

ABSTRACT

Title of Dissertation / Thesis: **PSYCHOTHERAPY PROCESS IN THE EXPLORATION STAGE**

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The purpose of this study was to examine the counseling process within the exploration stage of Hill and O'Brien's (1999) 3-stage helping skills model. Cochran-Mantel-Haenszel chi-square analyses revealed that: (1) therapists did not use significantly different response modes in response to client narrative process modes; (2) when therapists asked an open question about feelings or reflect feelings, clients were more likely to respond with the internal narrative processing code; and (3) there were no significant associations between therapist response mode and client shift or maintenance of narrative process modes. In addition the hypotheses that (1) client helpfulness ratings can be predicted by client narrative response mode in the previous turn and therapist predominant verbal response mode in that turn, and (2) that client helpfulness ratings can be predicted by client narrative response mode in the previous turn and therapist predominant verbal response mode in that turn were not supported.

PSYCHOTHERAPY PROCESS IN THE EXPLORATION STAGE

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Table of Contents

Acknowledgements.....	ii
Table of Contents.....	iii
Chapter 1: Introduction.....	1
Chapter 2: Review of the Literature.....	5
Chapter 3: Statement of the Problem.....	48
Chapter 4: Method.....	51
Chapter 5: Analyses.....	63
Chapter 6: Discussion.....	89
Appendix A.....	98
Appendix B.....	99
Appendix C.....	100
Appendix D.....	102
Appendix E.....	103
Appendix F.....	104
Appendix G.....	105
Appendix H.....	106
Bibliography.....	107

Chapter 1: Introduction

In order to understand how best to help their clients, therapists must understand what does and does not work in therapy. When therapists are trained, they are often taught how to effectively deliver interventions, which are assumed to help the client to different extents according to differing theoretical models. Surprisingly, however, little is known about the actual differential effects of these interventions. In order for therapists to be trained effectively in the delivery and implementation of these interventions it is important for educators and trainees to understand the differential effects of interventions on their clients' experience of the therapy hour.

In the past, counseling process has been examined using a variety of methods, many of which have had limited success. Most early process studies obtained measures of naturally occurring variation in counseling process and outcome and then assessed the intercorrelation of the components. These studies assumed that if a process component is indeed an active ingredient, then clients who receive more of it should have better outcomes, and that measures of the process variable should be positively correlated with measures of outcome across clients.

Studies attempting to correlate frequency or proportion of counselor response with session or treatment outcome have been criticized because they do not take into account the timing, appropriateness, or context of the process variable (DeStefano, Bernardelli, Stalikas, & Iwakabe, 2001; Gottman & Markham, 1978; Hill, 1982; Hill, Helms, Tichenor et al., 1988; Russell & Trull, 1986; Stiles, 1988; Stiles & Shapiro, 1994b). In fact, Stiles and Shapiro (1994a) have said: "in suggesting that the strength

(percentage, frequency, intensity) of active process ingredients should predict which clients improve, the logic makes the absurd assumption that process components are delivered randomly with respect to client requirements” (Stiles & Shapiro, 1994a). In reality, therapists are trained to adapt the timing, intensity, directiveness, and strength of their interventions to their particular client’s needs at particular moments in the course of therapy.

A suggested alternative way of looking at therapy process is in terms of responsiveness (Hardy, Stiles, Barkham, & Startup, 1998; Hayes, Castonguay, & Goldfried, 1996; Jones, 1997; Marmar, 1990; Martin, Martin, & Slemon, 1989; Merbaum & Southwell, 1965; Russell & Trull, 1986; Schneider & Martin, 1992; Sechrest, 1994; Silberschatz, 1994; Silberschatz & Curtis, 1993; Stiles, Honos-Webb, & Surko, 1998; Stiles & Shapiro, 1989, 1994b). Responsiveness implies that the moment-by-moment outcome of a particular therapist intervention feeds back into the process and influences the type, intensity, and quality of the following intervention. It suggests that process components are actually contingent upon the actual or anticipated cues from the client.

The responsiveness paradigm is more useful in determining exactly what works in therapy and involves (a) identifying the critical incidents in therapy, (b) coding the therapist’s response, and (c) measuring the impact of the response (Stiles & Shapiro, 1994a). When therapists are trained, they learn not only specific interventions, but when, how, and with what intensity to use the interventions. Therapists’ responses are not selected at random throughout a therapy session, but rather they are deliberate products of the therapist’s responsiveness to his or her

client's needs at any given time. This new line of process research rests on the assumption that the moment-by-moment outcome of a particular therapist intervention feeds back into the process and influences the type, intensity, and quality of the following intervention. It suggests that process components are contingent upon the actual or anticipated cues from the client.

A number of studies have been conducted using this paradigm, including Hill, Helms, Tichenor, et al. (1988) who found that therapist intentions and previous client experiencing each accounted for more of the unique variance in session outcome than did the therapist's response mode. When clients were at low levels of experiencing, the most helpful interventions were ones in which therapists helped clients explore feelings and behaviors through paraphrase, interpretation, and confrontation. When clients were at a moderate level of experiencing all therapist interventions were perceived as equally helpful. In other words, the type of therapist intervention made a difference when clients were not very involved in therapy but did not matter as much when clients were involved in the task of therapy.

Wiser & Goldfried (1998) conducted a study in which clients' experiencing levels were observed both preceding and following a particular therapist intervention. They found that when clients received reflections and acknowledgments, affiliative or noncontrolling interventions, or interventions that highlighted nonspecific content they maintained their high levels of experiencing. However when clients received lengthier interventions and interventions that were affiliative but moderately controlling, they shifted to lower levels of experiencing. Thus, they found that different interventions helped shift or maintain clients' levels of experiencing.

Neither of these studies, however, differentiated processes in different stages of therapy. In their Helping Skills model, Hill and O'Brien (1999) theorized that successful therapy involves each of three stages: exploration, insight, and action. Because each of the stages of the Helping Skills model have different goals, various interventions should be differentially helpful in each stage. Hence, restricting investigation of counseling process to a particular stage, more specifically the exploration stage since it has received such limited empirical support, will be the focus of this study. Since the major goal of the exploration stage is exploring thoughts and feelings, the therapist response modes that will be focused on will be restatement, reflection of feelings, and open questions (open questions directed toward thoughts, open questions directed towards feelings, and open questions directed towards clarification).

Chapter 2: Review of the Literature

In this chapter, several literature areas will be explored that set the stage for the proposed study. First, I provide an overview of the exploration stage of Hill and O'Brien's (1999) Helping Skills model and the theoretical bases for the skills it emphasizes. Second, I provide a review of a number of empirical studies using experimental and naturalistic designs. Third, I review some of the criticisms of traditional process-outcome research. Finally, I provide an overview of the Narrative Processing Coding System (NPCC) and a review of the literature on the NPCC.

Overview of the Exploration Stage

Hill and O'Brien's (1999) exploration stage provides the foundation for the helping process. In the Exploration stage, therapists help clients explore their thoughts, feelings, and actions primarily through the use of restatements, reflection of feelings, and open questions. The goals for the exploration stage include establishing rapport and developing a therapeutic relationship, helping clients tell their stories, facilitating emotional arousal, and helping clients explore their cognitive and affective processes. In this stage, the therapist learns about his/her client and follows the client's lead in exploring concerns.

The theoretical foundation for the exploration stage is drawn primarily from Rogers' client-centered theory of personality development and change (see Rogers, 1942, 1951, 1957, 1959, 1967, 1980; Roders & Dymond, 1954). Rogers emphasized the client's thoughts, feelings, and subjective experiences and believed that there was variation in people's perceptions of the external world and that people's subjective

experiences guided their behavior. Consequently, the only way that therapists could understand their clients was to enter their subjective reality and journey with them towards self-actualization, which according to Rogers (1942, 1951, 1967) was the only basic motivational force. Rogers believed in the natural healing power of the organism and saw psychotherapy as a process of removing the constraints that grow out of people's tendency to place unrealistic demands on themselves as a condition of self-worth. The primary objective of Rogerian therapy is to help clients come to accept themselves, which therapists do through creating a therapeutic setting in which clients can feel unconditionally accepted and valued. In client-centered therapy, it is not the therapists' job to direct the course of therapy, but rather the therapist simply listens acceptingly to what the client wants to talk about. The therapist tries to maintain an empathic stance by listening attentively and interrupting only to restate and reflect what the client is saying to help the client clarify and acknowledge the thoughts and ideas that he or she is exploring.

The assumption is that exploration is needed as a foundation for the next two stages, which are insight and action. The client and therapist need to thoroughly explore the client's problem and situation before they can move on to the insight stage, in which the client and therapist seek to come to some sort of understanding of different dimensions of the client's problem. When adequate understanding and insight have been accomplished, the therapist and client will then move onto the action stage, when the client will generate an action plan incorporating knowledge and skills gained in the exploration and insight stage. The exploration stage serves as a vital first step for any kind of change to occur in therapy.

Description of Skills

Reflection of feelings. When therapists repeat or paraphrase the client's statement emphasizing the client's feelings, it is called a reflection of feelings. For example, a therapist may respond to a client's disengagement by saying, "you feel apathetic." The therapist's intention for a reflection of feelings is typically to help his or her client identify exactly what he or she is feeling and to express and explore the feeling extensively. The ideal reflection of feeling is short and concise, paraphrasing the clients' statement and emphasizing the emotion expressed.

Rogers (1942, 1951, 1954, 1980) noted that emotions are a key part of our experience. He believed that as we grow up, we learn to deny our feelings and come to believe that they are unacceptable. By providing reflection of feelings, therapists can provide support for their client's emotional experiencing and normalize the feelings that the client believes are unacceptable. Through providing this safe holding environment and encouraging the client to get in touch with his or her emotions, the therapist can later help the client decide what to do about the feelings.

Restatement. When a therapist repeats or paraphrases the context or the meaning of what the client has said, it is called a restatement. A restatement reflects the client's previous statement, but does so in a more concise and clear manner. They typically guide the client's thought process and encourage the client to further explore his or her thoughts. The typical intentions of a restatement are to help clients explore their concerns deeply, focus clients, help clarify, support clients, and encourage catharsis. An example of a restatement is "your mother doesn't acknowledge your

successes.” The ideal restatement is short and concise and emphasizes an important component of the client’s statement.

Rogers (1942) believed that therapists should mirror what the client is saying without judgment to give clients the opportunity to explore their thoughts and feelings. Often, when the therapist restates what the client says in slightly different words, the client can listen to the restatement and re-evaluate whether that is what the client truly thinks.

Open questions. When therapists ask their clients questions that do not require a simple yes or no answer, they are asking open questions. Therapists may use this technique in order to encourage his or her client to explore his or her thoughts and feelings, or to clarify a piece of information previously disclosed. Therapists may ask several types of open questions. We are most interested in open questions directed at thoughts, open questions directed at feelings, and open questions for clarification.

When a therapist asks an open question to explore what the client is feeling, it is termed open questions-feelings. An example of an open question directed at feelings could be: “How do you feel about your boyfriend’s statement?”

When a therapist asks an open question to explore what or how the client is thinking, it is termed open question-thoughts. An example of this kind of open question might be “Why do you think you get so angry when you talk to your sister?”

Open questions for clarification are intended to gather information so that the therapist can better understand the client. An example of an open question for clarification might be “Could you explain that to me a bit more?”

Empirical Research on Exploration Skills

Over the past 30 years, much research has been conducted to test the effectiveness of the different exploration skills using many different designs. In this section, I will briefly review the key studies in the field in which the client and therapist met face to face. First, I review experimental studies in which one or more variables have been manipulated. Second, I review naturalistic studies that examine the relationship of verbal response modes to session outcome. Finally, I will review naturalistic studies that examine the relationship of verbal response modes to immediate outcome. Within each of these sections, studies will be reviewed in chronological order.

Experimental Studies

Auserwald (1974) used an experimental design to compare the effects of interpretation (i.e., goal is to enable insight and expand self-knowledge) and restatement (i.e., paraphrase of the content of the client's statement) on client expression of self-referenced affect. She hypothesized that interpretation is a more effective tool for the client production of affective responses than restatement when measured by the proportion of affective client responses. Forty female participants were assigned randomly to counselors who conducted interviews using either restatements or interpretations. Interviews consisted of three time periods—baseline (8 minutes), conditioning (10 minutes), and extinction (8 minutes). During the baseline and extinction periods, the therapists responded to the client with minimal encouragers (ex. *mmhmm, uh-huh*). During the conditioning period, the counselor was cued on a variable-interval reinforcement to the verbal response mode

(restatement or interpretation) that had been assigned to the participant Client statements were then judged as containing self-referenced affect or non self-referenced affect.

Results suggested that interpretations significantly increased client production of self-referenced affect, whereas restatement significantly decreased self-referent affect. That is, clients talked about feelings in relation to self more when they were given interpretations than restatements. Auserwald (1974) suggested that these results are perhaps explained by the fact that restatement narrows clients' awareness and offers no new data, whereas interpretations add new data to the clients' awareness and expands his or her view.

One of the problems with this study was its design. Conditioning (counselors providing interpretations or restatement) occurred during time two, after only 8 minutes of baseline during which the therapist responded to the client with minimal encouragers. In a 30 minute session, the first few minutes often involves important exploration and can increase the depth of future exploration. According to the 3-stage Helping Skills model (Hill & O'Brien, 1999), a counseling session should begin with exploration so that both the client and the therapist gain understanding about the problem. Following the exploration stage, insight can be gained into the precipitants of the problem. It is possible that by the time that the counselors arrived at the conditioning time period in this study the insight stage was underway and thus exploration was no longer the goal.

Another problem with this study involves the way in which the therapist response modes were administered (on a fixed interval schedule). The results of this study have

limited external validity because of the contrived experimental environment. In real counseling, therapists are not constrained by experimental conditions and can choose when to provide a response based on numerous cues that they receive from the client.

Barnabei (1974) also examined the effects of counselor response modes on client verbal behavior. In his study, each of 20 participants was randomly assigned to one of 4 counselors for 42-min sessions. The first 2 minutes of the sessions was an orientation period, and the final 40 minutes were divided into four 10-minute segments during which one of the four stimulus conditions was administered in random order. The four stimulus conditions were reflection of feeling (defined as a restatement of what the client was saying in the counselors own words highlighting the feeling), probe (defined as an open question), confrontation (defined as a response indicating some sort of discrepancy in the client's message), and unspecified responses (the experimenter used any verbal response). During each treatment period the therapist was restricted to the use of the particular response mode associated with the condition. The three dependent variables were client affect words (defined as any word that implies affect), client self-referent pronouns (ex. *I, me, our*), and client use of a present verb state.

Results indicated no significant differences between the three response modes investigated (reflection of feelings, probe, and confrontation) in terms of client affect words, self-referenced pronouns, and time orientation. In sum, the results suggest no differential effects between the response modes in a single session of counseling. However, it is important to note that there was little flexibility for therapists to respond to their clients in the most appropriate ways. Counselors were required to

use a specific response mode, regardless of whether or not it was appropriate for the client at the particular time. The therapists' responses were given in a non-contingent (non-responsive) manner, and the results indicate that the indiscriminate use of counselor interventions does not have a reinforcing effect on client behavior.

