	4	5	4
Mean	5.00	4.67	5.00	4.67

Note: T = treatment client; C = control client. The Client Change In Awareness Measure is based on a 5 point scale. The questions were as follows:  
 (1) Did you have a shift in awareness?  
 (2) Did you increase awareness of yourself?

level of change in awareness. The similarity of the ratings on this measure is particularly evident when the overall mean is employed as the basis of comparison. In summary, the client's reported change of awareness is unrelated to his/her inclusion in the treatment condition. These results do not support hypothesis three.

The client's self reported level of discomfort associated with the presenting problem was rated before and after each session. The client's ratings were based on a 13-point scale, with 13 labeled "Couldn't be worse", 10 "Very Much", 7 "Quite a bit", 4 "A Little", and 1 "Not at all". For the second analysis, the results from these ratings are presented in the line graphs in figure 3.6a for the clients seen by therapist A, and in figure 3.6b for the clients seen by therapist B. Figure 3.6a shows that both clients T1 and C1 begin session I with a high level of discomfort and that both clients' level of discomfort decreased by the final rating, post session three. A similar pattern is present in figure 3.6a for clients T2 and C2. Both clients begin at a high level of discomfort and report a lower level of discomfort following the last session.

The magnitude of change in level of discomfort reported by each client is more clearly demonstrated by the third analysis. This method begins by employing the client's level of discomfort prior to session one as her/his base

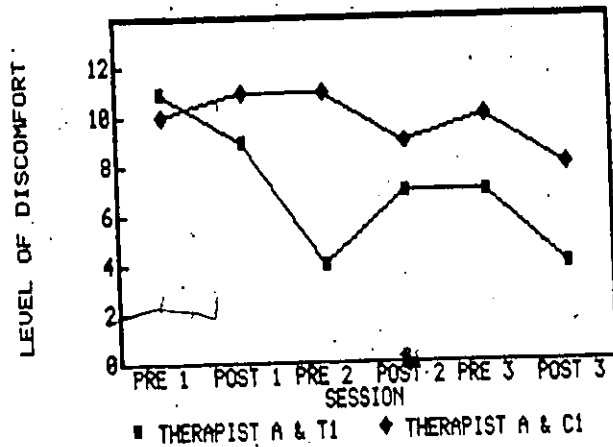


Figure 3.6a

Client self reported level of discomfort pre- and post-session for the two clients seen by therapist A.

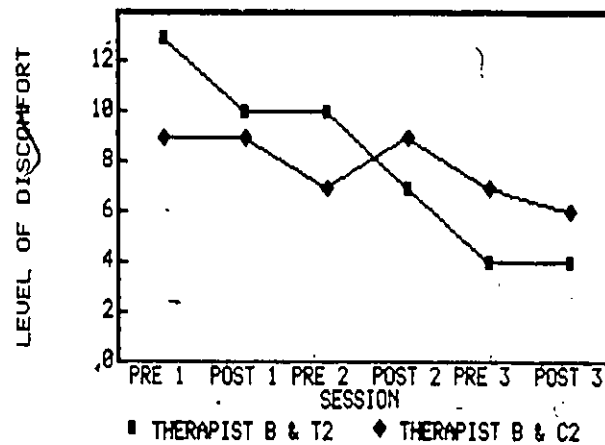


Figure 3.6b

Client self reported level of discomfort pre- and post-session for the two clients seen by therapist B.

Legend: T = treatment client; C = control client. The discomfort ratings are based on a 13 point rating scale, with 13 as 'couldn't be worse'.

line level. The client's level of discomfort is the only measure taken prior to session one, and therefore prior to the client's exposure to the treatment. Therefore, this rating may be viewed as the client's starting point or base line. For the purpose of comparison, each client's base line level is set to zero. For the graphs, each client's reported level of discomfort at the subsequent time intervals is then plotted in terms of the amount of change from their starting point. The results of the transformation of the data are presented in the graphs in figure 3.7a for the clients seen by therapist A, and in figure 3.7b for the clients seen by therapist B. Figure 3.7a clearly shows that client T1 reported a greater decrease in discomfort (overall seven points) than client C1 (overall two points). Again in figure 3.7b, the treatment client, T2, shows a greater overall decrease in discomfort (overall nine points) as compared to the control client, C2 (overall three points). Therefore, in both cases, the treatment clients reported a greater decrease in discomfort. In addition, the decrease in discomfort reported by both treatment clients exceeds two standard deviations (two standard deviations equals 5 points on a 13-point scale). These results are further supported by a repeated measures analysis of variance utilizing the clients' reported level of discomfort pre session I and post sessions I, II, and III. The analysis revealed that the client's level of

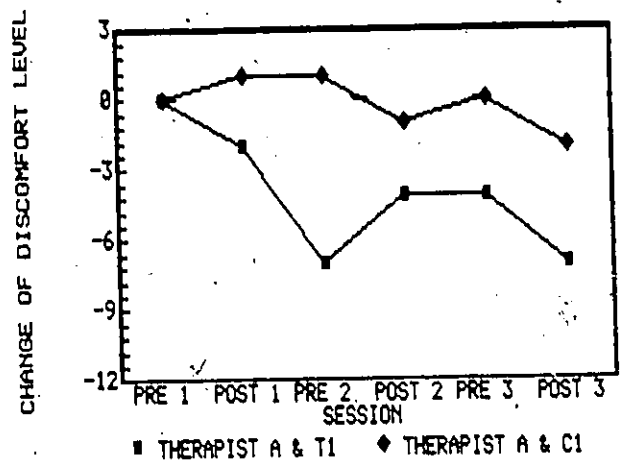


Figure 3.7a

Change in the client's level of discomfort across the series of three sessions for the two clients seen by therapist A.

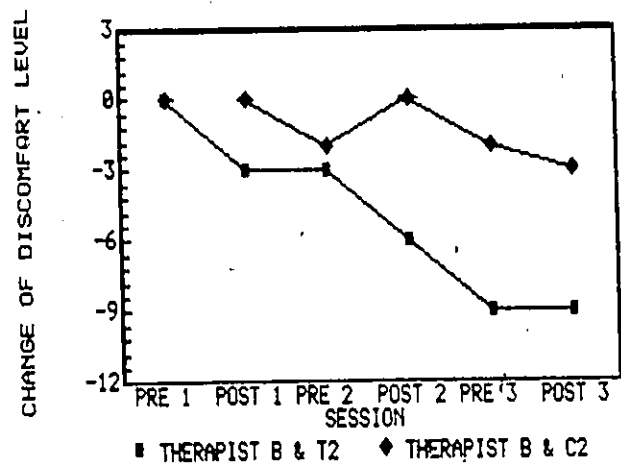


Figure 3.7b

Change in the client's level of discomfort across the series of three sessions for the two clients seen by therapist B.

Legend: T = treatment client; C = control client. The change in discomfort scores are based on the pre-session one score as the client's baseline level.

discomfort was not significantly related to the therapist ( $p= 0.844$ ) or treatment ( $p= 0.59$ ) factors. However, the client's level of discomfort did change significantly over time ( $p= 0.054$ ). Post-hoc analyses reveal that the treatment clients had greater variability in their discomfort scores ( $p= 0.037$ ) and demonstrated the greatest decrease in discomfort across sessions. These results support the third hypothesis.

