7-22-2012

# What Happens when Therapists are More Directive? Correlating Directiveness with Psychotherapy Process and Outcome

Henry You-Chee Hua

# WHAT HAPPENS WHEN THERAPISTS ARE MORE DIRECTIVE? CORRELATING DIRECTIVENESS WITH PSYCHOTHERAPY PROCESS AND OUTCOME

by

Henry You-Chee Hua

A Thesis

Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Science

Major: Psychology

The University of Memphis

August 2012

ACKNOWLEDGMENTS

Many thanks to Holley Haley, Kerry Jackson, Ashlee Kellum, Jeremy Luno, Kati McClung, Kevin Newton, Luc Salazar, Uche Ugorji, and Nicole Whitaker for their assistance on this project. My gratitude goes to Megan Battles, Jonathan Burlison, and Catherine Reich for spending time to proofread my thesis, and to Peter Taggart for teaching me never to give up or surrender. My biggest thanks go to my mentor Jeffrey Berman for guiding this project through completion.

ABSTRACT

Hua, Henry You-Chee. M.S., The University of Memphis. August 2012. What Happens When Therapists Are More Directive? Correlating Directiveness with Psychotherapy Process and Outcome. Major Professor: Jeffrey S. Berman, Ph.D.

This study examined the relationship between therapist directiveness and the process and outcome of psychotherapy. Fifty-two therapy sessions were coded for turn-by-turn therapist directiveness, client compliance, and overall perceived therapist directiveness. These scores were compared to ratings of therapy process and outcome, reported by clients after the session. Additional analyses controlled for client compliance, pretreatment problem severity, and the interaction of directiveness with compliance. This study found no support for directiveness having any reliable relationship with the process or outcome of psychotherapy. Possible improvements are offered for future research on this topic.

TABLE OF CONTENTS

LIST OF TABLES

# CHAPTER 1

# INTRODUCTION

Directiveness in psychotherapy refers to "a wide range of goals and procedures…characterized by the therapist's openly exerting control over the treatment process" (Frank, 1973, p. 206). In contrast, treatments and therapists on the lower end of the directiveness continuum—often referred to as nondirective—allow the conversation to be directed by the clients, essentially having them decide the issues and concerns that will be discussed (Sommers-Flanagan & Sommers-Flanagan, 2009).

Theories about directiveness and related constructs have been debated since the 1940s (e.g., Hadley, 1953; Snyder, 1945; Thorne, 1944) and often incorporated into explanations for the process of psychotherapy, or the ongoing qualities of treatment and the relationship between the therapist and the client. Greenberg, Rice, and Elliott (1993) have written about the importance of using directiveness in moderation, arguing that too much therapist directiveness may impede client independence and emotional growth. On the other hand, it has been argued that directiveness can give the client the impression that the therapist is professional, knowledgeable, and strong (Sommers-Flanagan & Sommers-Flanagan, 2009), and that directiveness can reduce ambiguity in certain situations in which a therapist can take a client down a specific conversational path, confront self-deceptions, and stir up potent emotions (Frank, 1973).

In contrast, nondirectiveness has been argued to communicate respect for client cognitions and behaviors (Miller & Rollnick, 2002; Rogers, 1951). This is supplemented by theories that state client control over the session is linked to client self-awareness (Elliott, Greenberg, & Lietaer, 2004; Greenberg & Bolger, 2001) and self-healing (Williams & Levitt, 2007). Bohart (2003) broadly describes nondirective therapists as often having few preconceptions of what solutions may come about from therapy, and

that such therapists are facilitators of the conversation rather than experts who know the correct answers.

Therapist directiveness has also been theorized to relate to the outcome of certain treatments. For instance, directive treatments such as cognitive-behavioral therapy and systematic desensitization point the client in the direction needed for behavioral and cognitive change, with the therapist fulfilling the role of a teacher or a guide (Beutler et al., 2004; Frank, 1973; Sommers-Flanagan & Sommers-Flanagan, 2009). Certain treatments with less directiveness—such as Rogerian and emotion-focused therapies—are based on the theory that the clients will learn the importance of change and create their own solutions if the therapist provides an environment of empathy and acceptance while affording the clients the majority of the time to talk (Bohart, 2003; Sexton, Alexander, & Mease, 2004; Rogers, 1951). Empirical research, however, makes it a challenge to obtain a clear picture that either validates or refutes these theories.