However, in their training therapists are taught to use appropriate responses and are usually given a choice as to which response to use. Thus, the results of this study that response modes do not have a differential effect on client affect, self-referenced, and present-oriented words is not surprising given the fact that the response modes were non-responsive and were likely often inappropriately administered.

Highlen and Baccus (1977) conducted a study similar to Auserwald's (1974) and examined probes into feelings (open-ended question that required more than a one-word answer, asking client to state feelings) and reflection of feelings (defined as a reformulation of client's affective verbal message). Forty female volunteer participants were randomly assigned to one of four treatment-experimenter groups (combinations of two experimenters and two treatments). Participants were instructed to talk about anything they wished during a 30 minute counseling interview and were responsible to initiate and continue conversation. The two female experimenters were experienced counseling psychology graduate students and completed a 6-hour training program. Each interview consisted of a warm-up, an experimental interview, and a postexperimental inquiry. The experimental interview was subdivided into three time periods: a baseline (8 minutes), conditioning (10 minutes), and extinction (8 minutes). During the baseline and conditioning periods, the experimenter responded minimally to the participant (ex. *Hmm, uh-uh*). During the conditioning

period, each participant was exposed to either reflection of feelings or probes. The interviews were transcribed and client speech was rated for self-referenced affect. A unit was rated self-reference affect if (a) a self-referent pronoun was used (ex. *me, mine, I*); (b) an affect word was included (ex. *love, fear, hate*); (c) the present tense of a verb was used.

No differences were found between the effect of reflections and probes on client discussion of feelings, suggesting that both were equally helpful in eliciting production of self-referenced affect. In addition, no differences were found between reflections and probes on the client's perception of the counseling climate, counselor comfort, or client satisfaction.

One of the problems with this study lies in its definition of probes and reflections of feelings. Like most other studies of therapist response modes, Highlen and Baccus (1977) did not differentiate between types of open questions and only studies open questions about feelings. Because different open questions have different intentions and foci, one might expect that different types of open questions have a differential affect on client response. Highlen and Baccus (1977) also defined reflection of feelings more narrowly than the Hill and O'Brien (1999) definition. Highlen and Baccus defined reflection of feelings as "a reformulation of the client's affective verbal message by the counselor" (p. 440). Hill and O'Brien however, do not limit the reflection of feeling to the client's expressed verbal message. That is, a reflection of feeling can be a reformulation of the client's affective verbal *or nonverbal* message.

In addition, as with the previous two studies, the contrived nature of the verbal responses is a weakness of this study. Because therapists were instructed to use a particular response mode at a particular time, regardless of the client's needs and cues, they could not utilize their clinical judgment as they would in a more naturalistic setting. The authors sought to establish a relationship between counselor verbal response mode and subsequent client self-referenced affect, but failed to take into account the relationship between client preceding behavior and counselor subsequent verbal response mode.

Hill and Gormally (1977) compared open questions about feelings, restatements, and reflections of feelings in a single session in an experimental study. The study followed an ABAB design in the format of baseline (6 minutes; minimal verbal stimuli and no non-verbal behavior), counseling intervention (9 minutes; manipulation of verbal and non-verbal stimuli), return to baseline (6 minutes), and return to counseling intervention (9 minutes). Forty eight subjects between the ages of 18 and 25 from undergraduate psychology classes volunteered to talk with one of two counseling psychologists. During the counseling intervention, the counselor was cued by a light that the counseling period had begun. For each verbal response, the counselor was cued by a light indicating which intervention to use (reflection, restatement, probe) on a variable-interval schedule of one response per minute, with a 30-second mean interval. A reflection was defined as a statement consisting of a feeling word and a subordinate clause beginning with "because" (i.e. "*You feel frustrated because your boyfriend doesn't listen to you*"). A restatement was defined as a statement that restates the content of the client's narrative without using a feeling

word (i.e. “*Your mother belittles you in front of your friends*”) A probe was defined as a statement that begins with “How” or “What” and contained a subject, verb, and subordinate clause that begins with “about” (i.e. “*How do you feel about your brother leaving home?*”) and was not necessarily directed at the clients’ feelings. The dependent variable was the proportion of client response units that contained affective self-referents (a response that begins with “I” or “We” and is followed by a feeling word). The 48 interviews were audiotaped, transcribed, and categorized into response units and the data was analyzed for affective self-referents.

Results suggested that probes, as opposed to restatements or reflections of feelings, led to clients talking more about their feelings, as assessed by independent raters for affective self-referents. In other words, clients talked about their feelings when they were directly asked to talk about them. The increase in the client discussion of feelings following probes about feelings seemed to be a reliable phenomenon because the increase occurred after both baselines. Hill and Gormally (1977) suggested that one reason probes resulted in a greater percentage of affect production than reflection of feelings or restatement may be that open questions contain a demand for a response. They found that clients usually did not even acknowledge the counselor’s reflections or restatements, whereas many clients responded to the probes.

The authors acknowledged that the results indicating that probes produced more self-referenced affect statements may be misleading. Greater affect discussion was not necessarily due to a greater reinforcing power of probes, because counselor responses were not contingent upon cues from the clients but were rather

administered at pre-determined intervals. The authors suggested that probes may have served the purpose of teaching the client how to behave in a counseling situation by subliminally instructing the client to focus on their feelings.

In addition, this study did not differentiate between different types of probes. Open questions can be about feelings, thoughts, or for clarification, and these were not differentiated in the design or analyses. It may be that one particular type of probe elicited more affective self-references than other types of probes.

An examination of experimental process studies reveals contradictory findings. Highlen and Baccus (1977) found no difference between the effect of reflections and probes on client discussion of feelings, suggesting that both were equally helpful in eliciting production of self-referenced affect. Barnabei (1974) also found no significant differences between reflection of feelings, probe, and confrontation in terms of client affect words, self-referenced pronouns, and time orientation. However, Hill and Gormally (1977) found that probes, as opposed to restatements or reflections of feelings, led to clients talking more about their feelings. In addition, Auserwald (1974) found that clients talked about feelings in relation to self more when they were given interpretations than restatements.

Naturalistic studies of response modes in relation to session outcome yield diffuse results. Hill et al. (1983) found that description was most likely to occur after closed questions and least likely to occur after direct guidance and interpretations, and experiencing was most likely to occur after silence and least likely to occur after closed questions. O'Farrell, Hill, and Patton (1986) found that client description occurred least often after interpretation, and client experiencing and exploration of the

relationship were more likely to occur after counselor interpretation. Hill and colleagues (1988) found that probes, as opposed to restatements or reflections of feelings, led to clients talking more about their feelings, and that clients usually did not even acknowledge the counselor's reflections or restatements, whereas many clients responded to the probes.

Naturalistic Studies of Response Modes in Relation to Session Outcome

Hill et al. (1983) conducted a case study of time limited counseling with a single client. The client was a 20-year old female student whose presenting problems included difficulties with her boyfriend and family, anxiety, and headaches. The counselor was an experienced female psychologist whose style was interpretive, confrontational, and experiential. The client and therapist participated in 12 sessions and the therapist conducted a follow-up after 3 months and after 7 months. The aims of this study were to describe the process and outcome of treatment and to explore the mechanisms of change within the counseling process. The researchers used several methods including a comparison of the best versus the worst sessions and analyses of the positive and negative events within the sessions from the perspectives of both participants. They also conducted a sequential analysis to determine how change occurred.

Analyses of client behaviors in the best versus the worst sessions suggested that the worst sessions had fewer simple responses, less experiencing, less silence, less client anxiety, and more description and activity. In the best sessions, the client decreased description of problem and activity level and increased experiencing, insight, and silence. For counselor behavior, the worst sessions included more

minimal encouragers and closed questions but fewer silences and interpretations. The counselor also was more anxious and less active in the worst sessions. Best sessions included more interpretations by the counselor. When asked after the sessions about positive and negative results, both the client and the counselor noted the effectiveness of pointing out feelings that the client had not acknowledged previously. Negative events for the client included not getting the immediate answers that she desired and not knowing how to cope with the “abrupt” end of treatment. The counselor mentioned that the only negative event was the awareness of the observers and the mechanical difficulties with the recording equipment. The sequential analysis revealed that description was most likely to occur after closed questions and least likely to occur after direct guidance and interpretations. Experiencing was most likely to occur after silence and least likely to occur after closed questions. Insight occurred rarely, but immediately after silence or two units after open questions or confrontation.

One weakness of this study was that it was a case study and only included one counselor and one client. Because of its design, the study fails to study between-subject variance. Every client and every therapist are different, and the results of this study can not be generalized beyond this particular therapy dyad. In addition, the impact of the observation and recording undoubtedly influenced the therapy process, hindering generalization to other counseling settings.

O’Farrell, Hill, and Patton (1986) also used a case study methodology to investigate the process and outcome of another therapy dyad and to compare results to the Hill, et al. (1983) study (Case 1; see above). The client in this case (Case 2)

was also a 20-year old female student. Her presenting concerns included low self-concept, depression, and lack of control over eating. The counselor was an experienced female who used a relationship- and insight-oriented approach that combined client-centered and psychodynamic principles. The treatment was generally insight-oriented within a supportive relationship that focused on the present. A number of outcome and process measures were used to compare the results of this and the Hill et al. (1983) study, and a sequential analysis was also conducted.

Results indicated that while the client in Case 1 demonstrated improvement in outcome between pretest and posttest, the client in this study experienced mixed results that suggested some improvement. In Case 2, both the client and the therapist indicated that the helpful events included exploration of particularly negative or painful feelings, identifying self-critical behavior, interpretations, identification of inappropriate behavior patterns, reinforcement of behavioral changes, goal setting, and the use of analogies. The counselor indicated that the discussion of the relationship and of termination issues were also helpful events. The client indicated that the struggle to form the relationship and a particular interpretation were negative, while the therapist indicated that negative events included occasional confusion about the impact of her interventions, research arrangements, time management issues, and being too active. The most consistent positive event that was listed by both the client and the therapist was the exploration of feelings. The results of the sequential analysis in this study were similar to those in Case 1, thus the results of the two studies were combined. Results suggested that client requests were most likely to occur after counselor information and were less likely to occur after interpretation.

Client description occurred least often after interpretation, and client experiencing and exploration of the relationship were more likely to occur after counselor interpretation.

One weakness of this study, as was a weakness of the Hill et al. (1983) study, was its design as a case study which limits generalization to other cases. Another weakness is that the purpose of the study was to compare two cases, although in Case 1 the client received 12 sessions and in Case 1 the client received 20 sessions. The results from the second case suggest that the client benefited from the additional session, and so it is difficult to compare outcome for the two cases because of the differing treatment length.

Hill and colleagues (1988) studied the effects of various therapist response modes on treatment. Eight therapists completed 8-20 sessions with eight clients who had elevated scores on the Depression and Psychasthenia scales of the MMPI and met diagnostic criteria for either dysthymia, cyclothymia, or generalized anxiety disorder. They studied nine therapist verbal response modes (approval, information, direct guidance, closed question, open question, paraphrase, interpretation, confrontation, and self-disclosure) in relation to immediate outcome (therapist and client helpfulness ratings, client experiencing, client reactions), session outcome (therapist- and client-rated depth and smoothness), and treatment outcome (changes in symptomatology and self-concept). In this section, we will review the results related to session and treatment outcome only. The results related to immediate outcome will be reviewed in a later section.

Of the nine response modes studied, information and paraphrase were used most frequently, and self-disclosures were used least frequently. Of the exploration skills (open question, closed question, paraphrase), paraphrase was used the most often and was rated as more helpful by both therapists and clients (immediate outcome).

The measures of session outcome in this study were the Smoothness and Depth Scales of the Session Evaluation Questionnaire (SEQ; Stiles & Snow, 1984), which both therapists and clients completed. Hill et al (1988) found that information was negatively related to client-rated depth, whereas interpretation was positively related to client-rated depth. Thus, cases in which therapists used more interpretation and less information were associated with clients' higher ratings of session depth. Open questions were significantly negatively related to client-rated smoothness. That is, cases in which therapists used more open questions were viewed by clients as rougher sessions.

Confrontation was significantly negatively correlated to therapist-rated depth and smoothness, whereas information and direct guidance were significantly positively correlated to therapist-rated depth and smoothness. That is, cases in which therapists offered more information and direct guidance and less confrontation were associated with higher therapist-ratings of depth and smoothness

Client's treatment outcome was measured on the Anxiety and Depression scales of the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, Rickels, & Rock, 1976) and the Tennessee Self Concept Scale (TSCS; Fitts, 1965), each which were completed before and after treatment. Hill et al. (1988) found that therapists used more closed question and confrontation with depressed clients, and used less

paraphrase with clients who were more anxious. They also found that open question and paraphrase were significantly positively related to changes on the Anxiety subscale of the SCL-90-R. Approval was significantly negatively related whereas paraphrase was significantly positively related to positive change on the TSCS. These results suggest that cases in which therapists used more open question and paraphrase had more decreases in anxiety. Cases with more paraphrase but less approval and closed question had more increases in self-concept. Table 1 summarizes the session and treatment outcome results. The next section contains a critique of this study.

Results from naturalistic studies of response modes in relation to session outcome are difficult to summarize concisely. Hill et al. (1983) found that in the worst sessions, there were fewer simple responses, less client experiencing, less silence, less client anxiety, and more description and activity. In the best sessions there was less description and activity, increased experiencing, insight, and silence. O'Farrell, Hill, and Patton (1986) found that the most consistent positive event that was listed by both the client and the therapist was the exploration of feelings. Hill and colleagues (1988) found that cases in which therapists offered more information and direct guidance and less confrontation were associated with higher therapist-ratings of depth and smoothness. In addition, they found that therapists used more closed question and confrontation with depressed clients, and used less paraphrase with clients who were more anxious.

Naturalistic Studies and Immediate Outcome

Elliott, Barker, Caskey, and Pistrang (1982) conducted a study in which an analogue sample and an actual counseling sample were compared. The 28 clients in the analogue sample were undergraduate students from the psychology research subject pool and the 15 counselors were advanced graduate students and faculty members. Clients in the analogue sample discussed actual personal problems and were later referred to campus counseling facilities. The sixteen client-counselor dyads in the actual counseling sample were recruited from ongoing counseling relationships in a variety of outpatient settings. Counselors had between 6 and 35 years of experience and client-counseling dyads were evenly balanced between early or later sessions in counseling. Data from the analogue sample came from 4-minute videotape segments from the beginning, middle, and end of the 30-minute sessions. Data from the actual counseling sessions came from three 5-10 minute audiotape segments automatically recorded beginning at 5, 25, and 40 minutes into the session. Clients in both samples rated the helpfulness of the interventions and counselors in the counseling condition rated the helpfulness of the intervention. The verbal response modes were coded using a framework proposed by Goodman and Dooley (1976).

In the actual counseling sample, interpretations received the highest helpfulness ratings from both client and counselor, advisements were more helpful than non-advisements, and questions were more helpful than non-questions. However, questions were significantly negatively correlated with client helpfulness ratings in the analogue study, but not in the actual counseling study. Reflections were not significantly related to helpfulness in either study. Client-perceived reassurance was

correlated significantly with helpfulness as perceived by clients in both samples. In sum, the results suggested that interpretations were the most helpful type of counselor interventions, advisements were the second most helpful, and questions were the least helpful.