In summary, the results of the first analysis, utilizing the client self reported change in awareness data, do not support hypothesis three. However, the results based on the client's level of discomfort, from the second and third analyses, do support hypothesis three. The clients in the treatment condition reported a greater decrease in level of discomfort associated with the presenting problem.

#### Clinical Rating Of The Client's Awareness (Hypothesis 4)

**Hypothesis 4:** The client's behaviour as rated by clinical judges, during sessions in which the therapist explicitly responds to nonverbal expressions of the client (treatment sessions), will exhibit greater self-awareness than will the client's behaviour during control sessions.

The analyses address hypothesis four in two ways, (1) by comparing the distributions of segments of client behaviour that correspond to each of the levels of awareness for each treatment and control client, and (2) by comparing the proportion of segments rated either level 2 or level 3

(ie. awareness level greater than level one) across sessions for each of the treatment and control clients. The results of these analyses are presented below.

For the first analysis, the distribution of segments of client behaviour rated as (1) low, (2) shifting, or (3) high level of awareness was prepared for each client. These distributions are presented as bar graphs in figure 3.8a for the two clients seen by therapist A, and in figure 3.8b for the two clients seen by therapist B. Visual inspection of the bar graph in figure 3.8a reveals that both the treatment and control clients seen by therapist A have the largest proportion of ratings in the low awareness category. The treatment client (T1) has some ratings in the high awareness category while the control client does not. In figure 3.8b, the bar graph indicates that both the treatment and control clients seen by therapist A have the majority of ratings in the low awareness category with little variability.

The second group of analyses which address hypothesis four compares the proportion of segments rated either as level 2 (shifting awareness) or level 3 (high awareness) for each client in each of the sessions. These results are presented graphically in figure 3.9a for the clients seen by therapist A, and in figure 3.9b for the clients seen by therapist B. Figure 3.9a shows that client T1 exhibits a higher proportion of segments rated at awareness levels

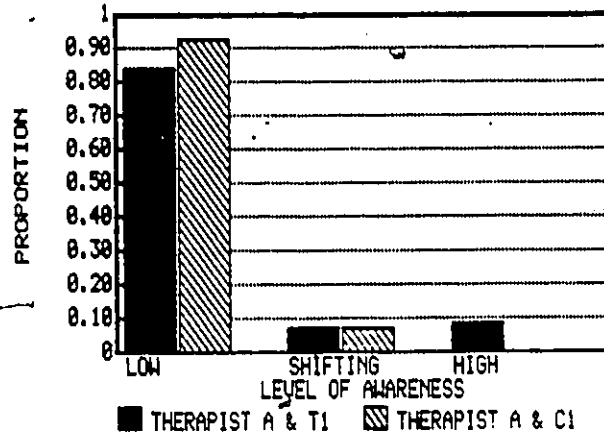


Figure 3.8a

Distribution of segments of client behaviour rated according to level of awareness for the two clients seen by therapist A, expressed as proportions.

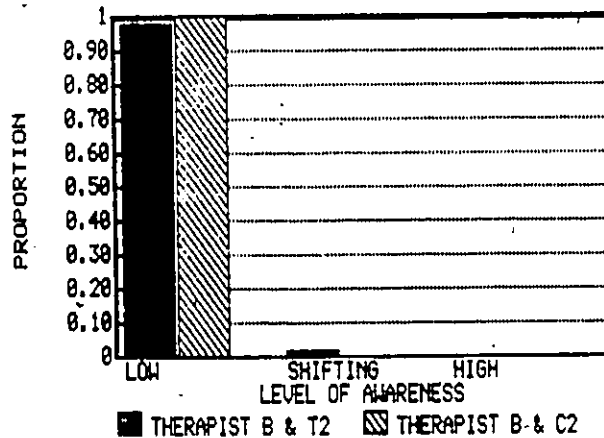


Figure 3.8b

Distribution of segments of client behaviour rated according to level of awareness for the two clients seen by therapist B, expressed as proportions.

Legend: T = treatment client; C = control client;

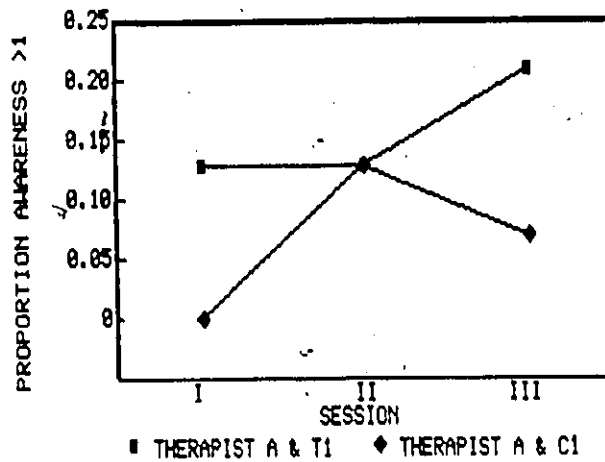


Figure 3.9a

Proportion of segments of client behaviour in each session rated as either level 2, shifting awareness, or level 3, high awareness, for the two clients seen by therapist A.

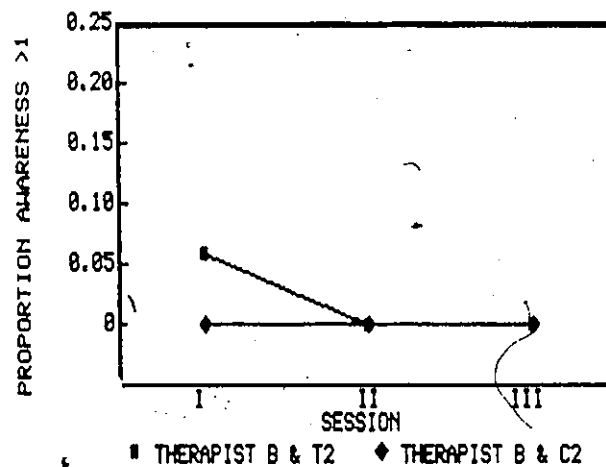


Figure 3.9b

Proportion of segments of client behaviour in each session rated as either level 2, shifting awareness, or level 3, high awareness for the two clients seen by therapist B.

Legend: T = treatment client; C = control client.

greater than one in session one. Client T1 maintained that level for session two, and showed an increase in session three. Client C1 had no segments rated higher than level one in session one, then showed a marked increase in session two, and then decreased somewhat in session three. Overall, the treatment client showed a higher level of awareness compared to the control client. Figure 3.9b shows that there is less variability on this measure for therapist B's clients. Client T2 shows a small proportion of segments at levels greater than one for the first session. However, client T2's proportion falls to zero for sessions two and three. Client C2 shows no segments higher than level one in any of the three sessions. Overall, the level of awareness for the two clients seen by therapist B is quite similar and shows little variability.

As an adjunct to this second analysis, a two way analysis of variance was performed on the total number of segments rated higher than level one for all clients. The analysis revealed that the number of segments rated either as level 2 or level 3 for each client is not significantly related to either the therapist ( $p = 0.205$ ) or the treatment ( $p = 0.344$ ) factors. These results concur with the previous analyses which indicate that the client's rated level of awareness was not significantly influenced by the treatment interventions.