Much of the current empirical understanding of directiveness comes from studies that compared the outcomes of whole treatments (Beutler et al., 1991; Borkovec & Costello, 1993; Karno, Beutler, & Harwood, 2002; Klausner et al., 1998; McLean & Hakstian, 1990; Miller, Benefield, & Tonigan, 1993; Shapiro et al., 1995). The relationship of directiveness and treatment effectiveness was inferred based on the effectiveness of treatments that varied on directiveness. A meta-analysis investigated studies that compared at least two treatments, and two-thirds of those studies linked the more-directive treatment to better outcome (Beutler et al., 2004). However, any outcome differences in these treatment-comparison studies risked entangling directiveness with any combination of other ways that the treatments were not equivalent. Although this type of methodology would demonstrate which treatment was more effective, outcome differences cannot necessarily be traced to directiveness because the treatments had many additional factors on which they differed.

Other researchers measured directive components of therapy to examine their relationship with various facets of the process of therapy (Barkham & Shapiro, 1986; Bischoff & Tracey, 1995; Elliott, Barker, Caskey, & Pistrang, 1982; Sadler, Ethier, Gunn, Duong, & Woody, 2009; Tiedens & Fragale, 2003). The existing literature does not provide clear patterns for process components such as empathy (Barkham & Shapiro, 1986; Wenegrat, 1976) and dominance (Sadler et al., 2009; Tiedens & Fragale, 2003). Meanwhile, client resistance (Bischoff & Tracey, 1995) and perceptions of therapist helpfulness (Elliott et al., 1982), were positively associated with therapist directiveness. Qualitative research found that clients preferred therapists who prepared a plan for the session (Littauer, Sexton, & Wynn, 2005).

This type of research has also associated directive components of therapy with the outcome of therapy (Karno & Longabaugh, 2005; Shaw et al., 1999; Stiles & Shapiro, 1994). Directive components identified in these studies consisted of specific behaviors such as interpretation, providing advice, and the use of closed-ended questions that restrict appropriate ways the client may respond. Contrasting with studies comparing whole treatments, this type of research addresses the complication of disentangling directiveness from other techniques or characteristics associated with a given treatment. Such studies too are mixed, as directiveness has been found to be positively, (Shaw et al., 1999), negatively (Karno & Longabaugh, 2005), and negligibly (Stiles & Shapiro, 1994) related to better outcome.

The heterogeneity of these findings can perhaps be attributed to two broad areas in which the literature differs. The first difference can be found in the dependent-variable constructs of interest. In addition to psychological process and outcome, directiveness has been investigated for its association with disparate dependent-variable constructs such as clients' alcohol consumption (Karno et al., 2002; Karno & Longabaugh, 2005; Miller et

al., 1993), noncompliance (Bischoff & Tracey, 1995; Patterson & Forgatch, 1985), and no-shows to therapy sessions (Tracey, 1986).

The second difference, the wide array of operational definitions for directiveness, provides additional information about directiveness with its own caveats. In some studies, directiveness was operationalized as subjective perceptual constructs including treatment structure (Shaw et al., 1999), therapist dominance (Sadler et al., 2009; Tiedens & Fragale, 2003), therapist assertiveness (Wenegrat, 1976), and therapist control (Sabatelli, Buck, & Dreyer, 1983). Such studies observed therapy sessions and scored directiveness using coding systems that generalized to perceptions of the session (Fisher, Karno, Sandowicz, Albanese, & Beutler, 1995; Karno et al., 2002; Karno & Longabaugh, 2005; Stiles & Shapiro, 1994).