In this study, counselor response modes account for only a small proportion of the variance in helpfulness ratings, probably because contextual variables such as timing of counselor response, counselor skill with particular modes, and client preferences were not taken into account. In their discussion, Elliott et al.'s (1982) initial qualitative analyses reported that, for each response mode, significantly helpful and significantly unhelpful examples can be found. The overall effect is that the helpfulness ratings cancel each other out.

Hill et al. (1988; reviewed in previous section) also studied the relationship of therapist verbal response modes and immediate outcome. The helpfulness of the response modes were rated by both the therapists and the clients in a videotape review immediately following each session on the Helpfulness Scale (Elliott et al., 1982), in which the rater indicates the helpfulness of the therapist's intervention on a scale from 1 (extremely hindering) to 9 (extremely helpful). A multivariate analysis of variance (MANOVA) with one main effect (response modes) indicated that response modes were significantly related to the three immediate outcome measures (therapist helpfulness, client helpfulness, and client reaction). The amount of unique variance accounted for was only about 1%. Therapists rated interpretations the most helpful and self-disclosures the least helpful. Clients, on the other hand, rated self-disclosures as the most helpful and closed questions the least helpful. When

Table 1. Correlations Between Proportions of Response Modes and Client Pretreatment Symptomology, Session Outcome, and Treatment Outcome.

Measure	Response mode								
	App	Info	DirG	CIQ	OpQ	Par	Int	Con	Dis
Pretreatment									
Anxiety	.19	.11	.18	.48	-.35	-.63*	.07	.28	.41
Depression	.08	-.28	-.30	.81***	.12	-.54	.09	.73**	-.03
TSCS	.58	.12	-.30	.19	-.49	.18	-.32	-.42	.49
Session outcome									
Therapist depth	.12	.42	.59	-.16	-.18	.11	-.57	-.64*	-.31
Therapist smoothness	.28	.62*	.62*	-.36	-.51	.08	-.49	-.8**	.02
Client depth	-.02	-.7**	-.54	.39	.16	.26	.68*	.05	-.14
Client smoothness	.28	.41	.21	.13	-.66*	-.58	.14	.10	.49
Treatment outcome									
Anxiety	-.44	-.38	-.49	-.54	.65*	.64*	.17	.18	-.16
Depression	.04	-.48	-.54	.29	.15	.04	.38	.31	.31
TCSC	-.66*	-.52	-.26	-.63*	.54	.83***	.55	-.20	-.17

Note. *N* = 8 cases. App = approval, Info = information, DrG = direct guidance, CIQ = closed question, OpQ = open question, Par = paraphrase, Int = interpretation, Con =

confrontation, Dis = self-disclosure. Anxiety and Depression are subscales of the Symptom Checklist; TSCS = the total score from the Tennessee Self Concept Scale. Session outcome was determined by the Session Evaluation Questionnaire; treatment outcome was determined by squared difference scores between pre- and posttesting.

* $p < .10$. ** $p < .05$. *** $p < .01$.

comparing client and therapist helpfulness ratings, clients gave higher ratings for approval, information, closed question, paraphrase, interpretation, and self-disclosure than therapists did, but therapists gave higher helpfulness ratings for direct guidance and open question than clients. Thus, clients and therapists perceived therapist interventions differently. The proportion and therapist and client-rated helpfulness are summarized in Table 2.

Another important finding in the Hill et al. (1988) study was that the effectiveness of the therapist intervention depended more on the client's previous experiencing level than on any of the other process variables. When clients were at lower levels of experiencing, therapists offered more information and fewer interventions aimed at feelings and clients rated the interventions in which the therapist helped the clients explore their thoughts and behaviors as the most helpful. When clients were at high levels of experiencing, they generally rated all therapist interventions as helpful. Therapist intentions and previous client experiencing each accounted for more of the unique variance than did therapist response modes, as did an interaction between previous client experiencing and therapist intentions. Based on these results, the authors concluded that the context in which the therapist intervention is delivered is very important in determining the outcome of the intervention.

One of the problems in this study has to do with the specificity of the definitions of the response modes studied. In this study, the paraphrase category included both restatements and reflections of feelings. Thus, the study could not distinguish the helpfulness of restatements and reflections of feelings, nor could it reveal if restatements and reflection of feelings were differentially helpful at different levels of

Table 2: Therapist and Client Helpfulness Ratings for Therapist Response Modes

Response modes	N	Proportion	Therapist helpfulness		Client helpfulness	
			M	SD	M	SD
Approval	1041	.06	6.25	1.20 _d	6.67	1.42 _b
Information	3929	.24	6.29	1.30 _{cd}	6.46	1.45 _c
Direct guidance	769	.05	6.42	1.26 _b	6.28	1.54 _d
Closed question	3029	.19	6.13	1.14 _e	6.24	1.41 _d
Open question	2160	.13	6.42	1.16 _b	6.33	1.50 _d
Paraphrase	3316	.20	6.46	1.23 _b	6.71	1.50 _b
Interpretation	1192	.08	6.57	1.21 _a	6.77	1.65 _b
Confrontation	759	.05	6.38	1.18 _{bc}	6.49	1.54 _c
Self-disclosure	124	.01	5.73	.97 _f	7.13	1.36 _a
Total	16319		6.34	1.20	6.49	1.47

Note: Duplicate response modes in the same turn were eliminated. Within each dependent measure (client or therapist helpfulness ratings), response modes that share the same subscript letter (a-f) were not significantly different; a = highest ratings; f = lowest ratings.

experiencing. One might suspect that reflections of feelings would be more helpful to clients at high levels of experiencing whereas clients at low levels of experiencing might respond better to restatements, given that experiencing relates to affect.

In addition, one might expect that interventions have different effects depending on which stage of the Hill and O'Brien (1999) Helping Skills Model in which they are used. The stages of the Helping Skills model each have different goals, and thus it could be important to focus on the effects of interventions (particularly restatements, reflections, open questions, and closed questions) exclusively within the exploration stage.

Shapiro, Barkham, and Irving (1984) posited that an important response mode had been omitted from most response system. Hence, they added exploration, which falls between Reflection (client's frame of reference) and Interpretation (therapist's frame of reference) and involves shared frame of reference characterized by negotiation between client and counselor. Thus, they conducted a study with the purpose of examining the hypothesis that exploration responses are more strongly associated than are interpretations or reflections with client-recalled empathy within established, ongoing counseling relationships. They collected data from 12 initial and 12 ongoing counselor-client dyads. Each of six counselors saw two clients in an initial group and two clients in an ongoing group. Recall sessions were held within 2 days for clients and 5 days for counselor of when the session occurred. The client had a keyboard with two switches marked – and + and were instructed to press + when counselors understanding their problems well, and – when they felt misunderstood. Therapists pressed + when they felt they were successfully

communicating their understanding of the client in an empathic fashion and - when they had the feeling they misunderstood the client's message. Response modes were coded using Shapiro, Barkham, and Irving (1980) revisions of Elliott's (1979) Helper Behavior Rating System.

There were no significant differences between the initial and ongoing sessions in terms of correlations between client-perceived empathy and the frequency of any response mode. Results indicated that client-perceived empathy was negatively correlated with general advisement and with reassurance, and counselor-perceived empathy was positively correlated with Exploration. The exploration mode was the most strongly and consistently associated with both participant' perceptions of the counselor's understanding.

Some methodological considerations for this study include the fact that data from different clients was collected in initial sessions and continued sessions. Perhaps it would have been better to collect data from the same clients across sessions to eliminate between-client bias. In addition, clients and therapists were asked to recall how they felt during the counseling sessions up to two to five days later. Memory of the actual feelings during the session may not have been accurate.

Mahrer, Sterner, Lawson, and Dessaulles (1986) looked at the sequence of statements made by six therapists representing different therapeutic approaches. They coded the therapist statements into 35 mutually exclusive categories. Each therapist statement (defined as the therapist's speech between client statements) was placed into a single predominant category. The results of this study indicated that therapists do indeed follow pattern sequences in which particular categories of

responses are preceded and followed by other categories. They found that therapists relied on a small number of response categories over the session, and that a sequence including interpretation and explanation-description of external world was a common sequence across therapeutic orientations. One common sequence included interpretation and explanation-description of external world. In this sequence, the therapist explained or described the client and then told the client what the external world was like. A common role among therapists across therapeutic orientation was that of the interpreter-describer-explainer of inner and outer reality and the knowledgeable authority. That is, therapists often gave interpretations and information.

One weakness of this study is that it failed to incorporate the clients' statements and lacks an estimation of how well the therapists' statements responded to the clients' statements. This study also failed to investigate how therapist response sequences vary throughout different phases of the session.

Barkham and Shapiro (1986) conducted a study in which client and counselor perceptions of empathy were examined at different stages in the counseling process in relation to the verbal response modes used by counselors in 24 client-counselor dyads. Sessions from 12 initial and 12 ongoing counselor-client dyads were compared. The six counselors were experienced and worked within a client-centered framework. The clients in the initial group were randomly assigned to available counselors. The ongoing clients were selected by their counselors according to both the counselor's willingness to approach the clients and the client's willingness to participate in the study. Counseling sessions were conducted in a small laboratory

and were videotaped. Within 2-5 days of the sessions being recorded, clients and therapists viewed the videotapes of the sessions. Clients were asked to press the + switch on a keyboard when they were feeling that the counselor was understanding their problem particularly well, and the – button when the client was feeling misunderstood. Therapists were asked to press the + button when they felt they were successfully communicating their understanding of the client empathically, and the – button when they were feeling they had misunderstood the client's message. The times of the button-pressing was matched with the appropriate point on the transcript of the session. Transcripts were coded using Shapiro et al.'s (1983) Helper Behavior Rating System. Results suggested that client-perceived empathy was negatively correlated with General Advisement, whereas counselor-perceived empathy was also negatively correlated with Reassurance (though only in the initial sessions). There were no significant differences between initial and ongoing sessions in terms of correlations between client-perceived empathy and the frequency of any response mode. At the microscopic level, reflection, exploration, and interpretation all became more frequent as the client-recalled empathic event was approached.

Weaknesses of this study include the different methods of recruitment for the initial and ongoing sessions. Descriptive information was not gathered for many of the clients, and thus demographic information was limited. It would be more appropriate to use clients chosen at random for a study at different stages of counseling. Another weakness was the time lapse in between the actual session and the videotape review. The interval was not controlled, and it would have been

preferable if all the dyads completed the videotape review immediately after the session.

Martin, Martin, & Slemon (1989) conducted a study aimed at providing empirical data about the probabilities of patterns of relations among counselor intentions, counselor behaviors, client cognitive operations, and client responses. They obtained data from 92 counseling sessions with 18 counselor-client dyads who contributed data from 3 to 8 sessions selected at regular intervals. The eight counselors in the study were experienced counseling psychologists and participated in between one to four counseling dyads. The 18 clients who participated in the study were university undergraduates and graduate students who were experiencing problems typical of clients who seek counseling from university-based counseling services. Counseling sessions were observed and videotaped, and a research assistant randomly selected eight different instances of counselor behavior at regular intervals across the session (counselor's speaking turn after every approximately 100 feet of tape). The therapists and clients then participated in a stimulated-recall interview in which the research assistant asked the interviewees to describe what they thought during the session at each of the eight points. Counselors' intentions were coded into Hill and O'Grady's (1985) intentions list and counselors' behaviors were coded into the Counselor Verbal Response Category System (CVRCS; Hill et al., 1981). Clients' descriptions of their cognitive operations were coded into one or more of the 11 categories described by Martin et al. (1986), and clients' responses were coded with the nine categories from the CVRCS-client form (Hill et al., 1981). All coding was done independently by

two of the authors and data was thrown out if it could not be coded with perfect inter-rater reliability.

Results indicated that the most common counselor behaviors were open question and reflection, the most common client cognitive operation was registering information, and the most common client response was description (.62). Martin, Martin, and Slemon (1989) then investigated different sequences of counselor intentions-counselor behaviors-client cognitive operations to examine the probabilities of the various sequences and found considerable evidence of distinctive patterns of counselor behavior and that there was at least some stability in the relations between counselor intentions and behaviors. The counselor behaviors open question and confrontation led most frequently to the client cognitive operations recalling something and analyzing or registering information, respectively. The counselor behaviors reflection, interpretation, and direct guidance all lead most often to the client cognitive operation registering information.

Although Martin et al. (1989) drew data from a number of sessions, they only used a small sample of instances of counselor behavior. Because the instances were taken at random intervals about 5-10 minutes apart, instances of clients shifting behavior could not be examined. Client behavior before the therapist's intervention was not recorded, and so much of the context of the intervention was not captured. Another weakness of this study was the use of only two coders. When the coders did not agree, the data was thrown out of the study.

Fitzpatrick et al. (2001) investigated various types of therapist verbal response modes from 21 sessions and related them to the client's immediate response in the

context of varying levels of the therapeutic alliance. Therapists were from a variety of therapeutic orientations and were considered experts in the field. No demographic information was available for the clients. The Working Alliance Inventory was used to measure the working alliance inventory, the Hill Counselor Verbal Response Category System-Revised was used to categorize counselor interventions, and the Category System of Client Good Moments was used to categorize moments of in-session progress. Independent ratings on all instruments were made by students in counseling graduate programs who used audiotapes and transcripts of the sessions.

Loglinear modeling procedures indicated that the alliance was present in all best-fitting models of the data, thus indicating that working alliance was important in predicting client's good moments. Exploratory examination of the models revealed that client good moments did not necessarily increase in frequency as the working alliance increased, as was hypothesized. Furthermore, different response modes were associated with client good moments at different alliance levels. Chi-square analyses of the frequency of response modes at different levels of working alliance revealed that counselor reflections and restatements occurred less often than expected at low and high alliance levels and more than expected at moderate alliance levels. These findings suggest that qualitatively different therapeutic processes are in operation at different alliance levels and that different alliance levels seem to be differentially related to various types of interventions and client progress.

Although the design of this study is an improvement on the more contrived experimental designs of the past, a few weaknesses should be noted. In analyzing the data, the authors first separated the sessions into alliance levels and then looked at the

response modes within each section. However, alliance levels would shift within sessions. Another, perhaps more informative approach, would be to look at the therapist response modes and client affect and behavior that actually initiate shifts in alliance levels. In addition, the use of alliance level as an outcome variable could be too wide—it fails to measure the impact of particular response modes.