In summary, the results of the analyses addressing hypothesis four do not support the prediction that the clients in the treatment sessions will exhibit higher levels of awareness. However, one treatment client (T1) did show a higher proportion of segments at awareness levels greater than one. Overall, hypothesis four could not be confirmed.

#### Summary

This chapter presented the data and data analyses based on the six major variables employed in the study. The first section presented the ratings and analyses which confirmed that the therapists followed the guidelines for the employment of the specified list of interventions, presence of the client marker, and frequencies of occurrence of the treatment and control interventions. These analyses indicated that the therapists, although they made adjustments for individual clients, employed the specified list of interventions. Finally, the treatment and control interventions were employed with sufficient frequency in each session, and for the majority of treatment and control interventions, the client marker was present.

The second section presents the results of the analyses intended to test the first hypothesis. Hypothesis one predicted that the clients in the treatment sessions will exhibit higher levels of experiencing as measured by the Depth of Experiencing Scale (Klein et al., 1969). These

analyses produced somewhat different results for the clients with therapist A and those with therapist B. For those clients with therapist A, the distributions of the client's levels of experiencing and the client's average level of experiencing per session were similar for both the treatment and control clients. With therapist B, there were differences in the distributions of experiencing levels, with the control client (C2) displaying larger proportions at the higher experiencing levels, and a somewhat higher average level of experiencing per session. These results either did not confirm hypothesis one (as in the case of the two clients seen by therapist A), or contradicted it (as in the case of the two clients seen by therapist B). Hypothesis one, therefore, could not be confirmed.

The third section summarized the analyses addressing hypothesis two, which refers to the client's Vocal Quality (Rice et al., 1979). Hypothesis two predicted that the clients in the treatment condition would exhibit more frequent instances of focused voice compared to the clients in the control condition. Comparison of the distributions of client statements according to voice quality category indicated that the treatment clients (T1 and T2) exhibited a higher proportion of segments rated as focused. In fact, the control clients (C1 and C2) did not have any segments rated as focused. In addition, the treatment clients increased the proportion of segments in the focused category

across the three sessions, with T1 having 50 percent of segments and T2 having 44 percent of segments rated as focused in the third session. These results confirm hypothesis two.

The fourth section presented the analyses corresponding to hypothesis three, which deals with the two client self report measures. Hypothesis three predicted that the treatment clients would report greater awareness and lesser discomfort compared to the clients in the control sessions. The client's self reported change in awareness data demonstrated that all clients reported a high level of change of awareness with little variability among the clients. With respect to the client's level of discomfort, all clients reported a high level of discomfort prior to session one, and demonstrated a decrease in their level of discomfort in the rating post session three. However, the difference lies in the magnitude of the decrease in discomfort. The treatment clients (T1 and T2) showed a markedly greater decrease over the three sessions compared to the control clients (C1 and C2). In summary, the results of the client change in awareness measure did not confirm hypothesis three. However, in terms of the level of discomfort associated with the presenting problem, the treatment clients did demonstrate a greater decrease. This result does support the prediction put forth in hypothesis three.

The final section presented the analyses involving the clinical ratings of the client's level of awareness. Hypothesis four predicted that the clients in the treatment sessions will exhibit higher levels of awareness than will the clients in the control sessions. The distributions of the ratings on this variable revealed that for all clients, the highest proportion of segments were rated as low awareness. Treatment client, T1, was the only client to have segments rated as displaying high awareness. The proportion of segments rated at awareness levels higher than level one across sessions showed that treatment client T1 did have a larger proportion of segments at higher levels of awareness. For the two clients seen by therapist B there was little variability in the proportion of segments rated at awareness levels two and three. Nevertheless, the total number of segments of client behaviour rated at awareness levels greater than one was not significantly related to the therapist or treatment factors. Overall, these results do not confirm hypothesis four. However, treatment client T1 did demonstrate a higher proportion of segments at awareness levels greater than one.

The interpretation of these results will need to take into account the idiographic or case study nature of the data. The interpretation of the results and their conceptual implications is the focus of the next chapter.

## CHAPTER IV DISCUSSION

### Introduction

In this chapter, the implications of the data analyses and hypothesis testing presented in the previous chapter will be considered. Initially, the results will be examined within the context of the conceptual rationale based on the gestalt approach to psychotherapy. Secondly, the implications of the results within the context of related research will be considered. Thirdly, implications for the clinical practice of gestalt therapy will be proposed. Finally, considerations regarding the methodology will be examined.

### Implications Related To The Gestalt Conceptual Rationale

Many authors from within the gestalt approach to therapy favour the use of therapeutic interventions which explicitly respond to the client's nonverbal expressions (Enright, 1970; Naranjo, 1980; Perls, 1959; Yontef, 1975; Van De Riet et al., 1980). In most cases, these authors propose that the use of these interventions will lead to increased awareness for the client (Perls, 1959, 1973; Simkin, 1976; Yontef, 1975). For example, Baumgardner (1975) suggests that unfinished situations and unexpressed feelings are revealed in bodily tensions. Perls (1959)

notes that the aim is to increase the client's awareness of him/herself. In most cases, gestalt authors advocate the use of these interventions in a broad manner, without specifying the appropriate context or manner of employing the technique.

An exception is Enright (1975), who more specifically delineated the characteristics of the interventions, and the therapeutic context for their use. The four characteristics presented by Enright (1975) are (1) the intervention must build on actual present behaviour, (2) the intervention is non-interpretive, (3) the style of the intervention is such that it acts to increase the client's sense of responsibility for his/her own behaviour, and (4) the questions which initiate these interventions are generally "what" and "how" questions. In terms of the therapeutic context, Enright (1975) cited incongruence between the client's verbalizations and his/her nonverbal expressions as the therapist's cue to draw the client's attention to the nonverbal expression.

Overall, the gestalt literature views these interventions as important therapeutic tools to aid the client in the steps toward increased awareness and responsibility. In other words, positive therapeutic progress, within a gestalt approach, ought to be associated with the therapist's use of interventions which respond specifically to the client's nonverbal expressions.

The results of the present study partially support the notion that interventions which explicitly respond to the client's nonverbal expression will be associated with positive therapeutic progress for the client. One clear result from this study is that the use of these interventions is associated with a client process indicated by focused voice quality (Rice et al., 1979). This client process involves a turning inward of attentional energy and engagement in differentiating new facets of experience (Rice et al., 1979). The therapeutic process associated with focused voice has been linked to positive progress in therapy (Orlinsky and Howard, 1978; Rice et al., 1979). In addition, of special importance to this study, is the shift in attentional energy indicated by the client's use of focused voice.

A shift in awareness coincides with Enright's (1975) description of the typical therapeutic context for the use of interventions responding to the client's nonverbal expressions. Enright (1975) described a situation in which the client's awareness is concentrated on the content of his/her verbalizations, talking about a problem with the therapist. When the therapist identifies incongruence between the client's verbalizations and his/her nonverbal expressions, he/she will ask the client to devote some attention to what he/she is doing, sensing, or feeling. This process is described by Brown (1973) as asking the

client to turn his/her foreground awareness upon the bodily expression.