Other studies measured directiveness each time the therapist spoke for a list of behaviors such as topic initiation (Tracey, 1986), confronting the client (Bischoff & Tracey, 1995), providing advice (Barkham & Shapiro, 1986; Elliott et al., 1982), interpretation (Stiles & Shapiro, 1994), closed-ended questions (Elliott et al., 1987; Fisher et al., 1995; Friedlander, 1982; Karno & Longabaugh, 2005). However, operationalizing directiveness as a count of specific behaviors does not necessarily provide information about the degree of directiveness of each occurrence. For example, if therapist interpretation was among a study's list of directive behaviors, all instances of interpretation would then be considered equally directive.

One measure representing how the construct of directiveness can vary during any in-session behavior is *response restriction*, or the therapist narrowing down the number of relevant ways the client can respond. Identified behaviors such as closed-ended questions (e.g., Karno & Longabaugh, 2005), and the seeking of further information (e.g., Friedlander, 1982) can be described as restrictive, and the amount of restrictiveness can vary between occurrences. For example, an information-seeking direction such as, "Tell

me more," has an open-ended expectation of the number of appropriate responses, but an information-seeking turn such as, "Of the three things upsetting you, which one was most upsetting?" would be more restrictive, as it offers the client fewer degrees of freedom for where the conversation could go next.

A different way to conceptualize directiveness could be the degree that the therapist takes the initiative and attempts to shift the conversation to issues and events not previously brought up by the client. This type of directiveness, which can be termed *topic change*, can occur with restriction; perhaps the therapist switches the topic and insists they discuss a certain aspect of it. Topic change may also occur without restriction; perhaps the therapist changes the topic but allows a great deal of freedom for how this topic can be addressed. Likewise, restriction can occur with topic change or without topic change, such as in the case of a therapist asking a multiple-choice question that could contain new topics or no new topics among the choices.

One more measure of therapist directiveness that can be seen in each speech turn is a word count of the speech turn, as it can be argued that turns with more words occupy more time in which the client does not speak.

Topic change, response restriction, and word counts can occur independently of each other during speech turns in therapy, and client adherence to such attempts can be conceptualized as the degree the client complies with therapist direction. Directiveness may have different meanings depending on the match of client compliance. For example, a therapist may use a certain amount of directiveness for different clients, and perhaps one client follows up by complying, and another client may reject that therapist's attempts to control the session. It would not be surprising if those cases ended up with different results, as therapy sessions with a poor match between therapist directiveness and client compliance have been linked with poorer treatment outcomes (Beutler, Harwood, Michelson, & Song, 2011).

Therefore, the current study investigated the relationship of therapist directiveness with psychotherapy process and outcome while addressing client compliance and its interaction with directiveness. This study rated psychotherapy transcripts on multiple measures that rated directiveness for each time the therapist spoke and for overall perceived therapist directiveness. These scores were then assessed for any relationship with client self-reports of therapy process and outcome directly after the session.

# CHAPTER 2

# METHOD

## *Therapy Transcripts*

The study used 52 therapy transcripts from a larger project conducted from 2004 to 2007 at the Center for Psychological and Career Counseling at the University of Memphis. This project asked clients to fill out a questionnaire of therapy process and outcome measures after the session. The majority of the selected transcripts came from Session 3, the most commonly transcribed session. For cases lacking a Session 3 transcript or client self-report measures, Session 2 or Session 4 transcripts were used if they were linked with client self-reports. To streamline discussion, the coded sessions will all be referred to as Session 3.

## *Therapists*

The current study included 16 therapists, 15 of whom (3 males, 12 females) provided demographic information. This sample included 11 Caucasians, 3 Asian or Pacific Islanders, and 1 African American. One therapist had a PhD degree, 13 therapists had a master's degree, and 1 therapist had a bachelor's degree. Their job positions included 1 paid staff, 9 practicum students, and 5 interns. Training orientations included 5 cognitive-behavioral therapists, 2 feminist therapists, 2 humanistic therapists, and one therapist each using a constructivist, client-centered, family-systems, multicultural, integrative, or eclectic approach. Mean therapist experience was 3.21 years ($SD$ = 2.02) ranging from less than 1 year to 7 years. Each therapist saw an average of 3.25 clients ($SD$ = 2.67) in this dataset, with a range of 1 to 11 clients per therapist.