A review of naturalistic studies and immediate outcome raises some questions about when and how certain interventions are effective. Elliott, et al. (1982) found that counselor response modes account for only a small proportion of the variance in helpfulness ratings, probably because contextual variables such as timing of counselor response, counselor skill with particular modes, and client preferences were not taken into account. Hill et al. (1988) found that the effectiveness of the therapist intervention depended more on the client's previous experiencing level than on any of the other process variables. When clients were at lower levels of experiencing, therapists offered more information and fewer interventions aimed at feelings and clients rated the interventions in which the therapist helped the clients explore their thoughts and behaviors as the most helpful. When clients were at high levels of experiencing, they generally rated all therapist interventions as helpful. Shapiro, Barkham, and Irving (1984) found that client-perceived empathy was negatively correlated with general advisement and with reassurance, and counselor-perceived empathy was positively correlated with exploration. Mahrer, Sterner, Lawson, and Dessaulles (1986) found that a common sequence in therapy included interpretation and explanation-description of external world. In this sequence, the therapist explained or described the client and then told the client what the external world was

like. Barkham and Shapiro (1986) reflection, exploration, and interpretation all became more frequent as the client-recalled empathic event was approached. Martin, Martin, & Slemon (1989) found that the counselor behaviors open question and confrontation led most frequently to the client cognitive operations recalling something and analyzing or registering information, respectively. The counselor behaviors reflection, interpretation, and direct guidance all lead most often to the client cognitive operation registering information. Finally, Fitzpatrick et al. (2001) found that counselor reflections and restatements occurred less often than expected at low and high alliance levels and more than expected at moderate alliance levels. These findings suggest that qualitatively different therapeutic processes are in operation at different alliance levels and that different alliance levels seem to be differentially related to various types of interventions and client progress.

Summary of Empirical Findings

In conclusion, we can't conclude much. Regarding open questions, one study (Hill & Gormally, 1977) found that open questions about feelings led more to clients talking about their feelings than restatements or reflections of feelings. Elliott et al. (1982) found that questions received slightly higher helpfulness ratings from client and therapists than non-questions. However, Hill, Helms, Tichenor et al. (1988) found that open questions were significantly negatively related to client-rated smoothness, and that therapists gave significantly higher ratings for open questions than clients. Barnabei (1974) and Highlen and Baccus (1977) found no significant differences between probes and reflections of feelings.

Regarding reflection of feelings, Hill, Helms, Tichenor et al. (1988) found that of the exploration skills (open questions, closed question, paraphrase), paraphrase was used most often and was rated as more helpful by both clients and therapists. Martin et al. (1989) found that reflections were one of the most common counselor behaviors (along with open questions). Hill, Helms, Tichenor et al. (1988) also found that the cases in which the therapists used more open question and paraphrase had more decreases in anxiety, and cases with more paraphrase but less approval and closed question had more increases in self-concept. However, Elliott et al. (1982) found that reflections were not significantly related to helpfulness.

None of the studies reviewed here found restatement to be more effective than the other response modes in the exploration stage. In fact, Auserwald (1974) found that counselor restatements decreased client self-reference affect. However, many authors found that the effectiveness of the response mode can depend on factors such as experiencing level (Hill, Helms, Tichenor et al., 1988) and working alliance level (Fitzpatrick et al., 2001).

There are many reasons why the results of this study are inconclusive. A primary reason is that most of the studies use different definitions of the helping skills; probes may be open or closed questions, open questions may be oriented towards thoughts or feelings, etc. Also, these studies look at the effectiveness of the interventions at different at different points in therapy and with different types of clients. Looking at the effectiveness of well-defined helping skills in just one stage of therapy is important in getting a clearer view of the impact of these helping skills.

Criticisms of Traditional Process Research

Stiles and Shapiro (1989) argue that the way that research has been conducted in the past is inappropriate. They claimed that in the past, process-outcome research has followed the *drug metaphor* which suggests that the “ingredients” of psychotherapy can be treated like the ingredients of pharmacological therapist in their evaluation. If a component is high, then administering a high level of it is supposed to yield a positive outcome (Barkham & Shapiro, 1986).

Stiles and Shapiro (1989) suggested that the drug metaphor is no longer appropriate. They argued that the drug metaphor logic overlooks the therapist and client responsiveness to the clients constantly changing requirements for process components. In suggesting that the strength of active process ingredients should predict which clients improve, the drug metaphor falsely assumes that process components are delivered randomly with respect to client requirements (Stiles & Shapiro, 1994a). When therapists are trained, they are not only taught to correctly implement verbal response modes, but are also trained to adapt verbal response mode type, depth, timing, intensity, and phrasing to clients’ individual needs and individual moments.

In the place of traditional research using the drug metaphor, Stiles and Shapiro (1994a) suggested increased attention on the idea of *responsiveness* (Hardy et al., 1998; Hayes et al., 1996; Jones, 1997; Marmar, 1990; Martin et al., 1989; Merbaum & Southwell, 1965; Russell & Trull, 1986; Schneider & Martin, 1992; Sechrest, 1994; Silberschatz, 1994; Silberschatz & Curtis, 1993; Stiles et al., 1998; Stiles & Shapiro, 1989, 1994b) which implies that outcome actually feeds back to influence

process. That is, “therapists intervene because they think it will be beneficial, and they adjust their interventions moment by moment in response to the effects of previous interventions, so process components are contingent on (anticipated) outcomes or related cues” (p. 947). They suggested that if responsiveness were absolutely perfect, that is, if therapists were perfectly responsive to their clients’ needs at any given time, process and outcome components would not covary because each client would be receiving exactly enough of the response that they needed. Stiles and Shapiro (1994a) also suggested methodological creativity is needed to more correctly assess the theoretical links between process components and outcomes.

A number of researchers wrote responses to Stiles and Shapiro’s (1994a) article, including Silberschatz (1994). Silberschatz (1994) suggested that, although Stiles and Shapiro (1994a) argued that the relationship between process and outcome may be “unanswerable within a conventional linear framework” (p. 15), existing statistical models are able to describe and empirically test process-outcome relationships. Silberschatz suggested looking for new ways to conceptualize and measure the therapists’ influence on the therapeutic process rather than look for new statistical or research paradigms. He claimed that the menial correlations typically found between process components and outcome are typically due to “(a) inadequate conceptualization of how process components lead to therapeutic progress and (b) imprecise, overly global measures and methods of evaluating process components” (p. 2), but that correlational designs are appropriate for many kinds of process-outcome research. In fact, he suggested that responsiveness itself should be treated as

an active ingredient in psychotherapy that can be adequately assessed using correlational statistical tools. Thus, Silberschatz agrees with Stiles and Shapiro (1994a) on most points, but disagrees with Stiles and Shapiro's proposition that correlational statistical tools are no longer useful in psychotherapy process-outcome research.

Sechrest (1994) also responded to Stiles and Shapiro's (1994a) article, arguing that "acceptance of the conclusions proffered by Stiles and Shapiro would have negative effects on psychotherapy research and practice" (p. 952). Instead, Sechrest maintains that researchers should not abandon the search for effective elements in psychotherapy, but should use alternative statistical tools such as multivariate analytic approaches and growth curve analyses, as well as pay closer attention to statistical power as a better approach to process-outcome research. In general, however, Sechrest agreed with Stiles and Shapiro, stating that "if Stiles and Shapiro are right, then better and more detailed initial measures of patient status will be needed, and those measures will have to be much more specific to requirements for therapeutic interventions than standard measures of psychopathology" (p. 953).

In a rejoinder, Stiles (1994b) argued with his critics' statements that the drug metaphor can be rescued by more complex measures (Silberschatz, 1994) or by more complex statistical procedures (Sechrest, 1994). He says that the drug metaphor can not be rescued because it fails to incorporate the important concept of responsiveness. Stiles (1994b) argues again for responsiveness and further developed the idea of the *responsiveness critique*. According to Stiles, the responsiveness critique concerns: "(a) process components that are specific, more-or-less voluntary in-session behaviors

or behavior qualities and (b) outcomes that are measured as psychological changes across the course of treatment” (p. 957). He argued that therapists’ and clients’ contributions to the process are in response to constantly changing and emerging requirements, and thus studies in which responses are independently manipulated or randomly assigned can not adequately assess process components. Thus, a process components correlation with an outcome variable (as in the drug metaphor) does not reflect its importance in a true psychotherapy setting.

Summary of Criticisms of Traditional Process Research

Early psychotherapy process-outcome research attempted to correlate the frequency of some process variable with an outcome variable. In many of these studies, process variables accounted for a negligible amount of variance in the outcome variable, leading researchers to search for more advanced statistical and methodological means of assessing the active components of psychotherapy. In recent years, many researchers have maintained that to more accurately assess the effectiveness of process components, one must pay careful attention to the entire context in which the process component is delivered. Researchers have suggested paying more attention to the client’s cues and the therapist’s response to these changing cues. In addition, methodological advances are recommended to more accurately address the sequential nature of psychotherapy process components.

Overview of the Narrative Process Coding System

The Narrative Process Coding System (NPCS) was developed by Angus, Levitt, and Hardtke (1996) to empirically measure change processes in psychotherapy. Following a dialectical constructivist model (Greenberg & Pascual-Leone, 2001), the

NPCS includes concepts of central importance to change in psychotherapy, including: a) client agency, b) human reflexivity and meaning making, c) story telling and narrative themes in the construction of self-identity, and d) emotion schemes and emotion processing. The NPCS operationally defines three basic processing modes that generally occur in psychotherapy discourse: a) an external mode, which includes autobiographical memories; b) an internal or emotion-focused mode, which includes the expression and articulation of affect; and c) a reflexive or conceptual meaning making mode, which includes the expression or articulation of insight. The NPCS model views the engagement of all three of these modes as key to the facilitation of client change in psychotherapy.

Description of Narrative Process Types

External narrative sequences. When the client elaborates on details surrounding an event or issue, the narrative sequence is coded as external. The event or issue can be actual or imagined; past, present, or future. The client may provide a general overview of events or issues, or highlight a specific incident or event. External narrative sequences are often presented as personal memories or concrete examples to highlight issues raised in any of the three narrative sequence types. An example of a client external narrative sequence would be: “My mother is constantly putting me down. Last night, for example, I told her that I got a B on my history exam and she asked what my friend Julie got. I told her that Julie got a B+ and my mom responded by pointing out that Julie had always been a very smart child.”

Internal narrative sequences. An internal narrative sequence occurs when the client describes how he or she feels in past, present, or future tense. Internal narrative

sequences often result when the therapist asks directly how the client feels and are often evidenced by the client's feeling words; emotional expressions such as shouting, crying, or sighing; pauses in the dialogue; and metaphoric descriptions of experiential states (e.g. *I feel as if I'm going to explode*). An example of an internal narrative sequence is: "I've just been so upset lately. Whenever I try to sleep I just get so wound up that all these thoughts keep on running through my head and just don't stop. Even right now, I feel like things are never going to get better."

Reflexive narrative sequences. During reflexive narrative sequences, the client focuses on the interpretive analysis of event descriptions and/or descriptions of subjective experiences. At this time, the client attempts to understand events, his/her own feelings, and/or his or her patterns across experiences. The individual may examine his or her own behavior in situations or relationships, plan future behavior alternatives, examine his/her own thinking or emotions in situations, and/or discuss patterns in the behavior of self or that of others. In reflexive narrative sequences, the client is often self-questioning, using words such as "why", "maybe", "I guess", "I wonder", etc. An example of a reflective narrative sequence is: "This wasn't the first time I lost my temper with my girlfriend. It seems like whenever I start to doubt if she really likes me I find things to be mad at her about. I wonder if I do that because it is easier to reject her than to have her reject me."

Empirical Studies of the Narrative Process Coding System

Levitt (1993) conducted a study that compared the NPCCS and the Experiencing Scale (Klein, Mathieu-Coughlan, Gendlin, & Kiesler, 1970). The Experiencing Scale has seven levels of functioning. The first three levels reflect an increasing referencing

of inner state within the client's discourse. In the fourth level, the client's main focus is his or her experiential state. In levels five, six, and seven the client is identifying, exploring, and resolving issues related to his or her inner experiential state. Levitt (1993) examined the three early, three middle, and three late sessions of three good outcome therapist/client dyads (one psychodynamic, one process-experiential, and one perceptual-processing). The therapy sessions were transcribed and unitized by the NPCS and were also coded by the Experiencing Scale. This study found that the external narrative processes were rated almost exclusively within levels two or three on the Experiencing Scale. The internal narrative processes were rated mostly as level 4 of the Experiencing scale. The reflexive narrative processes were rated mostly within levels five or six of the Experiencing Scale.

Levitt (1993) also found that psychodynamic, process-experiential, and perceptual-processing therapeutic approaches were significantly different from one another in terms of the types of narrative sequences across the three therapy dyads. The psychodynamic therapy session was constructed of 40% Reflexive and 54% External, meaning that therapist and client were engaged in a process of meaning construction (Reflexive) linked to the client's past experiences (External). The process-experiential therapy session included 29% Internal and 46% Reflexive, meaning that the client and therapist worked on identifying and differentiating different emotional experiences (Internal) and then generated new understanding of these experiences (Reflexive). Finally, the perceptual processing therapy dyad evidenced a pattern of Reflexive (54%) and External (36%) narrative sequences,

whereby the client and therapist engaged in extended analysis (Reflexive) of both life events (External) and emotional experiences (Internal).

Another study (Levitt, Angus, & Hardtke, 1993) examined the three “Gloria” sessions from Shostram’s film *Three Approaches to Psychotherapy*. The three approaches were Rational Emotive Therapy (RET) as delivered by Albert Ellis, Gestalt Therapy (GT) by Fritz Perls, and Client-Centered Therapy (CCT) by Carl Rogers. Different narrative sequence patterns were evidenced in each of the three sessions. Ellis’ session of RET included many consecutive reflexive sequences, with a few external sequences at the beginning and at the end. Perls’ GT session was characterized by reflexive and internal sequences, with external sequences in the middle of the session. The beginning and end of Rogers’ session was characterized by reflexive sequences intermixed with external and internal sequences. However, during the middle part of the session, reflexive sequences were mixed exclusively with internal sequences. Thus, both of the humanistic approaches (CCT and GT) evidenced a higher number of internal sequences, which perhaps speaks to the importance of emotional processing within these therapies.

In a another study, (Levitt, Korman, & Angus, 2000) examined the burden metaphors (e.g. “carrying the load”) within a good outcome and a poor outcome process-experiential counseling dyad. They found a significant difference in terms of narrative sequence subtype and the occurrence of burden metaphors. In the good outcome dyads, client used more internal narrative sequences and more burden metaphors within the internal narrative sequences than the client in the poor outcome dyad. The good outcome dyad did not use any burden metaphors within the external

narrative sequences. Thus, client engagement in more internal narrative sequences may lead to better outcome in process-experiential counseling.

In summary, the NPCS has demonstrated its use as a heuristic for exploring clients' narrative discourse in therapy. Studies have shown its convergent validity with the Experiencing Scale, as well as its convergent validity with therapeutic orientation and outcome (Levitt, 1993; Levitt et al., 1993).

Chapter 3: Statement of the Problem

In the past, counseling process has been examined using a variety of methods, many of which have had limited success. Studies attempting to correlate frequency or proportion of counselor response mode with session or treatment outcome have been criticized because they do not take into account the timing, appropriateness, or context of the process variable (De Stefano et al., 2001; Gottman & Markham, 1978; Hill, 1982; Hill, Helms, Tichenor et al., 1988; Russell & Trull, 1986; Stiles, 1988; Stiles & Shapiro, 1994b). When therapists are trained, they learn not only the specific interventions to use in therapy, but also when, how, and with what intensity to deliver them. Thus, it seems important to know how therapists decide in the moment which intervention to use.