This conceptualization of the therapeutic process involving a shift in the client's awareness is further supported by the voice quality data. The overall distributions of voice quality ratings for the treatment clients demonstrate that the largest proportion of ratings for both clients are in the Externalizing category. The Externalizing style of vocal quality is described as a deployment of attentional energy outward in an effort to produce some effect in the outside world, and the energy is being invested in the recounting rather than in the exploration (Rice et al., 1979). This pattern appears consistent with the picture of a client who is concentrating on the verbal content of the problem he/she is describing to the therapist. The treatment clients show an increased in the proportion of segments rated as focused across sessions. In order to establish that the treatment interventions are directly associated with the shift in awareness, as indicated by a movement from Externalizing voice to Focused voice, further micro-analysis of the client process associated with these interventions would be required. Nevertheless, the clinical description of the therapist aiming to shift the client's awareness from the content of his/her verbalizations to other aspects of self appears to be supported by the voice quality data.

Another result, which points to the presence of positive therapeutic process in the treatment sessions, is that the clients exposed to the target interventions reported a greater reduction in their level of discomfort associated with the presenting problem. Thus, by the end of the series of three sessions, the treatment clients felt less bothered by the issue they had presented upon entering the project.

The remaining results of the present study could not confirm the research hypotheses. In most cases, these results showed little variability between the treatment and control clients. Thus, the treatment and control intervention, reflection, had similar influences on the client's behaviour. The variables involved were the Client Change in Awareness Measure, Depth of Experiencing Scale, and a clinical rating of the client's self awareness.

According to the Client Change In Awareness Measure, all clients, treatment and control, reported that they experienced a shift in awareness in the direction of increased self-awareness. These results indicate that there was no difference between the treatment and control conditions as would have been expected from the gestalt literature. It appears that both conditions (treatment and control) were effective, leading to reported changes in client awareness.

The Experiencing Scale data do not confirm the prediction that the treatment clients would exhibit higher levels of experiencing. In fact, the results indicate that with one therapist, the treatment and control clients demonstrated comparable levels of experiencing, and with the other therapist, the control client had somewhat higher levels of experiencing. Therefore, it appears that the target interventions are not related to client process which leads to higher levels of experiencing. High levels of experiencing (levels 5, 6 and 7) are characterized by an exploration of feelings and new awareness leading to problem solving. The ratings are based on the content of the client's verbalizations (Klein et al., 1969) and are seen as being at a global and semantic level, looking at whether or not the process is moving toward problem resolution (Greenberg and Rice, 1980). The results provide no indication that interventions which explicitly respond to the client's nonverbal expressions are associated with this type of process.

To understand why the target interventions did not lead to higher levels of experiencing in the treatment clients, the reader is referred back to Van De Riet and co-authors' (1980) description of the steps in the process of gestalt therapy. They proposed that the client's process be divided into four therapeutic steps, 1) Expression, 2) Differentiation, 3) Affirmation, and 4) Choice and

Integration. In the first chapter, it was proposed that interventions which respond to the client's nonverbal expressions fit mainly in the first two steps because they aid the client toward greater self-awareness, and help the client to differentiate and recognize alienated aspects of self. These interventions are seen as playing a lesser role in the final two steps. The degree of similarity between the last two steps and the higher levels of experiencing is particularly noteworthy. Consequently, the results of the present study may be viewed as supporting the hypothesis that the target interventions play a less important role in the final stages of therapy. The fact that the treatment clients did not show higher levels of experiencing indicates that only a small portion of their verbalizations could be rated as involving exploration of feelings and new awareness leading to problem solving.

The last variable to be considered is the clinical rating of the client's change in awareness. Again this variable failed to consistently distinguish between the treatment and control clients. Nevertheless, one treatment client (T1) was the only client to have any segments rated as high awareness, and she was also exposed to a greater number of the treatment interventions. Consequently, it seems that although the data cannot confirm the prediction that the treatment clients will exhibit higher levels of awareness, there is a suggestion that the client who was

exposed to the largest number of treatment interventions (client T1 was exposed to a total of 45 treatment interventions across the three sessions, while client T2 was exposed to a total of 24) exhibited more behaviour at the higher awareness levels. Therefore, it may be that to achieve a measurable increase in awareness, interventions which explicitly respond to the client's nonverbal expression must be employed with a high frequency per session. This hypothesis cannot be confirmed or disconfirmed based on the present data, and consequently requires further investigation.

Nonetheless, in the context of the gestalt writings which suggest that increased awareness is the aim of interventions which respond to the client's nonverbal expressions, it must be questioned why the results of the present study do not support the prediction. The answer may be that the client's outward behaviour was not an accurate indication of his/her experience in that each client did report shifts in awareness and increased self-awareness. Further, the target interventions, as part of the category of gestalt awareness experiments, have been described as learning by doing rather than talking about (Yontef, 1975). Consequently, the client's verbalizations likely do not give a complete picture of the underlying client process.

### Implications For Research

Although there has been no systematic study of gestalt-based interventions which respond to the client's nonverbal expressions, the results of the present study must be considered in the context of previous research in related areas. Of particular importance are those studies which have examined client process in relation to other gestalt-based interventions. In this context, the largest group of studies come from the work of Greenberg and his co-workers (Greenberg, 1979, 1980, 1983; Greenberg and Clarke, 1979; Greenberg and Dompierre, 1981; Greenberg and Higgins, 1980; Greenberg and Rice, 1981; Greenberg and Webster, 1982), who have focused on the gestalt two-chair technique.


Previous research, examining client process associated with the gestalt two-chair technique, has found the Experiencing Scale sensitive to changes in the client process. However, the results from the present study indicate that changes in client process associated with the use of gestalt interventions which respond to the client's nonverbal expressions were not apparent in the experiencing scale ratings. The differences in results may be related to two factors, 1) the implicit demands that each intervention makes on the client, and 2) the aim or goal of the intervention. The two-chair technique requires the client to engage in a dialogue between the parts of the split

(Greenberg, 1979), thereby giving a voice to the thoughts and feelings associated with the two sides of the split (Van De Reit et al., 1980). The goal of the two-chair technique is conflict resolution (Greenberg, 1983) and the facilitation of integration (Greenberg, 1980). On the other hand, interventions responding to the client's nonverbal expressions frequently include instructions to repeat or exaggerate the nonverbal behaviour, and generally aim to facilitate the client's learning by doing rather than talking about. The goal of these interventions is to increase the client's awareness of alienated or unrecognized aspects of self associated with the nonverbal expression. Consequently, changes in client process associated with these two different gestalt-based interventions may not be measurable on the same scale. The experiencing scale appears more compatible with the demands and goals of the two-chair technique because it relies on verbal content, and at higher levels measures client behaviour compatible with the goals of the two-chair technique.

Another difference between the research examining the two-chair technique and the present research is that the definition of the conflict split employed with the two-chair technique defines a specific issue to focus the therapy (Greenberg, 1979, 1980, 1983). Consequently, it is more likely that the client could achieve a higher degree of resolution on a more circumscribed issue, and thereby

achieve higher experiencing scale ratings. On the other hand, in the present research, although the client was asked to define an issue to be addressed in the sessions, the presenting problem remained broad. As a result, it may take more sessions for the client to achieve the degree of resolution associated with higher levels of experiencing. More research is required to investigate this possibility.