## *Clients*

The dataset consisted of 52 clients (20 males, 32 females). The mean age was 25 years (range = 18–44 years). Thirty-six clients identified themselves as Caucasian, 10 as

African American, 2 as Hispanic, 1 as an unspecified "mixed" race, and 1 as an unspecified "other" race. One client did not provide demographic information.

*Observers*

Eight research assistants (mean age = 24.50 years, range 21–32 years) from the Psychotherapy Research Lab at the University of Memphis coded the transcripts. Each observer coded the complete set of 52 transcripts. There were 3 male and 5 female observers.

*Procedure*

*Observer Recruitment.* Observers were selected from the research assistants of the University of Memphis Psychotherapy Research Lab.

*Observer Training.* An instructional document for the directiveness measures (see Appendix A.1) was used in conjunction with a verbal presentation during which the investigator provided a demonstration for each directiveness measure. Training finished with a question-and-answer session and a supervised practice-coding of a simulated therapy transcript unrelated to the current dataset. Observers began coding the actual transcripts after their performance on the simulated transcripts reflected understanding of the coding procedure.

*Coding Procedure*. Observers rated all 52 transcripts for every speech turn, defined as a pair of occurrences in which the therapist and then the client spoke a series of whole substantive words that carried meaning. Speech turns began with the therapist's substantive words, continued until the client spoke substantive words, and ended at the next instance of substantive therapist speech. The next speech turn began at that point. The therapist's part in the speech turn will be referred to as the *therapist speech turn*, and the client's part will be referred to as the *client speech turn.* Brief utterances such as "mm-hmm" or "I see" were not coded. After each transcript was coded, observers

completed a questionnaire assessing their subjective impressions of the directiveness of that session. Coding lasted approximately 7 months.

*Observer Measures*

*Speech Turn Measure*. Each therapist speech turn was rated for response restriction, the degree that the therapist limited the amount of pertinent responses of the client's following speech turn. Response restriction was scored from 0 to 4 (0 = *low*, 2 = *moderate*, 4 = *high*), and was highly reliable, Cronbach's $\alpha$ = .93. The lowest degree of restriction permitted an open-ended expectation of nearly unlimited possible responses from the client. High restriction set up the client to select from a limited number of options to continue the conversation pertinently. Because speech turns could have many sentences and ideas, response restriction ratings focused on the end of the therapist speech turn.

Every client speech turn was rated for client follow-up, or how closely the client addressed the therapist's turn. Ratings were made from 0 (*low*) to 4 (*high*). Lower scores were given if the client either did not or barely addressed the therapist's words, and higher scores were given if the client followed therapist direction. The reliability of this measure was relatively modest, Cronbach's $\alpha$ = .55.

Topic change for every speech turn was coded dichotomously. Focusing on the end of each therapist speech turn, a score of 0 was given if no new issues or events were brought up by the therapist, and a score of 1 was given if the therapist attempted to shift the conversation onto a different issue or event than the ones discussed in the previous client turn. Therapist topic change had modest reliability, with Cronbach's $\alpha$ = .68. The client's turn was rated for whether it continued from issues and topics mentioned by the therapist. A score of 0 indicated that the client's topic was predominantly unfocused on topics from the therapist's last turn, and a score of 1 indicated that the client's speech turn

predominantly focused on topics from the therapist's last turn. Client topic compliance was only modestly reliable, Cronbach's $\alpha = .64$.

The speech turn measure also recorded word count of each therapist and client speech turn.

*Perceived Directiveness Measure*. Observers provided subjective impressions of the therapy session. Perceived directiveness refers to holistic aspects of the session that could not necessarily be discerned from turn-by-turn ratings, such as session structure and the therapist's role as a teacher. Ratings ranged from 1 (*not at all*) to 5 (*very much*), and this measure had good reliability, Cronbach's $\alpha = .88$. This measure used items written by the investigator as well as modified items from Fisher et al.'s (1995) Systematic Treatment Selection Therapy Rating Scale. (See Appendices A.2 and A.3 for all measures created for this study).