The responsiveness paradigm is more useful in determining exactly what works in therapy and involves (a) identifying the critical incidents in therapy, (b) coding the therapist's response, and (c) measuring the impact of the response (Stiles & Shapiro, 1994a). A number of studies have been conducted using this paradigm, including Hill, Helms, Tichenor, et al. (1988) who found that therapist intentions and previous client experiencing each accounted for more of the unique variance in session outcome than did the therapist's response mode. However, Hill, Helms, Tichenor, et al. (1988) did not differentiate processes in each of the three stages (exploration, insight, action). Because each of the stages of the helping skills model have different goals, various interventions should be differentially helpful in each stage. Hence, restricting investigation of counseling process to a particular stage, more specifically the exploration stage since it has received such limited empirical

support, was the focus of this study. Since the major goal of the exploration stage is exploring thoughts and feelings, the therapist response modes that were focused on were restatement, reflection of feelings, open questions of feelings, and open questions of thoughts.

The purpose of this study was to examine the counseling process within the exploration stage of Hill and O'Brien's (1999) 3-stage helping skills model. Thorough analyses of client narrative processes, client helpfulness ratings, therapist response modes, and therapist helpfulness ratings were conducted and the sequencing of these were examined.

Because there is so little empirical research on the exploration stage and because the research detailing the impacts of therapist and client response modes conflicts, a discovery-oriented approach was taken and research questions about the counseling process in the exploration stage were asked.

Research question 1: What verbal response modes to therapists use in response to clients' internal, external, and reflexive narrative processes?

Research question 2: What narrative modes do clients use after each of the therapists' response modes?

Research question 3: When clients shift from one narrative process mode to another, what therapist verbal response mode occurred in between?

A second major area of interest was in immediate outcome of therapist verbal response modes. The previous literature has focused completely on immediate outcomes in the context of one previous client statement (Hill et al, 1988). But any immediate outcome is also the product of all that has preceded that response mode in

the session. Hence, we examined not only the response mode and the preceding client narrative mode, but also how helpful the session has been previously.

Hypothesis 1: Client helpfulness ratings can be predicted by client narrative response mode in the previous turn and therapist predominant verbal response mode in that turn.

Hypothesis 2: Therapist helpfulness ratings can be predicted by client narrative response mode in the previous turn and therapist predominant verbal response mode in that turn.

Chapter 4: Method

Design Statement

This was a descriptive laboratory study of counseling processes within the exploration stage of Hill and O'Brien's (1999) 3-stage helping skills model, examining the relationship between therapist verbal response modes and client narrative processing.

Participants

Clients. The 26 female clients ranged in age from 19 to 24 ($M = 20.67$, $SD = 1.13$), and the sample was ethnically diverse (15 Caucasian, 2 African-American, 4 Asian-American, 4 Hispanic, 1 missing). Fourteen participants had previously been in therapy, and 2 were currently on psychotropic medication. Participants were excluded from the study if they were currently in therapy or if they had started taking psychotropic medication within the previous 2 months. There was no financial incentive for participants, though they were offered referrals if they wished to continue therapy elsewhere.

Therapists. Thirteen female therapists who had received training in the Hill and O'Brien (1999) helping skills model were recruited from the counseling psychology doctoral program at the University of Maryland. Therapists' ranged in age from 22 to 38 ($M = 27.00$, $SD = 5.29$). Twelve of the therapists were Caucasian, and the thirteenth was Asian. They had completed between one and six years in the graduate program ($M = 2.23$, $SD = 1.42$) and had between 8 and 450 hours of direct clinical service ($M = 145.38$, $SD = 152.52$). When asked how much they believed in an adhered to various theoretical orientations on a 5-point scale where 5 is high,

therapists rated themselves as 4.00 ($SD = .71$) on Client-Centered, 3.46 ($SD = .88$) on Psychodynamic, and 2.69 ($SD = .75$) on Cognitive-Behavioral Therapy.

Experimenters. Two graduate students and 4 undergraduate psychology students viewed the sessions, administered the post-session measures, and facilitated the videotape review after each session.

Videotape session coders. Six undergraduate research assistants (all female; 3 Asian American, 3 Caucasian) coded the therapist response modes and the client narrative code. Each research assistant was either of junior or senior standing and had read the *Helping Skills* book.

Measures

Beck Anxiety Inventory (BAI). The BAI (Beck & Steer, 1990), a self-report measure assessing anxiety symptoms, takes between 5-10 minutes to complete. It consists of 21 statements describing common symptoms of anxiety and asks the client how much she or he was bothered by the symptom over the previous week. The descriptive statements of anxiety symptoms are rated on a 4-point scale from “Not at all” (0) to “Severely, I could barely stand it” (3). Scores of 0-9 points reflect normal levels of anxiety, 10-18 indicates mild-moderate anxiety, 19-29 indicates moderate to severe anxiety, and scores of 30-63 indicate severe anxiety. Good content, concurrent, construct, discriminant, and factorial validity (Beck, Epstein, Brown, & Steer, 1988), as well as good internal consistency (Cronbach’s $\alpha = .94$; Beck et al., 1988) and test-retest reliability (one week correlation = $.75$, $p < .001$; Beck et al., 1988) have been demonstrated for the BAI. In the current sample of 26 female participants, there

was a range of 10 to 29 ($M = 18.04$; $sd = 7.64$), so these women were experiencing moderate anxiety. There was an alpha of .84.

Helping Skills Measure-Client Version (HSM-C). The HSM-C (Hill & Kellems, 2002) is a 13-item measure designed to measure client's perceptions of helper's performance of each of the exploration, insight, and action stages (Hill & O'Brien, 1999) of the helping skills model. Each item contains the stem "In this session, my helper. . ." followed by a statement pertaining to one of the goals of one of the stages. Items on the Exploration Scale include "asked questions to help me explore what I was thinking." Items on the Insight Scale assess the client's perception of the helper's ability to assist the client in gaining insight (ex. "encouraged me to challenge my beliefs"). Examples of items on the Action Scale include "helped me figure out how to solve a specific problem." Items are scored on a 5-point scale ranging from strongly disagree (1) to strongly agree (5), and six of the items are negatively stated.

Hill and Kellems (2002) conducted both exploratory and confirmatory factor analyses and found that the 3-factor structure of the HSM was the best representation of the data. Hill and Kellems (2002) reported adequate internal consistency for each scale (Exploration $\alpha = .73$; Insight $\alpha = .71$; Action $\alpha = .82$) as well as adequate concurrent validity for the HSM-C scales as they were significantly correlated to the corresponding scales of the Session Impact Scale (Exploration with SIS-Relationship $r = .43$, $p < .001$, Insight with SIS-Understanding $r = .44$, $p < .001$, and Action with SIS-Problem-Solving $r = .60$, $p < .001$).

In our sample, the mean was 2.97 ($SD = .30$) for the Exploration stage, 3.77 ($SD = .53$) for the Insight stage, 2.49 ($SD = .64$) for the Action stage, and 3.03 ($SD = .30$)

for the entire HSM. The alpha coefficient was .52 for the Exploration stage, .60 for the Insight stage, .76 for the Action stage, and .78 for the entire HSM. Because of the lower scale alphas, only the total scale will be used.

Helping Skills Measure-Therapist Version (HSM-T). The HSM-T scales are related to other measures of session process and outcome (e.g., Session Evaluation Questionnaire-Depth Subscale, Stiles & Snow, 1984; Session Impact Scale, Elliott & Wexler, 1994). Correlations are not above .70, however, indicating that the HSM scales measure something distinct from the other measures. Kolchakian and Hill (2003) found internal acceptable internal consistency ($>.70$) for the three scales.

In the current study, the HSM-T was used to assess the therapist's perception of their performance in each of the stages (exploration, insight, action). In our sample, the mean was 4.40 ($SD = .67$) for the Exploration stage, 3.38 ($SD = .63$) for the Insight stage, 3.15 ($SD = 1.11$) for the Action stage, and 3.61 ($SD = .56$) for the entire HSM. The alpha coefficient was .82 for the Exploration stage, .63 for the Insight stage, .85 for the Action stage, and .76 for the entire HSM. Only the total scale will be used for analyses.

The Relationship Scale-Client Version (RS C). The RS (Hill & Kellems, 2002) assesses the client's perception of the therapeutic relationship in each session of therapy. Each question on the RS uses the stem "In this session, I . . ." followed by each of four items (e.g. "did not feel a bond with my helper," "liked my helper," "trusted my helper", and "worked collaboratively with my helper"). The RS uses a 5-point Likert scale, ranging from strongly disagree (1) to strongly agree (5).

Exploratory and confirmatory factor analyses revealed one factor, with an internal

consistency of .78. The RS also has good concurrent validity as demonstrated by its correlation with the Working Alliance Inventory-S, $r = .51, p < .001$. Clients in our sample had a mean rating of 3.74 ($SD = .43$) on the Relationship Scale. There was an alpha coefficient of .84.

Relationship Scale-Therapist Version (RS-T). A parallel version of the RS was used to measure the therapist's perception of the quality of her/his relationship with the client. Therapists in our sample had a mean rating of 3.87 ($SD = .78$) on the Relationship Scale. There was an alpha coefficient of .92.

The Session Evaluation Scale-Client Version (SES-C). The SES (Hill & Kellems, 2002) uses the stem "I . . ." followed by 4 items (e.g., "am glad I attended this session," "did not feel satisfied with that I got out of this session," "thought the session was helpful," "did not think the session was valuable"). It uses a 7-point scale ranging from strongly disagree (1) to strongly agree (7). Exploratory and confirmatory factor analyses revealed one factor with an internal consistency of .91. Concurrent validity was demonstrated for the SES-C, in that it correlated significantly with the client-rated SEQ-Depth ($.51, p < .001$). Clients in our sample had a mean rating of 3.06 ($SD = .35$) on the Session Evaluation Scale. We found an alpha coefficient of .81.

Session Evaluation Scale-Therapist Version (SES-T). A parallel version of the SES will be used to assess the therapist's perception of the quality of the counseling session. Therapists in our sample had a mean rating of 3.89 ($SD = .78$) on the Session Evaluation Scale. There was an alpha coefficient of .90.

Narrative Process Coding System. The Narrative Process Coding System (Angus, et al., 1996) consists of three narrative types: external, internal, and reflexive. During external narrative sequences, the client is providing an overview of events or an issue that can be specific or general; past, present, or future. During internal narrative sequences, the client is elaborating on subjective experiences and feelings in relation to self and others. During reflexive narrative sequences, the client is giving an interpretive analysis of events or experiences. For this study, we coded predominant narrative sequences for each client speaking turn. Angus et al. (1999) reported acceptable interrater agreement levels of between 83-88% (Cohen's Kappa = .75) after 25 to 30 hours of training (number of raters not identified). Levitt (1993) reported that the three narrative sequence types represent different therapeutic approaches, giving the measure construct validity. That is, construct validity was demonstrated by the finding that therapists with different orientations use the NPCS in different ways. For example, psychodynamic therapists' clients use more external narrative sequences, while processing experiential and perceptual processing therapists' clients use more reflexive narrative sequences. In our teams of 4 coders, we had an average agreement of .90, with kappas ranging from .69 to 1.0 for individual sessions.

Helping Skills System. The Helping Skills System (Hill & O'Brien, 1999) is a modified version of the Hill Counselor Verbal Response Category System (Hill, Helms, Tichenor et al., 1988; Hill & O'Grady, 1985). It consists of 15 nominal, mutually exclusive categories of therapist verbal behavior. The categories are approval and reassurance; closed question; open question-thoughts; open questions-

feelings; open question-clarification; reflection of feelings; challenge; interpretation; self-disclosure; immediacy; information about the process of helping; facts, data, or opinions; direct guidance; directives; and other. Because this study examined just the therapist response modes in the exploration stage, only restatement, reflection of feelings, open questions directed at feelings, open questions directed at thoughts, and open questions to clarify will be analyzed (although all VRMs will be coded). For a previous version of the model (Hill, 1986), content validity was established through combining categories from existing measures and having expert therapists from different theoretical orientations determine the representativeness of categories; construct validity was established given that therapists from different theoretical orientations differed in their responses modes. Concurrent validity was established through high relationships between similar categories on other response mode systems (Elliott et al., 1987). Hill, Helms, Spiegel, & Tichenor (1988) reported interjudge reliability (kappas) between pairs of judges of .67. There have been no published estimates of interjudge reliability for the current Helping Skills System, although an unpublished study found average interjudge reliability of .79 between pairs of three judges (Hill et al., 2001). Kolchakian and Hill (in prep) found average kappas of .98 between pairs of five judges. In this study, we found average interrater reliability between three judges of .98, ranging from .94 to 1.0 for individual sessions.

Procedures

Client recruitment. The primary investigator and an undergraduate research assistant announced the study in undergraduate psychology classes at the University of Maryland. The researcher informed potential female clients that they would be

asked to participate in one 60-90 minute counseling session in which they would discuss a personal problem with their therapist, and in one 1-hour videotape review immediately following each of their counseling sessions. All students were asked to fill out a slip of paper indicating whether or not they were interested. If they indicated that they were interested, they also wrote their name, phone number, and email address. Prospective clients were screened by the investigator through a phone interview to ensure that they identified anxiety as a problem; were not currently in psychotherapy; if on medication, had been for at least one month. Prospective clients were then asked the questions on the Beck Anxiety Inventory (BAI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Females who scored between 10 and 29 on the BAI were invited to participate in the study. Those who did not qualify for the study were offered referrals for therapy.

The principle investigator recruited from 14 undergraduate classes at the University of Maryland. Out of these classes, 117 students indicated that they were interested in participating in the study. Of the 117 students, 74 were contacted, 43 were scheduled to participate, and 26 actually participated. The 17 clients who were scheduled but did not actually participate either did not show up to the session, showed up more than 20 minutes late, or cancelled the session within 24 hours of the session time and did not wish to reschedule. Of the 31 who were not eligible, 23 had BAI scores of under 10, and 8 did not have available times that matched those of the therapist.

Therapist recruitment. Of the 20 female therapists who were invited by the principle investigator to participate in the study, 13 agreed and conducted sessions.

The investigator invited therapists who she knew were familiar and competent with the Helping Skills model. Each conducted two 60-90 minute counseling sessions followed immediately by a 1-hour videotape review.

Counseling Sessions. Each therapist-client dyad participated in one 60-90 minute videotaped counseling session. The first 30-45 minutes of each session were focused on exploration of the client's problem. During the exploration stage, the therapists primarily used open questions, reflection of feelings, and restatement. Experimenters watched from another room and recorded the therapists' statements. At the end of the exploration stage, therapists made a statement indicating to the experimenter that he or she was moving into the insight stage (eg. "Now we are going to move on and try to understand why you tend to do that").

Post-session Measures. Immediately after the session, clients completed the Helping Skills Measure Client version, Relationship Scale-Client version, and the Session Evaluation Scale-Client version. Therapists were asked to complete the Helping Skills Measure-Therapist version, Relationship Scale-Therapist version, and the Session Evaluation Scale-Therapist version.