In the same vein, further research might reveal that therapists alter the style of intervention responding to the client's nonverbal expression at different stages of therapy. For example, in the early stages when the focus of therapy is on expression and differentiation (Van De Riet et al., 1980), therapists may tend to employ interventions which mirror the client's nonverbal expression, or request the client to repeat or exaggerate the behaviour. In the later stages, the therapist may employ different forms of the intervention to aid the client toward affirmation, choice and integration (Van De Riet et al., 1980). For example, he/she might ask the client to give words or further action to the nonverbal expression (Naranjo, 1980). Another possibility is that since these interventions appear to be associated more with initial therapeutic goals (expression and differentiation), therapists may employ interventions responding to the client's nonverbal expression with greater frequency in the early stages of



therapy. Again, further research is required to address these questions.

Referring back to previous research on the gestalt two-chair technique, mixed results have been found with the Client Vocal Quality scale (Greenberg, 1980, 1983; Greenberg and Rice, 1981; Greenberg and Webster, 1982). Greenberg (1980, 1983) has found that the occurrence of focused voice, (1) differentiates between the two sides of the conflict, and (2) is associated with the softening of the critic in the "other chair". However, the proportion of focused voice failed to differentiate between gestalt two-chair events and active empathy events (Greenberg and Rice, 1981). Greenberg and Rice (1981) concluded that the voice quality scale measures the more subtle moment by moment process of involvement and focus, as compared to the experiencing scale which is at a more global and semantic level, looking at whether or not the process is moving toward problem resolution. The results of the present research indicated that interventions which respond explicitly to the client's nonverbal expressions are strongly associated with more frequent instances of focused voice. A possible explanation is that focused voice, in the client, is more strongly associated with the expression and differentiation of new facets of experience by the client. Therefore, it is likely to be more frequent when new aspects of self and experiencing are beginning to unfold, such as in the earlier

stages of therapy. Again, this hypothesis requires further study to test its veracity.

The self report measures of client change, the Client Change In Awareness Measure and Target Complaint Discomfort Box Scale, have also brought mixed results in previous research on gestalt techniques (Greenberg and Clarke, 1979; Greenberg and Dompierre, 1981; Greenberg and Higgins, 1980; Greenberg and Rice, 1981; Greenberg and Webster, 1982). Some studies have found that the self report measures differentiated between treatments, while others did not. When the self report data do not differentiate between treatments, it is generally concluded that both treatments brought about the desired reported change. These measures, nevertheless, give the researcher an index of the success of the various treatment interventions from the client's perspective. In the case of the present study, the clients reported a greater decrease in discomfort with the gestalt interventions, and a comparable level of change in awareness in both the treatment and control conditions. In future studies, it might be wise to compare the treatment interventions with a less potent control intervention (that is, something other than reflection).

In terms of the clinical rating of the client's level of awareness, the measure employed was designed for the present study. Consequently, this new measure requires further validation and testing. The results of the present

study indicate that although the scale seems to be tapping some aspects of gestalt awareness, other measures of the concept may need to be added. For example, the measure is reliant on the client's verbalizations, and may be improved by greater emphasis on other components, like the congruence between the verbal and nonverbal expression. In addition, the client's level of awareness may be assessed in other ways, for example by asking the therapist to rate it. (

#### Implications For Clinical Practice

For the clinician who employs a gestalt approach to psychotherapy, the present study reveals some important aspects of interventions which respond to the client's nonverbal expressions in the context of incongruence between the client's verbal and nonverbal expressions. First, the results indicate that these interventions are most profitably employed when, new material, or previously alienated or unrecognized aspects of self, are emerging. Interventions which explicitly respond to the client's nonverbal expressions play an important role in aiding the client to express him/herself, and in separating different aspects of self. These therapeutic steps are thought to occur in the early stages of therapy (Van De Riet et al., 1980). Conversely, interventions which respond to the client's nonverbal expressions appear to play a lesser role in the later two therapeutic steps proposed by Van De Riet

and co-authors (1980), affirmation, choice and integration. Consequently, therapists ought to employ different interventions to facilitate the client's progress toward affirmation and integration.

Another pertinent result relates to the frequency with which to employ interventions which explicitly respond to the client's nonverbal expressions. It appears that the client's level of awareness within the therapeutic sessions seems to reach higher levels when the therapist employs these interventions with greater frequency..

#### Considerations Related To Research Design

The present study was designed to resemble, as closely as possible the naturalistic therapeutic situation. Important aspects of the design include, 1) the use of experienced therapists, 2) the clients presented with a personally meaningful issue, 3) experimental manipulations were kept to a minimum to preserve the naturalistic nature of the sessions (for example although the clients were aware of the camera, it was inconspicuous), 4) video recording of the sessions permit rating of more than verbal content, 5) in-depth study of the client's process including in-therapy and self report measures, and 6) the maintenance of similarity between the treatment and control conditions through instructing the therapists regarding the appropriate

context for the use of the target interventions and possible interventions in the absence of the client marker.

There are, however, some shortcomings to the method employed which have implications for the generalizability of the results. Specifically, the present study employed a small number of participants, two therapists and four clients, and studies the client's behaviour over a short-term therapeutic process (three sessions). Consequently, further study is required to determine if the results hold for a larger range of clients and therapists, and what happens in the later stages of therapy. In addition, a larger number of participants would permit further statistical analyses. In addition, future studies could include further verification of the therapist's behaviour. For example, judges or raters could verify that the therapist's behaviour outside of the actual treatment interventions was consistent with the gestalt approach, and examine more closely the content of the treatment interventions. Alternate research methods might provide interesting results and information regarding the treatment interventions. For example, if the influence of the treatment interventions were compared to a less potent control intervention. Or secondly, the data could be analyzed in a different manner to examine trends within the sessions or more immediate client consequences related to the treatment interventions.

Overall, the research design employed in the present study was selected to allow an in-depth analysis of the client process and to maintain the naturalistic nature of the data. The similarity to a genuine therapeutic situation aids in generalizing the results to clinical practice. Limitations to the generalizability of the results arise from the small number of participants employed and the time limited nature of the therapeutic sessions.

#### Summary

The results of the present study partially support the notion that Gestalt based interventions which explicitly respond to the client's nonverbal expressions (in the context of an incongruence between the client's verbalizations and nonverbal expressions) will be associated with positive therapeutic progress for the client. The clients in this study who were exposed to the target interventions exhibited more frequent instances of focused voice quality and reported a greater decrease in their discomfort in relation to the presenting problem. At the same time, there was no consistent difference between the clients in the treatment condition and the clients who were seen in the control (reflection) condition in terms of their level of experiencing, self reported change in awareness, or clinical ratings of the client's awareness. The

implications of these results in terms of gestalt theory, research, and clinical practice were discussed.

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## APPENDIX A

Newspaper Advertisement:

VOLUNTEERS needed by doctoral student for research project on psychotherapy. Must be willing to discuss personal issue on videotape. Research approved by School of Psychology. Confidentiality assured. Call Sharon 825-5376.

Advertisement in the University of Ottawa's student newspaper, the Fulcrum.

## APPENDIX B

First Telephone Contact With Potential Volunteer Clients:

I'd like to tell you a little about the study and what your commitment would be if you decide to participate. First of all, the research involves the study of what happens in psychotherapy. The study examines the relationship between certain therapist and client behaviours. Consequently, I need video recordings of therapy sessions to examine. I would like the therapy session to be as genuine as possible, therefore the volunteers will be asked to describe and discuss a genuine and meaningful personal issue. The volunteers will be asked to write a short description of their issue, to rate it, and discuss the issue on videotape with a trained psychotherapist.