*Measures for Analysis*

One possible method of data analysis was to aggregate the measures for directiveness, and aggregate the measures for compliance, essentially creating one measure each for directiveness and compliance. However, the current effort analyzed each measure separately, for certain reasons inherent to this dataset. The therapist directiveness measures correlated positively with each other, and two of the three correlations between the client compliance measures were positive, suggesting some shared variance among these aspects of both directiveness and compliance; for a full list of these correlations, please see Tables 1–2 of the Results section. However, despite the prevalence of correlations in the positive direction, these correlations were mostly modest in size. Although the measures for therapist directiveness were considered in the same conceptual category—as were the measures for client compliance—the current analysis used the individual measures in order to produce a clearer pictures of the different aspects of directiveness and compliance that may have been obscured with aggregation.

*Client Process Measures*

*Emotional Arousal Session Report Measure* (Warwar & Greenberg, 2002). Clients reported the intensity of the session's emotionality. The selected items contained 14 emotions including sadness, fear, pride, and forgiveness on a survey designed to assess the extent the client was emotionally aroused during the therapy session. Ratings were made on a 7-point scale (1 = *not at all*, 7 = *very much*). (See Appendix A.4 for a document called the postsession reflection questionnaire, which contains all client measures that administered at the time of treatment).

*Client Working Alliance Inventory, Short Form* (Tracey & Kokotovic, 1989). A 12-item questionnaire assessed the client's perceived alliance with the therapist. Items included, "I believe my therapist likes me" and "We agree on what is important for me to work on," and were scored from 1 (*never*) to 7 (*always*) such that higher scores indicated better degrees of alliance.

*Session Evaluation Questions*. Clients reported their experience of the session on a 6-item questionnaire that included items such as, "How helpful do you feel your therapist was to you in this session?" and "How much did you hold back feelings from your therapist during this session?" Items were scored from 1 (*not at all*) to 7 (*very much*). After the proper items were reverse-coded, higher scores of this measure reflected greater satisfaction with the session.

*Client Outcome Measures*

*Symptom Checklist-5* (Tambs & Moum, 1993). Anxiety and depression were rated on a 5-item survey with responses ranging from 1 (*not at all*) to 4 (*extremely*).

*Beck Depression Inventory for Primary Care* (Beck, Guth, Steer, & Ball, 1997). Client depression was assessed with a 7-item survey developed to diagnose major depressive disorder in primary care settings. This survey measured levels of sadness, hopelessness about the future, perceptions of failure, life satisfaction, blame, and suicide

ideation. Each item was rated in 4 categories of increasing intensity. For example, sadness ranged from 1 (*I do not feel sad*) to 4 (*I am so sad or unhappy that I can't stand it*).

*Outcome Questionnaire 45.2* (Lambert et al., 1996). Clients rated the quality of interpersonal relationships on 11 items of the Outcome Questionnaire. The relevant items included, "I get along well with others" and "I am concerned about family troubles." Ratings existed on a 5-point scale where, after some appropriate reverse-coding, higher scores indicated worse degrees of the quality of interpersonal relationships (1 = *never*, 5 = *almost always*).

*Presenting Problem Distress.* Before the start of the first treatment session, clients provided their presenting problem, or reason that they sought out therapy. After Session 3, clients were asked to rate the severity that the original presenting problem was still distressing to them. This was measured on a 7-point scale, with higher scores corresponding to higher distress.

# CHAPTER 3

# RESULTS

After the therapy transcripts were coded for directiveness and compliance, their scores were investigated for any possible relationships with the process and outcome of therapy. The first step was to determine if the measures for each construct were related. As can be seen in Table 1, all measures for therapist directiveness were positively correlated. Response restriction reliably covaried with two other measures, topic change and overall perceived directiveness. Additionally, the average number of words in a therapist speech turn had a statistically significant relationship with perceived directiveness. The other correlations were positive but small to modest. These positive correlations suggest that these were related constructs that shared variance with the common construct of therapist directiveness.

Table 1

*Correlations of the Therapist Directiveness Measures*

| | Turn-by-turn | | | |
|---|---|---|---|---|
| | Response restriction | Topic change | Word count | Perceived directiveness |
| Response restriction | — | | | |
| Topic change | .47* | — | | |
| Word count | .10 | .23 | — | |
| Perceived directiveness | .38* | .20 | .32* | — |

*Note.* N = 52.