Videotape Reviews. After the session and post-session measures were completed, both client and therapist accompanied the experimenter(s) to another room. Therapist and client sat next to each other facing the television screen but were not easily be able to see one another. The experimenter played the videotape and paused it following every therapist speaking turn (therapist's statement in between two client statements). When the tape was paused, the client and therapist independently rated the helpfulness of the speaking turn. During the review, the

experimenter corrected the transcription of the therapist's speaking turn. After the videotape review, the experimenter sometimes needed to review the tape once more to finalize the record.

In an analogue study of videotape recall, Katz and Resnikoff (1977) found moderate correlations between live ratings of comfort or discomfort and ratings recalled during a videotape review. In a quasi-counseling study similar to the proposed study, Hill et al. (1994) found no differences between client and therapist mean helpfulness ratings done during sessions and during a videotape review. Hence, use of a videotape review to collect helpfulness ratings seemed justified.

Videotape Coding of Therapist Response Modes. A graduate student familiar with the Helping Skills coding system trained three undergraduates who were familiar with the Helping Skills book in three two-hour sessions. First, they read *Helping Skills* and watched the Helping Skills video to familiarize them with the coding procedure. They then practiced unitizing and coding speaking turns found in the Helping Skills book. When judges disagreed on the response mode, they discussed the coding until they reached consensus. When they had reached high interrater reliability (.70), the three judges practiced unitizing and coding two tapes until they reached high interrater reliability in their coding (.70).

Because the entire sessions were not transcribed (only the therapist speaking turns and times they were delivered were recorded), the coding was done from the videotapes. Tapes from different therapist/client dyads were viewed in random order. The judges watched the client speaking turn for about 30 seconds before the therapist response mode to give them some context. They would then listen to the entire

therapist statement before rewinding the tape and listening to the therapist statement again. Individually, they decided on the number of units within each therapist speaking turn, and then took turns sharing their decision (in a random order). Disagreements were resolved through consensus. When the number of units was agreed upon, they again rewound the tape and paused it after each unit. Individually, they coded each unit for one helping skill, and then again they shared their decisions (in a random order). Disagreements were resolved through consensus. After they reached consensus about the helping skills, they individually decided what the predominant response mode was, and then again shared their decisions (in a random order). Disagreements were resolved through consensus. Reliability was calculated for predominant response mode only.

Videotape Coding of Client Narrative Process. A different team of three undergraduate judges and one graduate student coded each of the client's speaking turns according to predominant narrative processes types in the Narrative Processes Coding System (Angus et al., 1996). Students were trained by a graduate student familiar with the Narrative Process Coding System in six two-hour sessions. First, they reviewed the different narrative process modes and discussed examples given in the training manual until they had a basic cursory understanding of the categories. Second, the judges coded a transcript provided by Lynne Angus for training purposes. Judges individually read the transcript, coded the individual speaking turns on their own, and then discussed disagreements with the other team members. They then compared the consensual code to Angus's codes, and discussed discrepancies. Third, the students practiced coding two different audiotapes that Angus provided, along

with accompanying transcripts. They listened to the entire speaking turn, and then individually coded the narrative process code including any shifts that occurred within the speaking turn. Judges then discussed discrepancies in the placement of shifts, as well as in the codes. The consensual codes were then compared to Angus' codes and differences were discussed. After rating the two audiotapes, judges had an interrater reliability of over .70, and thus they began to code the actual videotapes.

Videotapes from the present study were viewed in a random order. Judges viewed a section of the videotape consisting of 4-5 exchanges to get some context for the individual speaking turns. They then rewound the tape and paused it after every client speaking turn. Judges then recorded their judgment of narrative process code, including any shifts within the speaking turn. After coding 4-5 speaking turns, judges shared their judgments with the other judges (in a random order) and discussed discrepancies, which were resolved through consensus.

Chapter 5: Data Analyses

For all analyses, we set alpha at .01 because of the large number of analyses. Table 1 shows intercorrelations for all the measures used in this study.

Preliminary Analyses

Response Mode Profile. Table 2 presents the frequency and proportion of each coded therapist response mode, as well as the mean and standard deviations for the client and therapist helpfulness ratings of the major four therapist response modes and the remainder (other). Open questions-thoughts, exploration, clarification occurred most often (35%), followed by restatements (29%), reflections (16%), and open question-feelings (8%). We cannot compare these frequencies directly to other studies because we used slightly different categories.

Narrative Process Codes. Each client speaking turn was coded for 2 narrative process codes; one for the first half of the speaking turn and one for the second half. This method increased sensitivity to narrative process code shifts within each speaking turn. Table 3 presents the frequency of the narrative process codes for the first half and second half of each speaking turn, as well as the total frequency and proportion of every speaking turn. External narrative process codes occurred the most often (58%); next was internal narrative process codes (27%), and reflexive narrative process codes occurred least often (15%). It is hard to compare directly to other studies using narrative process codes because the current study examined only the exploration stage of a single session and coded narrative process code for halves of speaking turns, whereas other studies involved coding larger units within several

Table 1. Correlations for Measures

	1	2	3	4	5	6	7	8
1. Therapist Helping Skills Measure Mean								
2. Therapist Relationship Scale Mean	.34							
3. Therapist Session Evaluation Scale Mean	.44	.76*						
4. Mean Therapist Helpfulness Rating	.53*	.24	.38					
5. Client Helping Skills Measure Mean	.04	.04	.25	-.04				
6. Client Relationship Scale Mean	.09	.24	.30	-.09	.58*			
7. Client Session Evaluation Scale Mean	-.00	-.40*	.35	-.08	.71*	.72*		
8. Mean Client Helpfulness Ratings	-.12	-.14	-.05	-.34	.01	.12	.08	
9. Client Beck Anxiety Inventory Total	.21	-.40	-.09	.40	.17	.06	.13	-.11

Note. * Correlation is significant at the 0.01 level (2-tailed)

Table 2. Frequency, proportion, and mean helpfulness of therapist helping skills.

Helping Skill	Frequency	Proportion	Client Mean Helpfulness	Therapist Mean Helpfulness
Reflection	236	.16	7.23 (1.58)	5.94 (1.46)
Restatement	421	.29	6.92 (1.50)	5.48 (1.44)
Open question- Feelings	118	.08	7.24 (1.48)	6.14 (1.53)
Open question- TEC	502	.35	7.24 (1.48)	5.72 (1.44)
Other	157	.11	7.08 (1.48)	5.44 (1.54)
Total	1438	1.00	7.00 (1.55)	5.69 (1.48)

Note: Proportion is the number of times a skill was used divided by the total number of skills used. Standard deviations are in parentheses.

Table 3. Frequency and proportions of narrative process codes.

NP Code	Frequency in 1 st half of speaking turn	Frequency in 2 nd half of speaking turn	Total Frequency	Proportion
Internal	408	381	789	.27
External	840	813	1653	.58
Reflexive	189	243	432	.15
Total	1437	1437	2874	1.00

Note: Proportion is the number of times a narrative process code was used divided by the total number of codes used.

sessions of therapy. However, Levitt (1993) found that psychodynamic therapy sessions involved 40% reflexive, 54% external, and 6% internal. Process-experiential therapy sessions were constructed of 46% reflexive, and 25% external, and 29% internal. Finally, the perceptual processing therapy sessions were constructed of 54% reflexive, 36% external, and 10% internal (see table 4). The results for more external and less reflexive make sense given that this study involved only the exploration stage when clients were typically telling their stories.

Main Analysis

Research question 1: What verbal response modes do therapists use in response to internal, external, and reflexive client narrative process codes?

I computed a Cochran-Mantel-Haenszel chi-square, which tests the null hypothesis of no association between narrative process code and following therapist response mode in any of the therapy dyads against the alternative that there is an association in at least one therapy dyad. The SAS manual states: “When there is more than one stratum, then the CMH statistic becomes a stratum-adjusted Pearson chi-square statistic. Note that a similar adjustment can be made by summing the Pearson chi-squares across the strata. However, the latter statistic requires a large sample size in each stratum to support the resulting chi-square distribution with $q(R-1)(C-1)$ degrees of freedom. The CMH statistic requires only a large overall sample size since it has only $(R-1)(C-1)$ degrees of freedom (SAS, 1999).”

The Cochran-Mantel-Haenszel chi-square was not significant, $\chi^2_{(8)} = 9.96, p = .27$. According to the SAS manual (1999), “a nonsignificant CMH statistic suggests either that there is no association or that no pattern of association has enough strength or consistency to dominate any other pattern.” In addition, the statistic has low

Table 4. Narrative Process Modes in Different Therapy Models

NP Code	Psychoanalytic	Process- Experiential	Perceptual Processing	Current Study
Reflexive	40%	46%	54%	15%
External	54%	25%	36%	58%
Internal	6%	29%	10%	27%

Note: Psychoanalytic, Process-Experiential, and Perceptual Processing based on Levitt (1993).

power for detecting an association in which the patterns of association for some of the strata are in the opposite direction of the patterns displayed by other strata.

For illustrative purposes, I formed a co-occurrence table (Table 5) for all subjects by pairing client narrative code with the following therapist response mode. Observed and expected values for each cell, as well as cell contributions to the total chi-square are included in this table, but it should be noted that the cells' contributions to the total chi-square are included for illustrative purposes only, and are not appropriate for analyses because they do not take into account differences across cases. Similarly, it would not be appropriate to compute the overall chi-square for this table because it does not take cases into account.

To determine if the lack of results was due to some cases operating in different directions (e.g. some therapists doing more reflections after internal, whereas other therapists doing fewer reflections after internal), I eyeballed the individual chi-squares and plotted on Table 6 how many cells had strong contributions toward the total chi-square, and in what direction. For this analysis, I used an arbitrary criterion of 4.0 for the cell contribution to the total chi-square. This number seemed to differentiate those cells that had strong contributions from those that had inconsequential contributions. It appears that there is no strong pattern of strong cell contributions to the total chi-squares.

In sum, therapists did not use significantly different response modes in response to client narrative process modes.

Research question 2: What narrative process codes do clients use after each of the therapists' response modes?

Table 5. Co-occurrence table for all subjects by pairing the predominant therapist response modes in speaking turns (using the response modes of interest) with the immediately previous client narrative code for that turn.

	Reflection of Feelings	Restatement	Open Question- Feelings	Open Question- TEC	Other	Total
Internal	76	93	38	128	31	366
	61.09	110.01	30.68	124.67	39.67	
	3.64	2.63	1.75	.10	1.89	
External	116	254	57	261	96	784
	130.86	235.65	65.71	266.81	84.97	
	1.69	1.43	1.15	.13	1.43	
Reflexive	39	69	21	82	23	234
	39.06	70.34	19.61	79.63	25.36	
	.00	.03	.10	.07	.22	
Total	231	416	116	471	150	1384

Note: Open Question-TEC is Open Questions-Thoughts, Explanation, Clarification.

The first number in each cell represents the observed frequency of the sequence. The second number in each cell represents the expected frequency of the sequence. The third number in each cell's contribution to the total chi-square. The total number (1384) indicates the total number of client to therapist sequences in the data set.

Please recall that the therapist response mode used in these analyses was the predominant therapist response mode for the speaking turn. Similarly, for every client

speaking turn, members of the narrative process coding system team coded two narrative process codes, one for the beginning part of the speaking turn and one for the ending part. The client narrative response modes included in this analysis are the second part of the clients' speaking turn, because they immediately precede the therapists' interventions.

Table 6. Number of cell contributions to the total chi-square significant at $p < .05$ for research question one.

		Reflection	Restatement	Open Question- Feelings	Open Question- TEC	Other
Internal	+	3		2	1	
	-		1			
External	+					
	-			1		
Reflexive	+	1	1	1	1	
	-					1
Total	+					
	-					

Note: Open Question-TEC is Open Question directed at Thoughts, Explanation, or Clarification. The + rows indicate a greater observed than expected frequency. The – rows indicate a greater expected than observed frequency.

The Cochran-Mantel-Haenszel chi-square was significant, $\chi^2_{(8)} = 93.46$, $p < .001$, which suggests that there was an association between therapist response mode and following client narrative process code in at least one therapy dyad. For illustrative purposes, I formed a co-occurrence table (Table 7) for all subjects by pairing therapist response mode with the following client narrative process code. Observed and expected values for each cell, as well as cell contributions to the total chi-square are included in this table, but it should be noted that the cells' contributions to the total chi-square are included for illustrative purposes only, and are not appropriate for analyses because they do not take into account differences across cases.

Because we cannot rely on the cell contributions to the chi-squares to determine statistical significant, we must instead just look for what appears to be large linkages. For this analysis, I used an arbitrary criterion of 4.0 for the cell contribution to the total chi-square. This number seemed to differentiate those cells that had strong contributions from those that had inconsequential contributions. It appears from Table 7 that clients used the internal narrative processing code when therapists reflected feelings or asked open question-feelings. In examining the individual cases, the pattern of clients responding to open questions about feelings with the internal processing code held for 4 of the 26 cases, with no cases showing the opposite pattern, and the pattern of clients responding to reflections of feelings by using the internal narrative processing code held for 8 of the 26 cases, with no cases showing the opposite pattern (see Table 8). Furthermore, when examining individual cases, we did not find evidence for opposing data for any other connections.

Table 7. Co-occurrence table with predominant therapist response modes in speaking turns (using the response modes of interest) with the immediately following client narrative code for that turn.

	Internal	External	Reflexive	Total
Reflection of Feelings	104	99	26	229
	65.642	133.27	30.09	
	22.42	8.81	.56	
Restatement	86	271	54	411
	117.81	239.18	54.01	
	8.59	4.23	.00	
Open Question-Feelings	68	38	10	116
	33.25	67.51	15.24	
	36.32	12.90	1.80	
Open Question-TEC	98	301	75	474
	135.87	275.84	62.29	
	10.56	2.29	2.59	
Other	41	97	17	155
	44.43	90.20	20.37	
	0.26	.51	.56	
Total	397	806	182	1385

Note: Open Question-TEC is Open Questions-Thoughts, Explanation, Clarification.

The first number in each cell represents the frequency of the sequence. The second number in each cell represents the expected frequency of the sequence. The third

number in each cell is the cell chi-square value. The total (1385) indicates the total number of therapist to client sequences in the data set. Please recall that the therapist response mode used in these analyses was the predominant therapist response mode for the speaking turn. Similarly, for every client speaking turn, members of the narrative process coding system team coded two narrative process codes, one for the beginning part of the speaking turn and one for the ending part. The client narrative response modes included in this analysis are the first part of the clients' speaking turn, because they immediately follow the therapists' interventions.

Table 8. Number of cell contributions to the total chi-square significant at $p < .05$ for research question two.

		Internal	External	Reflexive
Reflection	+	4		1
	-		1	
Restatement	+			
	-			
OQF	+	8		
	-		1	
OQTEC	+			1
	-	1		
Other	+	1		2
	-			

Note: Open Question-TEC is Open Question directed at Thoughts, Explanation, or Clarification. The + rows indicate a greater observed than expected frequency. The – rows indicate a greater expected than observed frequency.