Are you still interested in participating ?

As a first step, all volunteers will attend a screening session. At this session, questionnaires and rating forms will be completed. From this information, four volunteers who meet certain pre-set criteria will be selected for the study. They will then meet the therapist and schedule three one-hour long therapy sessions. However, if the volunteer is deemed unsuitable according to further pre-determined criteria at the end of the first session, they will not be seen for further sessions. An interview will be held at the

end of the sessions , to explain the study in more detail to the volunteers. Overall, participation in the study involves one screening session, three therapy sessions, one post-therapy session, and the completion of questionnaires and rating forms.

To ensure the confidentiality of the participants, a number of safeguards will be in place. The camera operator will be a senior graduate level psychology student. He/she will ensure that the questionnaires and videotapes are secured in a locked cabinet. It is likely that some portion of the interview will be transcribed. Pseudonyms will be employed in any written documents to preserve confidentiality. All data collected will only be employed for this study and direct follow-up studies conducted by the same investigators. Volunteers will sign a consent form indicating their agreement to be videotaped and for the tapes to be used for research purposes.

If you are still interested in participating in the project, I believe you will likely find it interesting. Also you might benefit from the experience of discussing a personal issue with a trained therapist and discovering what it might be like to be in psychotherapy.

Do you have any questions ?

May I have your name and phone number ?

The screening session is a group meeting and will be held on \_\_\_\_\_ at \_\_\_\_\_.

## APPENDIX C

Consent Form

I, \_\_\_\_\_, agree to participate in the psychotherapy research project being conducted by Dr. Henry Edwards and Sharon Francis Harrison of the School of Psychology at the University of Ottawa. The purpose of the research is to examine the interaction of specific therapist and client behaviours from videotapes of therapy analogue sessions.

I have seen the recruitment advertisement and been briefed about the study on the telephone. At the screening session, I understand that I will be asked to write a brief description of a personal issue and to rate my level of discomfort with the issue on a scale. These data will then be reviewed and only those individuals who meet certain pre-set criteria will continue on in the study. If I am selected out at this point, my data will be destroyed and I will receive a brief explanation of the criteria.

If I am one of the selected participants, I understand that I will be discussing a personal issue of my choice with a trained psychotherapist in three (3) one-hour sessions and that the interviews will be videotaped. I am aware that some individuals may find the sessions distressing, and that provisions have been made for follow-up assistance. I further agree to complete questionnaires and rating forms related to the sessions. I understand that I may be asked to discontinue the study after one interview due to pre-set criteria related to the research. If so, my data will be destroyed and I will receive a brief explanation of the criteria. If I continue on to complete the three sessions, I will be briefed about the study when they are completed.

I understand that the videotapes and other data will be employed for research purposes and will only be used for this project and a follow up study conducted by the same investigators, after which time the videotapes will be erased. This will not involve further participation on my part. It is estimated that the videotapes will be required for a period up to 12 - 18 months.

The camera operator(s), and research assistants will be graduate level psychology students or professionals trained in psychology and will respect the confidentiality of the information collected. The principal investigators, Dr. Henry Edwards and Sharon Francis Harrison, agree to preserve the anonymity of the participants and to preserve confidentiality in keeping with the ethical standards adopted by the Ontario Board of Examiners in Psychology.

If any questions or concerns arise, please do not hesitate to call Sharon Francis Harrison 825-5376.

\_\_\_\_\_  
(signature of participant)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(date)

## APPENDIX D

Therapist Information

General Information about the Project: Each therapist will see two clients for 3 one-hour sessions. Each client will be designated as being either in the treatment or control condition. In both the treatment and control conditions, the therapists will carry out a verbal therapy which is consistent with the gestalt approach to therapy without being technique bound. The therapists' behaviour within the sessions will be guided in general by the Gestalt approach and by the limitations of this project which requires the therapists to employ a restricted range of interventions and specific interventions in response to client markers dependent on the designation of the client as either treatment or control. With those clients designated as treatment, the therapist will employ the treatment intervention at the appropriate client marker (as described below). With the control clients, a control intervention will be employed following the client marker. In all other respects, efforts must be made to keep the sessions comparable. Consequently, the therapists must restrict their range of interventions to the list of possible interventions and maintain a style of intervention compatible with the gestalt approach (see possible interventions and gestalt guidelines below). The videotapes

will be reviewed by trained judges to ensure that the guidelines for the use of the treatment and control interventions, and the range of interventions were followed.

Prior to their first session, the volunteer participants will be seen at a screening session. At this time, they will be asked for a written description of the issue they wish to discuss in the sessions and to rate their level of discomfort. In order to help the therapist focus the sessions, they will be provided with a copy of the client's description of their issue. There will be a final debriefing session for all participants when the experimental sessions are complete.

#### General Gestalt Guidelines:

Gestalt therapy, by emphasizing the awareness continuum of oneself and the world, is a way (Tao) of living and enhancing one's experience. It is non-analytic. It attempts to integrate the fragmented, split personality through non-interpretive focusing in the here and now (taken from Yontef, 1975, p.171).

Most authors from the gestalt approach agree that there are two major principles in gestalt therapy, the here and now and the phenomenon of awareness. In terms of the here and now, the focus is on the immediate, current experience of the client (Van De Reit et al, 1980). The emphasis is placed on the content and structure of the individual's present experience (Levitsky & Perls, 1971). For example,

in practice, the client is encouraged to communicate in the present tense. Awareness is seen as the primary tool for change in gestalt therapy (Simkin, 1975). Much of the activity in gestalt therapy is experiments in directed awareness which involve developing the clients awareness of how and what he/she is doing via the re-sensitization of his/her sensory, motor, and intellectual equipment (Simkin, 1975). Experiments frequently return to the primary sensory data of experience (Yontef, 1975). According to Yontef (1975), the aim of the experiments is for the client to discover the mechanism by which he/she alienates parts of his/her self processes thus avoiding awareness of his/her self and environment. The role of the therapist is as participant-observer.

There are many other principles which guide the gestalt therapist, such as the concept of holism, organismic self regulation, and the I-Thou relationship. Many of these concepts are common to other humanistic approaches to psychotherapy and they are too numerous and complex to describe in this context. Nevertheless, they are all part of the philosophical basis of the gestalt approach.

Treatment Interventions: The target interventions include all interventions in which the therapist explicitly refers to the client's present nonverbal expressions. The form of these interventions is varied and includes simple reflection of the client's behaviour ("what" and "how" questions, and

nonverbal mirroring), invitations to the client to repeat or exaggerate the behaviour, and inviting the client to give words to the nonverbal expression. These interventions are generally non-interpretive and operate to enhance the client's sense of responsibility (Enright, 1975).

The key factor in determining the therapist's use of these interventions is an incongruence between the content or intensity of the client's verbalization and his/her nonverbal expressions (Brown, 1973; Enright, 1970, 1975; Perls, 1959; Yontef, 1975). Incongruence is considered to be the client marker necessary for the use of the treatment intervention. Frequently, the client's awareness is focused on the content of his/her verbalization. Thus the therapist asks the client to devote some attention to what he/she is doing, sensing, or feeling.