*$p < .05$.

Table 2 displays correlations of the client compliance measures. There is mixed evidence about whether they shared variance with a common construct. Client follow-up was reliably related to the average number of words in a client's speech turn. Follow-up was also positively related to client compliance of the therapist's topic, but the size of this relationship was modest. The degree of client topic compliance was strongly yet inversely linked to the amount of words spoken by the client, which could suggest that these two particular aspects of client compliance did not behave the same way.

Table 2

*Correlations of the Client Compliance Measures*

| | Follow-up | Topic compliance | Word count |
|---|---|---|---|
| Follow-up | — | | |
| Topic compliance | .27 | — | |
| Word count | .35* | -.61* | — |

*Note.* N = 52.

*$p < .05$.

The correlations in Table 3 indicate the strength and direction of the relationships of the therapist directiveness measures with the client compliance measures. In broad terms, these data modestly suggest that the therapist–client relationship is characterized with clients complying with therapists. Higher degrees of therapist response restriction were linked with increased instances of the client complying with the therapist's topic, and increased instances of therapist topic changes were linked with greater degrees of the client's follow-up of the therapist's turn. It is interesting to note that these two therapist

directiveness measures had statistically significant correlations with the client compliance measure intended to correspond with the other therapist measure. The amount of perceived directiveness was reliably correlated with client topic compliance, and also with briefer client responses. However, this pattern should not be over-interpreted, as the pattern is somewhat loose; for example, despite topic change having a reliable link with client follow-up and word count, the link with client topic compliance was almost 0.

Table 3

*Correlations of Therapist Directiveness and Client Compliance Measures*

| | Therapist directiveness | | | |
|---|---|---|---|---|
| Client compliance | Response restriction | Topic change | Word count | Perceived directiveness |
| Follow-up | .24 | .29* | .22 | -.09 |
| Topic | .29* | .02 | .21 | .41* |
| Word count | -.23 | .28* | .17 | -.35* |

*Note.* N = 52.

*$p < .05$.

Table 4 indicates the strength of the direct, unmodified relationships between the therapist directiveness measures and each of the therapy process and outcome measures. The top half of the table focuses on the therapy process measures: emotional intensity, working alliance, and client evaluation of the session. These relationships were quite small, many of them approaching zero, and none were statistically significant. There appears to be no pattern.

Table 4

*Correlations of Therapist Directiveness Measures with Therapy Process and Outcome*

| | Turn-by-turn | | | |
|---|---|---|---|---|
| Therapy measure | Response restriction | Topic change | Word count | Perceived directiveness |
| | Process | | | |
| Emotional intensity | .00 | -.08 | -.17 | -.06 |
| Working alliance | -.24 | -.10 | .08 | -.09 |
| Session evaluation | -.06 | -.03 | .20 | .00 |
| | Outcome | | | |
| Symptom checklist items | .21 | .05 | -.01 | .22 |
| Depression items | .17 | .01 | -.02 | .00 |
| Interpersonal distress | .22 | -.17 | -.12 | .04 |
| Presenting problem distress | -.17 | -.21 | .14 | .10 |

*Note.* N = 50–51. No *r* was statistically significant (all *p*s > .05).

The bottom half of Table 4 focuses on the outcome measures: items from the Symptom Checklist, items of the Beck Depression Inventory, excerpts of the Outcome Questionnaire that focus on interpersonal distress, and a measure of presenting problem distress. As with the therapy process measures, there were no reliable relationships. Aside from many of the correlations being very close to zero, there were no clear patterns in this table.

Table 5 displays the strength of the direct, unmodified relationships between the measures of client compliance with the measures for therapy process and outcome. These

correlations were small, and most approached zero. Although this study failed to find significant direct relationships in therapist directiveness or client compliance, it was theorized that relationships may emerge by controlling for various other predictors. Several models were created to investigate therapist directiveness by analyzing one directiveness measure at a time while controlling for a client measure or characteristic.