In sum, it appears that there are significant patterns in the data. It appears that when therapists ask an open question about feelings or reflect feelings, clients are more likely to respond with the internal narrative processing code. However, these associations are not universal and may reflect only a few cases.

Research question 3: When clients shift from one narrative process code to another, what therapist verbal response mode occurred in between?

The final research question paired each therapist response mode with every client narrative process shift or maintenance possibility from one speaking turn to the next (internal to internal, internal to external, internal to reflexive, external to internal, external to external, external to reflexive, reflexive to internal, reflexive to external, and reflexive to reflexive). The Cochran-Mantel-Haenszel chi-square was significant, $\chi^2_{(32)} = 110.15, p < .0001$, which suggests that there was an association between therapist response mode and client narrative process code shift or maintenance in at least one therapy dyad.

I formed a co-occurrence table (5 x 9) (Table 9) for all subjects by pairing each therapist response mode with every client narrative process shift or maintenance possibility from one speaking turn to the next (internal to internal, internal to external, internal to reflexive, external to internal, external to external, external to reflexive, reflexive to internal, reflexive to external, and reflexive to reflexive). Observed and expected values for each cell, as well as cell contributions to the total chi-square, are included in this table, but it should be noted that the cells' contributions to the total chi-square are included for illustrative purposes only, and are not appropriate for analyses because they do not take into account differences across cases.

Table 9. Co-occurrence table for all subjects by pairing each therapist response mode with every client narrative process shift or maintenance possibility from one speaking turn to the next.

	Reflection of Feelings	Restatement	Open Question- Feelings	Open Question- TEC	Other	Total
Internal-	48	47	32	51	18	196
Internal	32.74	58.51	16.44	66.75	21.26	
	7.16	2.37	14.73	3.72	.50	
Internal-	22	37	4	59	9	131
External	21.88	39.31	10.99	44.61	14.21	
	.00	.14	4.44	4.64	1.91	
Internal-	6	9	2	18	4	39
Reflexive	6.51	11.70	3.27	13.28	4.23	
	.04	.62	.49	1.68	.01	
External-	34	30	23	40	15	142
Internal	23.72	42.61	11.91	48.36	15.40	
	4.46	3.73	10.33	1.78	0.01	
External-	75	205	32	200	75	587
External	98.05	176.14	49.24	199.91	63.67	
	5.42	4.73	6.03	.00	2.02	

External-	7	18	2	21	6	54
Reflexive	9.02	16.20	4.53	18.39	5.86	
	.45	.20	1.42	.37	.00	
Reflexive-	21	8	12	8	7	56
Internal	9.35	16.80	4.70	19.07	6.07	
	14.50	4.61	11.36	6.43	.14	
Reflexive-	5	31	3	36	8	83
External	13.86	24.906	6.96	28.27	9.00	
	5.67	1.49	2.25	2.12	.11	
Reflexive-	13	30	6	38	8	95
Reflexive	15.87	28.51	7.97	32.35	10.30	
	.52	.08	.49	.99	.52	
Total	231	415	116	471	150	1383

Note: Open Question-TEC is Open Questions-Thoughts, Explanation, Clarification.

The first number in the cell represents the frequency of the sequence. The second number in the cell represents the expected frequency of the sequence. The third number in the cell is the cell chi-square value. The total (1383) indicates the total number of client to therapist to client sequences in the data set. Please recall that the therapist response mode used in these analyses was the predominant therapist response mode for the speaking turn. Similarly, for every client speaking turn, members of the narrative process coding system team coded two narrative process codes, one for the beginning part of the speaking turn and one for the ending part. The client narrative response modes included in the first part of the sequence are the

second part of the clients' speaking turn because they immediately precede the therapists' response, while the client narrative response modes in the second part of the sequence are the first part of the clients' speaking turn because they immediately follow the therapists' response.

It appears from Table 9 that clients stayed in the internal mode when therapists asked an open question about feelings. It also appears that clients shifted from reflexive to internal when therapist reflected feelings, however because the chi-square statistic does not account for differences across strata, we can not make assumptions about the significance of these sequences.

In examining the individual cases, the pattern of therapists delivering an open question-feelings to maintain clients from internal to internal narrative process code held for 3 of the 26 cases, with no cases showing the opposite direction (using the criterion of 4.0). The pattern of therapists delivering a reflection of feelings to shift clients from reflexive to internal held for 2 out of the 26 cases, with no cases showing the opposite direction. However, when examining Table 10 we also found that there were a number of other patterns that held for 2 to 3 of the individual cases. Thus, the patterns we found likely are more reflective of a few strong cases, rather than of overall trends.

In sum, an association was found between shifts in narrative process mode and therapist response mode, but these associations may be due to just a few cases.

Hypotheses

The data present many problems for choosing the appropriate analyses. Therapist response modes and client narrative processing codes (independent variables) are nominal, while both client and therapist helpfulness (the dependent variables) are interval. In addition, response modes and narrative process modes do not occur independently either within or across therapist's speaking turns or sessions, which violates the assumptions of the analysis of variance (ANOVA). After taking

Table 10. Number of cell contributions to the total chi-square significant at $p < .05$ for research question three.

		Reflection	Restatement	Open Question- Feelings	Open Question- TEC	Other
Internal	+	2		2	1	
to						
Internal	-					
Internal	+	2	1		2	1
to						
External	-					
Internal	+				1	2
to						
Reflexive	-					
External	+	3		3		2
to						
Internal	-					
External	+		1			1
to						

External	-				
External	+	1			2
to					
Reflexive	-				
Reflexive	+	2		2	2
to					
Internal	-				
Reflexive	+		1	2	1
to					
External	-				
Reflexive	+	1	1		3
to					
Reflexive	-				
Total	+				
	-				

Note: Open Question-TEC is Open Question directed at Thoughts, Explanation, or Clarification. The + rows indicate a greater observed than expected frequency. The – rows indicate a greater expected than observed frequency.

each of these limitations into account, we decided to use ANOVAs, recognizing that they were not completely appropriate, although the large sample and the lower alpha ($p < .01$) might mitigate some of these concerns. In addition, clients were nested within therapists to control for differences across dyads.

The two independent variables used in these analyses, predominant therapist response mode and client narrative process code, deserve some clarification. In each therapist speaking turn, a number of response modes could have been delivered, and so the predominant response mode was selected by members of the helping skills coding team and was used in these analyses. For every client speaking turn, members of the narrative process coding system team coded one narrative process code for the beginning half of the speaking turn and another for the second half of the speaking turn. In this sample, 1181 (83%) of the total client speaking turns maintained one narrative process code (i.e. internal to internal), while 204 (17%) shifted from one process code to another within a speaking turn (i.e. internal to external). The client narrative response modes included in these analyses are the second part of the clients' speaking turn, based on the assumption that the therapist is responding to the most recent client narrative process code.

Hypothesis 1: Client helpfulness ratings can be predicted by client narrative response mode in the previous turn and therapist predominant verbal response mode in that turn.

Table 11 shows the means and standard deviations for the client helpfulness ratings for the therapist response modes and preceding client narrative process modes. An ANOVA was conducted, with client helpfulness ratings as the dependent variable;

Table 11. Means and standard deviations for client helpfulness ratings of therapist interventions.

	Internal		External		Reflexive		Total	
	M	SD	M	SD	M	SD	M	SD
Reflection of Feelings	7.35	1.44	7.22	1.67	7.18	1.59	7.26	1.58
Restatement	7.15	1.44	6.82	1.54	7.12	1.38	6.94	1.50
Open Questions- Feelings	7.05	1.63	7.40	1.41	7.22	1.49	7.22	1.49
Open Questions- TEC	7.04	1.48	7.08	1.45	7.46	1.37	7.14	1.45
Other	6.81	1.85	6.21	1.70	7.13	1.55	6.47	1.74
Total	7.11	1.51	6.93	1.57	7.25	1.43		

Note: Open Questions-TEC is Open Questions directed at Thoughts, Explanation, and Clarification.

the independent variables were the preceding client narrative process mode and the therapist response mode; and client was nested within therapist to control for variance due to dyad differences (recall that each therapist saw two clients). The ANOVA indicated no significant effects for narrative process code $F(26, 1382) = 1.61, p = .12$, therapist response mode $F(52, 1382) = .97, p = .55$, or the interaction between most recent client narrative process mode and previous therapist response mode $F(82, 1382) = .96, p = .57$. There was, however a significant effect for client nested within therapist $F(13, 1382) = 6.89, p < .001$, which indicates that therapists were not perceived as equally helpful by different clients.

In sum, the hypothesis that client helpfulness ratings can be predicted by client narrative response mode in the previous turn and therapist predominant verbal response mode in that turn was not supported.

Hypothesis 2: Therapist helpfulness ratings can be predicted by client narrative response mode in the previous turn and therapist predominant verbal response mode in that turn

Table 12 shows the mean and standard deviation for the therapist helpfulness ratings based on therapist response mode and preceding client narrative process mode. An ANOVA was conducted, with therapist helpfulness ratings as the dependent variable; the independent variables were most recent client narrative process mode and previous therapist response mode; and client was nested within therapist to control for variance due to dyad differences. The ANOVA indicated no significant effects for narrative process code $F(26, 1382) = .92, p = .59$, therapist response mode $F(52, 1382) = 1.07, p = .41$, or the interaction

Table 12. Means and standard deviations for therapist helpfulness ratings of therapist interventions.

	Internal		External		Reflexive		Total	
	M	SD	M	SD	M	SD	M	SD
Reflection of Feelings	5.96	1.37	5.76	1.48	6.36	1.48	5.93	1.46
Restatement	6.00	1.43	5.33	1.42	5.45	1.49	5.50	1.45
Open Questions- Feelings	6.21	1.30	6.14	1.47	5.95	2.01	6.13	1.52
Open Questions- TEC	5.88	1.53	5.56	1.43	5.85	1.42	5.69	1.46
Other	6.10	1.47	5.07	1.52	6.26	1.66	5.47	1.61
Total	5.98	1.44	5.50	1.47	5.87	1.55		

Note: Open Questions-TEC is Open Questions directed at Thoughts, Explanation, Clarification.

between most recent client narrative process mode and previous therapist response mode $F(82, 1382) = .58, p = .99$. There were also no significant effects for client nested within therapist $F(13, 1382) = 2.80, p = .03$, indicating that therapists rated helpfulness consistently across clients.

In sum, the hypothesis that client helpfulness ratings can be predicted by client narrative response mode in the previous turn and therapist predominant verbal response mode in that turn was not supported.

Chapter 6: Discussion

The present study investigated the therapy process in the exploration stage. More specifically, I studied the relationship between therapist verbal response modes and client narrative process modes.

Research Question 1: What verbal response modes do therapists use in response to internal, external, and reflexive client narrative processes?

I found no significant association between therapist response mode and preceding client narrative process mode. In other words, therapists did not use significantly different response modes in response to different client narrative process modes. This contrasts with Hill et al. (1988), who found that therapists gave different responses when clients were at low versus moderate levels of experiencing. The difference in results could be due to a number of factors. First, the different client populations may have contributed to the difference in findings. Clients in the Hill et al. study had elevated scores on the Depression and Psychasthenia scales of the MMPI, whereas clients in the current study had elevated scores on the Beck Anxiety Inventory. Clients in the Hill et al. study were all over 25 years of age, whereas clients in the present study ranged in age from 19 to 24 ($M=20.67$, $SD=1.13$). In addition, the therapists in Hill et al. were experienced therapists who may have been more responsive to differences in clients' experiencing levels than the beginning therapists used in the current study. The experiencing scale used by Hill et al. may also be more sensitive than the narrative process mode system employed in the present study. Finally, Hill et al. combined both restatements and reflection of

feelings into a single category of paraphrase, which may account for some of the differences in findings between the two studies.

We were surprised by the results because it provides no evidence of therapists intervening based on different clients' narrative process modes. It may be that the therapists do not pay attention to client process, or think that different client narrative process modes did not call for different therapist response modes, but it is more likely that we did not use the right measure of client behavior to examine this question. Clients engage in a wide variety of behaviors in any given therapy session, and it seems inadequate to lump all behaviors into merely three categories. For example, there is a qualitative difference between a client's obsessive worry and a client's arrival at insight. However, in the narrative process coding system, both would be coded as reflexive, illustrating the weakness of the coding system for this particular study.

Research question 2: What narrative modes do clients use after each of the therapists' response modes?

When therapists gave a reflection of feeling or asked an open question directed at feelings, clients often used the internal narrative processing code. These results make intuitive sense, and fit theory (e.g. Hill & O'Brien, 1999) that therapists focusing on feelings helps clients talk about feelings.

Interestingly, it did not seem to matter if the therapists used reflections or open questions aimed at feelings, rather the focus on feelings was the important issue. In a very tightly controlled laboratory study, Hill and Gormally (1977) found that probes, as opposed to restatements or reflections of feelings, led to clients talking

more about their feelings. In other words, clients talked about their feelings when they were directly asked to talk about them. Hill and Gormally (1977) suggested that one reason probes resulted in a greater percentage of affect production than reflection of feelings or restatement may be that open questions contain a demand for a response. They found that clients usually did not even acknowledge the counselor's reflections or restatements, whereas many clients responded to the probes. However, in the current study it seemed that clients responded to open questions and reflection of feelings similarly. This difference in findings is likely due to the difference in methodology between the two studies. Hill and Gormally (1977) acknowledged that greater affect discussion was not necessarily due to a greater reinforcing power of probes, because counselor responses were not contingent upon cues from the clients but were rather administered at pre-determined intervals. The authors suggested that probes may have served the purpose of teaching the client how to behave in a counseling situation by subliminally instructing the client to focus on their feelings. Similarly, in the current study, the reflection of feelings and open questions of feelings likely instructed the client to focus on their feelings, regardless of how the request was communicated.

Research question 3: When clients shift from one narrative process mode to another, what therapist verbal response mode occurred in between?

Although there was some evidence to suggest that therapists' open question-feelings and reflections of feelings shifted clients to the internal narrative processing mode, the patterns only held for a few cases. It is interesting, however, that there was no evidence to suggest that open question-feelings or reflections of feelings shifted

clients from external to internal. It is plausible that therapists in this study hesitated to move clients from external to internal because of the nature of the session (first session, limited time). Therapists may have felt that hearing their clients' recount life events was important in developing a relationship and also in gathering a context for the session. First sessions are often spent gathering information about the presenting problem, and hence therapists likely felt that external narrative modes were valuable. However, they may have felt it more necessary to move clients out of reflexive and into internal because of the nature of clients' reflexive statements. In the reflexive narrative modes, clients were generally obsessively worrying. For example, a client statement "I just don't know what to do. I thought maybe I should talk to my mother about it because she started the whole mess, but she would probably just yell at me and we wouldn't get anywhere" would be coded as reflexive. A therapist may be more likely to respond by asking what it feels like to be stuck (in order to stop them from premature problem solving and instead focus on feelings) than to give restatements, which would likely encourage the client to continue their worrying.

Hypothesis 1: Client helpfulness ratings can be predicted by client narrative response mode in the previous turn and therapist predominant verbal response mode in that turn.

Hypothesis 2: Therapist helpfulness ratings can be predicted by client narrative response mode in the previous turn and therapist predominant verbal response mode in that turn.