Control Interventions: The rationale for specifying control interventions is to provide the therapists with a defined alternative intervention to be employed in the control sessions. The alternative intervention is to be employed when the context is similar to the appropriate context for the target interventions, that is when there is incongruence between the client's verbalizations and his/her nonverbal expressions (either in content or intensity). It is important to provide the therapists with an alternative intervention that is appropriate within a gestalt framework. Thus, the therapist is instructed to employ reflection as

the alternate intervention with the clients in the control condition. The definition of reflection provided by Hill (1978) will be employed for this project. However, the therapist must not directly refer to the nonverbal expression of the client in the reflection.

Reflection: This is a repeating or rephrasing of the client's statement (not necessarily just the immediately preceding statements). It must contain reference to stated or implied feelings. It may be based on previous statements, nonverbal behaviour, or knowledge of the total situation. It may be phrased either tentatively or as a statement (Hill, 1978 p.467).

Other Possible Interventions: To maintain similarity between the therapeutic dyads, the therapists are further instructed to restrict their range of possible interventions. In addition to employing the experimental or control interventions at the appropriate client marker, they are provided with a list of possible interventions to be employed during the sessions. The interventions must be consistent with the gestalt approach. In addition, to keep the focus on the target interventions, the other possible interventions must be kept simple. For example, the influence of the target interventions would be less clear if the therapist performed an in depth dream analysis in one session and a two chair technique in the next. The

interventions and their definitions are taken from Hill (1978). In a study by Hill, Thames, and Rardin (1979), it was demonstrated that these interventions were employed by Perls in a therapeutic interview.

The therapists will be instructed to restrict their interventions to the following:

Minimal encourager

Approval-reassurance

Information

Direct guidance

Closed Question

Open Question

Restatement

Reflection

These interventions have been defined by Hill (1978, p.467) as follows:

**Minimal Encourager:** This consists of a short phrase that indicates simple agreement, acknowledgement, or understanding. It encourages but does not request the client to continue talking; it does not imply approval or disapproval. It may be a repetition of key word(s) and does not include responses to questions (see information).

**Approval-reassurance:** This provides emotional support, approval, or reinforcement. It may imply sympathy or tend to alleviate anxiety by minimizing client's problems.

**Information:** This supplies information in the form of data, facts, resources, theory, and the like. It may be information specifically related to the counselling process, counselor's behavior or arrangement (time, place, fee, etc.). It may answer direct questions but does not include directions for what the client should do (see direct guidance).

**Direct guidance:** This consists of directions or advice that the counselor suggests for the client, or for the client and counselor together, either within or outside the counseling session. It is not aimed at soliciting verbal material from the client (see closed or open question).

**Closed question:** This is a data-gathering inquiry that requests a one- or two-word answer, a yes or no, or a confirmation of the counselor's previous statement. The possible client responses to this type of inquiry are typically limited and specific. If statements are phrased in the form of a closed question but meet the criteria for another category, they should be put in the other category.

**Open question:** A probe requests a clarification of feelings or an exploration of the situation without purposely limiting the nature of the response to a yes or no or a one- or two-word response. If statements are phrased in the form of an open question but meet the criteria for another category, they should be put in the other category.

**Restatement:** This is a simple repeating or rephrasing of the client's statement(s) (not necessarily just the immediately preceding statements). It typically contains fewer but similar words and is more concrete and clear than the client's message. It may be phrased tentatively or as a statement.

**Reflection:** This is a repeating or rephrasing of the client's statement (not necessarily just the immediately preceding statements). It must contain reference to stated or implied feelings. It may be based on previous statements, nonverbal behaviour, or knowledge of the total situation. It may be phrased either tentatively or as a statement (Hill, 1978, p.467).

## APPENDIX E

Therapist Self Description Of Therapeutic Approach

In answering the following questions, please keep in mind the therapeutic approach you employed with the two clients you saw as part of the research project.

1. Would you classify your therapeutic approach as more (circle one)  
 Gestalt      Rogerian      4 Analytic      Behavioural  
 Other (please specify \_\_\_\_\_)?
2. If your therapeutic style is a combination of approaches, to what extent would you classify it as gestalt ?  

1	2	3	4	5
not at		some-		very
all		what		much
3. What percent of what you do would you consider as gestalt or compatible with the gestalt approach ?  
 \_\_\_\_\_ %
4. Please give a brief description of your therapeutic approach.

## APPENDIX F

Target Complaint Discomfort Box Scale

Keeping in mind the issue you selected for the focus of the sessions. In general, how much does this issue bother you ?

Please answer the question by placing an 'X' in the box that best describes the amount of disturbance you feel because of the problem.

Couldn't be worse

Very Much

Quite a bit

A little

Not at all

## APPENDIX G

Experiencing Scale

**Stage One:** The chief characteristic of this stage is that the content or manner of expression is impersonal. In some cases the content is intrinsically impersonal, being a very abstract, general, superficial, or journalistic account of events or ideas with no personal referent established. In other cases, despite the personal nature of the content, the speaker's involvement is impersonal, so that he/she reveals nothing important about him/herself, and his/her remarks could well be about a stranger or an object.

**Stage Two:** The association between the speaker and the content is explicit. Either the speaker is the central character in the narrative or his/her interest is clear. The speaker's involvement, however, does not go beyond the specific situation or content. All comments, associations, reactions, and remarks serve to get the story or idea across but do not refer to or define the speaker's feelings.

**Stage Three:** The content is a narrative or a description of the speaker in external or behavioural terms, with added comments on his/her feelings or private experiences. These remarks are limited to the events or situation described, giving the narrative a personal touch without describing the

speaker more generally. Self-descriptions restricted to a specific situation or role are also at stage three.

**Stage Four:** The content is a clear presentation of the speaker's feelings, giving his/her personal, internal perspective or feelings about him/herself. Feelings or the experience of events, rather than the events themselves, are the subject of the discourse. By attending to and presenting this experiencing, the speaker communicates what it is like to be him/her. These interior views are presented, listed or described, but are not interrelated or used as the basis for systematic self-examination or formulation.

**Stage Five:** The content is a purposeful exploration of the speaker's feelings and experiencing. There are two necessary components. First, the speaker must pose or define a problem or proposition about him/herself explicitly in terms of feelings. The problem or proposition may involve the origin, sequence, or implications of feelings or relate feelings to other private processes. Second, he/she must explore or work with the problem in a personal way. The exploration or elaboration must be clearly related to the initial proposition and must contain inner references so that it functions to expand the speaker's awareness of his/her experiencing. Both components, the problem and the elaboration, must be present.

Stage Six: The content is a synthesis of readily accessible, newly recognized, or more fully realized feelings and experiences to produce personally meaningful structures or to resolve issues. The speaker's immediate feelings are integral to his/her conclusions about his/her inner workings. He/she communicates a new or enriched self-experiencing and the experiential impact of the changes in his/her attitudes or his/her feelings about him/herself. The subject matter concerns the speaker's present and emergent experience. His/her manner may reflect changes or insights at the moment of their occurrence. These are verbally elaborated in detail. Apart from the specific content, the speaker conveys a sense of active, immediate involvement in an experientially anchored issue with evidence of its resolution or acceptance.

Stage Seven: The content reveals the speaker's expanding awareness of his/her immediately present feelings and internal processes. He/she demonstrates clearly that he/she can move from one inner reference to another, altering and modifying his/her conceptions of him/herself, his/her feelings, his/her private reactions to his/her thoughts or actions in terms of their immediately felt nuances as they occur in the present experiential moment, so that each new level of self-awareness functions as a spring board for

further exploration (taken from Klein et al., 1969, p.53-63).

## APPENDIX H

Client Vocal Quality

**Focused:** This vocal style involves a turning inward of attentional energy, deployed toward tracking inner experience and finding a way to symbolize it in words. There is a good deal of energy used in a concentrated way rather than being discharged in overflow. Little energy seems to be directed outward, toward affecting the listener. The effort to symbolize seems to be as much for oneself as for the listener. There is often a quality of groping and hesitation, but it does not seem to be the non-fluency of thought-disruption. Instead it has the pondering quality of feeling one's way through new territory, of generating new facets of experience.

**Externalizing:** The Externalizing vocal style seems to involve a deployment of attentional energy outward in an effort to produce some effect in the outside world. The regularity of the emphasis pattern, the use of pitch rise on accented syllables, and the intonational contours at the ends of clauses all suggest that the content (whether it be ideas, feelings or past experiences) is not being newly experienced and symbolized. It has a pre-monitored quality; the energy is being invested in the recounting rather than in the exploration. Although the high energy and wide pitch

range may initially give an impression of color and expressiveness, the rhythmic intonation pattern conveys a "talking at" quality.

**Limited:** The Limited voice pattern seems to involve a holding back or withdrawal of energy. The effect of thinness is much more pronounced than the inward or outward focus, although there will sometimes be a recognizable tendency one way or the other. This pattern suggests a walking-on-eggs quality, distance from what is being said, and probably from what is being experienced.

**Emotional:** The Emotional pattern was not found in sufficient quantity to permit any meaningful correlations with outcome. From the evidence available it seems probable that combining the Emotional and Focused categories improves the predictive power for client-centered therapy (taken from Rice et al., 1979, p.4-10).

## APPENDIX I

Clinical Rating of the Client's Awareness Level

By definition, gestalt awareness refers to the present experiencing of the individual. It is the spontaneous sensing by the individual of what he/she is doing, feeling, planning. Awareness is an integral element of the organism-environment transaction from which it develops. As such, it is always based on the individual's perception of the current situation in the immediate present, and includes perceptions, thoughts, and feelings which the individual senses in the immediate present. From this perspective, awareness may be summarized as the individual being conscious of that to which the organism is attending.

Behaviour indicative of "high awareness" often fits the statement "I, here and now, am aware of doing thus and so". Awareness is always in the present. For example, even while relating a story, the individual may become aware of present sensations and reactions.

Within the context of gestalt therapy, awareness is seen as developing on three levels: (1) awareness of the self or inside world which involves sensory contact with inner events in the present, (2) awareness of the outside world which involves sensory contact with objects and events in the present, and (3) awareness of the intermediate zone of thought and fantasy which includes all mental activity.

Frequently, the emphasis in therapy is on self awareness and nonintellectual awareness. Thus, the focus is on sensory data, feelings, and emotional reactions to experiences. In therapy, stress is placed on the use of external senses and the internal proprioceptive system of self awareness.

The above definition of awareness according to the gestalt approach is the context employed for the clinical ratings of the client's awareness during a therapy session. In addition, a number of client behaviours indicative of "high awareness" can be delineated from the gestalt literature. They are as follows;

(i) Use of the present tense (the client may be discussing a personally relevant situation, which although it occurred in the past, has been brought into the present).

(ii) Use of I-language (the client uses I rather than it and relates own experience rather than talking about others).

(iii) Congruence between the client's verbal and nonverbal expressions (no behaviours which are incongruent with the content or intensity of the client's verbalizations).

(iv) Concentration (the client is able to stay with his/her awareness without interruptions or splits in awareness).

(v) Attentional focus on sensory contact with

objects, events, and inner events in the present.

The clinical ratings of the client's awareness will be based on the conceptual definition and concrete behaviours described above. The actual numerical ratings will be based on a three-point rating scale on which the client's level of awareness ranges from "high awareness" to "low awareness". Examples of typical client behaviour for the three levels are given. The raters will indicate their ratings of the client's awareness by the appropriate numbers. Each rater rated two thirds of the video tapes, thereby employing the overlapping third for the calculation of inter-rater reliability. The ratings will be performed every four minutes throughout each therapy session. Four minute segments were selected to keep the ratings similar to the other clinical scales employed (ie. Depth of Experiencing). The three-point scale provides the raters with a choice of categories without requiring him/her to make minute distinctions between a large number of categories which would likely render the ratings less reliable.

The following descriptions are provided to further delineate client behaviour typical of each level.

Level 1: An individual's awareness would be rated level 1, "low awareness", when his/her focus is on the content of his/her verbalizations and he/she relates his/her story with little emotional involvement or responsiveness in the present. He/she shows little understanding or knowledge of

the nonverbal aspects of his/her self expression or his/her style of interaction. In addition, he/she may demonstrate difficulty concentrating and staying in the present. Generally, the individual is involved in a flow of fantasy-imagery and thinking which is not deeply rooted in ongoing organismic activity.

Example 1:

C: It was as if she didn't even know I was there. She didn't consider my feelings at all.

T: And how did you react? What was going on with you?

C: Well, I just ignored her. She wasn't thinking of me so why should I try?

Example 2:

C: All my family members have achieved quite a high level of success, both in university and in their careers.

T: And how about you? What are you doing?

C: I'm studying toward my degree. My grades aren't that high but I do alright.

T: Do you feel pressured coming from that family background?

C: Yeah, but if you look at it in terms of time, I have achieved as much by my age.

Level 2: An individual's awareness would be rated level 2 when he/she displays the ability to focus on his/her present

experience but is inconsistent. For example, he/she may be distracted or display incongruence between the content or intensity of his/her verbal and nonverbal expressions. Alternately, the individual might slip away from his/her present awareness of his/her self and world into fantasy or other mental activity.

Example 1:

C: I get really upset in those situations.

T: Tell me how you feel that. How are you experiencing it in your body ?

C: Well, I feel a tenseness across my shoulders and a lump in my stomach.

T: OK, just stay with that. What comes to you ?

C: (pause) Oh, it's just a physical response to the pressure.

Example 2:

C: Well, I'm all worked up.

T: Tell me what you're experiencing.

C: Ah, I'm tense and sad. And I'm feeling rejected.

T: Rejected ? Does that fit for you ? That he rejected you ?

C: I don't know. In some ways, but in others it doesn't. I was thinking about Sam and how he was last weekend ... (continues story).

**Level 3:** An individual's awareness would be rated level 3 "high awareness" when he/she is focused on the present and is consistent in his/her verbal and nonverbal expressions. He/she generally employs the present tense, relates his/her own experience, and is not troubled by difficulties in concentrating. Overall, she/he is in constant contact with his/her self and world, in the present.

Example 1:

T: What's that like for you ?

C: It makes me feel empty and ah - helpless like -

T: Like he didn't hear you?

C: Yeah. Like there's a big wall between us and I can't reach him.

Example 2:

C: I just feel really sad.

T: Can you tell me how you experience the sadness ?

C: I have a real lump in my throat and I feel I could cry.

T: What comes to you with that ?

C: (crying) A real sense of loss. That I won't see him again.