Analyses suggested that there were no significant differences between both client and therapist helpfulness ratings for different therapist response modes or

narrative process modes. Hill et al. (1988) found that clients gave significantly different ratings for different therapist helping skills when skills were the only independent variable. However, when Hill et al. added other variables into the prediction model, therapist response modes no longer were significant predictors. Rather, client experiencing and therapist intentions were more important contributions. It is not clear why narrative process mode was not a significant predictor given that client experiencing levels were significant in the Hill et al. study. Perhaps the narrative process coding system was not sensitive to clients' shifts.

It is also possible that there really are no differences because all the skills are equally valuable for helping clients explore. After all, this study only examined helpful skills used by highly trained therapists. Therefore, we had a minimal range of helpfulness scores.

Conclusions

Although therapists did not use different response modes in response to different client narrative process modes, clients responded differently to different therapist response modes. More specifically, clients more often talked about feelings when therapists focused on feelings, either through reflection of feelings or open questions directed at feelings. Furthermore, when therapists asked open questions directed at feelings, clients often shifted from a reflexive mode to an internal mode and to maintain an internal mode. Finally, neither of the hypotheses were supported. Neither previous narrative process mode, therapist response mode, or an interaction significantly predicted either therapist or client ratings of helpfulness.

One possible explanation for these results is that what therapists do in the exploration stage actually doesn't matter. Exploration is a rather blunt stage, and it is possible that almost anything would lead the client to explore. The range of skills examined in this study was small, and they were all quite closely related. Perhaps if we included skills that are used less frequently such as self disclosures, interpretations, etc., the wider range of skills would lead to more differences in client reaction patterns and differences in helpfulness ratings. In addition, this was a naturalistic study in which 13 therapists all trained to similarly to use whatever skills seem to work at the time.

Limitations

There were several limitations to the current study. One limitation was the coding systems used. The narrative process coding system may not be sensitive enough to accurately measure client behavior. One concern is that the system clumps together what is in fact a large number of different client behaviors into only three categories. An example of this is the external category, which the coders felt was very broad. A client's speaking turn discussing a relationship experience that is related to her presenting problem would be coded as external, as would a client talking about her recent trip to the zoo. While both speaking turns clearly fit into the external code, one is participating more actively in the therapy experience than the other.

The range of therapist response modes included in this study was also very narrow and similar theoretically. When used in actual therapy, an open question-feelings and a reflection of feelings are very similar and not easily distinguished by

teams of coders (for example, “I wonder if you feel sad about that”). An inherent limitation in any coding system of behavior is that there will be limitations in the applicability of broad categories to specific examples. Many of the therapist response modes are closely linked theoretically, and it is difficult to code them using a concrete system.

Another limitation was the client population. Clients were anxious female undergraduates, and the study may not be generalizable to other populations. Perhaps the content and distribution of the narrative process codes would be different in a depressed population. One possibility is that the clients in the present study used anxiety as a defense against emotion, resulting in fewer internal narrative process modes and more external narrative process modes.

Another limitation was the experience level of the graduate student therapists. While some therapists were very experienced, other therapists were much less experienced and perhaps less attentive to their client’s affect. It is possible that because many of these graduate students were in the early stages of training, they lacked the responsiveness to client behaviors that more experienced therapists would exhibit. Although the large range of their experience is somewhat of a concern (range 8 to 450 hours of direct clinical service, $M = 145.38$, $SD = 152.52$), psychotherapy research indicates that therapist training, skill, experience, and style are weak contributors to outcome (Beutler, et al., 2003).

A final limitation is the utilization of the responsiveness paradigm, which is based on Stiles and Shapiro’s premise that determining what is most effective in therapy includes, among other things, identifying critical incidents. In the present

study, we identified critical incidents as the predominant therapist intervention and the preceding client narrative process code. It may be that critical incidents may best be measured by something else. Perhaps immediacy, the psychotherapy relationship, or therapy ruptures are more important critical incident that can better predict immediate outcome.

Implications

Research. Future research is needed to measure the delayed effects of therapist interventions. The present study only compared the helpfulness of therapist interventions immediately following a single client narrative process code. It is possible that helpfulness is actually rated not skill by skill, but rather with the entire session in mind. Perhaps when a client rates the helpfulness of an intervention, it is influenced by previous interventions. However, it is unknown whether clients take the whole session into account or rate based on significant previous events in the session. Future research could study the delayed effects of therapist interventions and how significant events in a session influence a clients rating of future events. More complex statistical models could be employed to demonstrate the delayed and differential effects of different therapist interventions throughout the session.

Future research could also study how therapists choose which interventions to deliver at different times. It is unlikely that they are simply acting randomly, so further research on therapists' intentions and choices may be like a promising direction. One approach to this question would be to ask therapists to write down their intentions for their interventions every time one is delivered. However, this could disrupt the flow of the session.

Practice. The results of this study indicate that both reflection of feelings and open question-feelings are equally effective in moving clients to a more affective narrative. According to many theories of psychotherapy (e.g. client-centered), feelings-oriented interventions are an important part of psychotherapy and should be utilized freely in order to encourage clients to explore their emotions in sessions. Although both reflection of feelings and open question-feelings were found in this study to be useful, in practice it is probably important to vary them in order to not sound redundant. It is important for therapists to be attentive to clients' reactions to their interventions, and to avoid becoming monotonous in the types of interventions they use.

Appendices

Appendix A: Client Recruitment Memo

Subject : Counseling Study

Location : Biology - Psychology

Seeking female volunteers for counseling study. Must experience difficulty with anxiety and be willing to meet with a trained therapist for one session of counseling. Time commitment will be approximately 3 hours; session will be held on campus. If interested, please contact Melissa Goates at mgoates@psyc.umd.edu or call 301- 405-5820.

For more information contact:

Melissa Goates

301-405-5820 , mgoates@psyc.umd.edu

Appendix B: Client Eligibility Interview Protocol

Interviewer: “Hello _____.” This is Melissa Goates and I am the primary investigator for the study you have volunteered to participate in. I am going to ask you a few questions to determine your eligibility for this study, but please know that if any of these questions make you uncomfortable you have every right to refuse to answer. Does that sound okay to you?”

Interview questions:

- 1) Do you experience problems with anxiety? (If answer is no, applicant is not eligible).
- 2) Are you currently in therapy for these problems? (If answer is yes, applicant is not eligible).
- 3) Are you on any psychotropic medications? If yes, for how long? (If applicant has been on psychotropic medications for less than 2 months, applicant is not eligible).
- 4) Have you thought about hurting yourself in the past 2 months? (If answer is yes, applicant is not eligible for the study. However, risk will be assessed and appropriate precautions will be taken).

If applicants are determined to be ineligible appropriate referrals will be made to competent licensed psychotherapists in the area.

Appendix C: Client Consent Form

Project title: Psychotherapy Processes in the Exploration Stage

Investigator: Melissa K. Goates, U of Maryland, College Park, 301-585-0599, mgoates@psyc.umd.edu ; Dr. Clara E. Hill, U of Maryland, College Park, hill@psyc.umd.edu

Approval period of project: September 16, 2002 to May 31, 2003

Purpose of study: This project is designed to examine the relationships between different events that happen within the therapy hour during the first part of the session.

Procedures: I am aware that I will be asked to participate in one counseling session followed by a videotape review of the session, in which I will be asked questions regarding my perception of the session. I am aware that there will be two trained research assistants observing the session from behind a two-way mirror. I am also aware that I will be asked to complete a brief questionnaire immediately following the session. I am aware that my participation in this study will take about 3 hours.

Confidentiality: I am aware that all information collected in the study is confidential, and that I will not be identified at any time. The research questionnaires will contain as the only identifier the last four digits of my social security number (or another 4-digit number known only to me), which will allow a research assistant to match up each students' responses to the different administrations. All questionnaires will be kept in a secure facility, my counselor will not have access to them at any time. The videotapes will be coded with a 4-digit number and stored in a locked file cabinet and will not be accessible to anyone other than the experimenters. The videotapes will only be viewed by experimenters, and when the study is over they will be destroyed. My counselor will not have access to my questionnaires for videotapes at any time, as the data is private.

Risk/benefit statement: I am aware that there are no known risks to my participation in this research. The research is not designed to help me personally, but the hope is that I will benefit from learning more about the process of counseling and having the opportunity to discuss some area of concern with a counselor-in-training. My participation will help the investigator hopes to learn more about the process and outcome of psychotherapy in the exploration stage so that, in time, better programs and techniques can be designed for assisting students to develop counseling skills. I am aware that I may withdraw from the study at any time without penalty.

Statement of Willingness to Participate: I understand that my participation is completely voluntary and that I may withdraw participation and consent at any point within the study without consequence. I also understand that I may ask questions at any time without penalty. I certify that I am over 18 years of age, in good physical health, and am willing to participate in the research project under the direction of Ms. Goates and Dr. Hill.

Printed Name _____ Signature _____ Date _____

If you have any questions about your rights as a research participant, you may contact the project directors listed above, Dr. Harold Sigall, 301-405-5920, Chair of Human Subjects Committee in the Department of Psychology at the University of Maryland.

Please keep a copy of the Consent Form for your records.

Appendix D: Therapist Consent Form

Project title: Psychotherapy Process in the Exploration Stage

Investigator: Melissa K. Goates, U of Maryland, College Park, 301-585-0599, mgoates@psyc.umd.edu ; Dr. Clara E. Hill, U of Maryland, College Park, hill@psyc.umd.edu

Approval period of project: September 16, 2002 to May 31, 2003

Purpose of study: This project is designed to examine the relationships between different events that happen within the first part of the therapy hour.

Procedures: I am aware that I will be asked to participate in a counseling sessions followed by a videotape reviews of the session, in which I will be asked questions regarding my perception of the sessions. I am aware that the counseling sessions will be viewed by two trained research assistants from behind a two-way mirror. I am also aware that I will be asked to complete a brief questionnaire following each session. I am aware that my participation in this study will take about 3 hours.

Confidentiality: I am aware that all information collected in the study is confidential, and that I will not be identified at any time. The research questionnaires will contain as the only identifier the last four digits of my social security number (or another 4-digit number known only to me), which will allow a research assistant to match up each students' responses to the different administrations. All questionnaires will be kept in a secure facility. The videotapes will be coded with a 4-digit number and stored in a locked file cabinet and will not be accessible to anyone other than the experimenters. The videotapes will only be viewed by experimenters, and when the study is over they will be destroyed. My client will not have access to my questionnaires for videotapes at any time, as the data is private.

Risk/benefit statement: I am aware that there are no known risks to my participation in this research. The research (completing the questionnaires) is not designed to help me personally, but the investigator hopes to learn more about the process and outcome of psychotherapy in the exploration stage so that, in time, better programs and techniques can be designed for assisting students to develop counseling skills. Completion of the questionnaires will give me an opportunity to reflect upon my development as a counselor to this point. I am aware that I may withdraw from the study at any time without penalty.

Statement of Willingness to Participate: I understand that my participation is completely voluntary and that I may withdraw participation and consent at any point within the study without consequence. I also understand that I may ask questions at any time without penalty. I certify that I am over 18 years of age, in good physical health, and am willing to participate in the research project under the direction of Ms. Goates and Dr. Hill.

Printed Name _____ Signature _____ Date _____

If you have any questions about your rights as a research participant, you may contact the project directors listed above, Dr. Harold Sigall, 301-405-5920, Chair of Human Subjects Committee in the Department of Psychology at the University of Maryland.

Please keep a copy of the Consent Form for your records.

Appendix E: Client Demographic Form

Name:

Address:

Telephone:

Preferred Time to Call:

Age:

Gender:

Race/Ethnicity: _____ Caucasian (non-Hispanic)
_____ African-American
_____ Asian-American
_____ Hispanic
_____ American-Indian
_____ Other (please specify)

Highest Degree Completed:

Occupation:

Have you ever been in therapy/counseling before? Yes / No
If yes, please describe (e.g. how long, group or individual, etc.)

Are you currently taking any medication that might intentionally or unintentionally affect your thoughts and feelings on a daily basis? (e.g. medication for depression or anxiety)?

No / Yes (please describe):

What do you hope to get out of this therapy experience? (Rank your interest)

_____ Changing my behaviors
_____ Changing my feelings
_____ Changing my thoughts
_____ Improving relationship(s)
_____ Learning about/understanding myself better
_____ Solving a problem
_____ Understanding a problem
_____ Other (please describe):

Are you willing to be audiotaped and videotaped, if all materials are confidential and destroyed after the study? Yes / No

Is there anything else that might affect your ability to participate in this study?

Appendix F: Therapist Demographic Form

Name:

Phone:

Age:

Gender:

Race/Ethnicity: _____ Caucasian (non-Hispanic)
_____ African-American
_____ Asian-American
_____ Hispanic
_____ American-Indian
_____ Other (please specify)

Departmental Area:

Year in program: 1 2 3 4 5 6 Other _____

Approximately how many hours of direct therapy service do you have?

Please circle how strongly you adhere to each of the following theoretical orientations:

Cognitive-Behavioral

1 2 3 4 5

Psychodynamic

1 2 3 4 5

Client-Centered

1 2 3 4 5

Appendix G: Videotape Review-Client Version

We are interested in knowing your reactions to therapist interventions. In every session, no matter how good the therapist is, there are helpful and hindering events that occur. You will be most helpful to us in our research by letting us know your honest reactions to what were the most and least helpful events that occurred during this particular session

When the tape is stopped, PLEASE TRY TO RECALL HOW YOU FELT AT THAT SPECIFIC POINT DURING THE SESSION. DO NOT RESPOND ACCORDING TO HOW YOU FEEL RIGHT NOW, BUT RATHER HOW YOU FELT AT THE TIME IN THE SESSION. Rate how helpful or hindering the most recent therapist intervention was using the helpfulness scale at the top of the coding form. Remember that the average rating should be a 5 and try to use the whole range of the scale.

REMEMBER THAT THERE ARE NO RIGHT OR WRONG ANSWERS.

SCALE

1 2 3 4 5 6 7 8 9

Hindering

Helpful

Response Unit #	Helpfulness Rating
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	

Appendix H: Videotape Review-Therapist Version

We are interested in knowing how you think the client was reacting to your interventions. In every session, no matter how good you are, there are helpful and hindering events that occur. You will be most helpful to us in our research by letting us know your honest reactions to what were the most and least helpful events that occurred during this particular session.

When the tape is stopped, TRY TO RECALL HOW YOU FELT AT THAT SPECIFIC POINT DURING THE SESSION. DO NOT RESPOND ACCORDING TO HOW YOU FEEL RIGHT NOW BUT RATHER HOW YOUR FELT AT THE TIME IN THE SESSION. Rate how helpful or hindering the most recent therapist intervention was using the helpfulness scale at the top of the coding form. Remember that the average rating should be a 5 and try to use the whole range of the scale.

REMEMBER THAT THERE ARE NO RIGHT OR WRONG ANSWERS.

SCALE

1.....2.....3.....4.....5.....6.....7.....8.....9

Hindering

Helpful

Response Unit #	Helpfulness Rating
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
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