Table 5

*Correlations of Client Compliance Measures with Therapy Process and Outcome*

| Therapy measure | Follow-up | Topic compliance | Word count |
|---|---|---|---|
| | Process | | |
| Emotional intensity | .21 | -.04 | -.03 |
| Working alliance | .02 | -.03 | .08 |
| Session evaluation | .15 | -.03 | .17 |
| | Outcome | | |
| Symptom checklist items | -.04 | -.04 | -.08 |
| Depression items | .05 | .03 | -.02 |
| Interpersonal distress | .05 | -.10 | .02 |
| Presenting problem distress | .01 | -.09 | .08 |

*Note.* N = 50–51. No *r* was statistically significant (all *p*s > .1).

One model was created to predict therapy process and outcome with therapist response restriction. This model controlled for client follow-up, which was designed to correspond explicitly with response restriction as the equivalent measure for client compliance. Table 6 presents the unique relationship of therapist response restriction and

the client's follow-up as part of the same predictive model. There was no clear pattern, and these modest correlations failed to indicate the presence of any reliable relationships.

Table 6

*Partial Correlations of Therapist Response Restriction and Client Follow-Up with Therapy Process and Outcome*

| Therapy measure | Response restriction | Follow-up |
|---|---|---|
| | Process | |
| Emotional intensity | -.03 | .21 |
| Working alliance | -.26 | .09 |
| Session evaluation | -.10 | .17 |
| | Outcome | |
| Symptom checklist | .21 | -.07 |
| Depression items | .17 | .01 |
| Interpersonal distress | .22 | .02 |
| Presenting problem distress | -.17 | .03 |

*Note.* N = 50–51. No *r* was statistically significant (all *p*s > .05).

Table 7 contains the correlations of a model that assessed for therapist topic change while controlling for its directly equivalent client measure, compliance to the topic or topics that the therapist used. Each column displays the unique correlation between therapist topic change and client topic compliance on the therapy measures. As with the model from Table 6, both measures were used as predictors in the same model. It was difficult to discern any pattern. Moreover, the correlations with therapy process and

therapy outcome both consist of statistically nonsignificant relationships that approach zero.

Table 7

*Partial Correlations of Therapist Topic Change and Client Topic Compliance with Therapy Process and Outcome*

| | Topic | |
|---|---|---|
| Therapy measure | Therapist change | Client compliance |
| Process | | |
| Emotional intensity | -.08 | -.04 |
| Working alliance | -.10 | -.03 |
| Session evaluation | -.03 | -.03 |
| Outcome | | |
| Symptom checklist | .05 | -.04 |
| Depression items | .01 | .03 |
| Interpersonal distress | -.17 | -.10 |
| Presenting problem distress | -.21 | -.09 |

*Note.* N = 50–51. No *r* was statistically significant (all *p*s > .1).

The model summarized in Table 8 was used to investigate the connection between therapist word counts per turn and therapy process and outcome. This model controlled for the average number of words in client speech turns by entering the average word count of both speakers as predictors. As with the preceding analyses, the relationships

were quite small. Due to how close these relationships were to zero, it was difficult to infer patterns from the direction and size of these correlations.

Table 8

*Partial Correlations of Word Counts with Therapy Process and Outcome*

| Therapy measure | Word count | |
|---|---|---|
| | Therapist | Client |
| Process | | |
| Emotional intensity | -.16 | .00 |
| Working alliance | .07 | .06 |
| Session evaluation | .18 | .14 |
| Outcome | | |
| Symptom checklist | .01 | -.08 |
| Depression items | -.01 | -.02 |
| Interpersonal distress | -.13 | .04 |
| Presenting problem distress | .12 | .06 |

*Note.* N = 50–51. No *r* was statistically significant (all *p*s > .2).

The models presented in Tables 9 and 10 investigated perceived therapist directiveness while controlling for client compliance. Because this study did not have a directly corresponding client equivalent for the therapist's perceived directiveness, the turn-by-turn measures of client compliance were used. Table 9 presents the unique

relationships of perceived therapist directiveness and client follow-up on therapy process and outcome. There were no statistically significant correlations or notable patterns.

Table 9

*Partial Correlations of Perceived Therapist Directiveness and Client Follow-Up with Therapy Process and Outcome*

| Therapy measure | Perceived therapist directiveness | Client follow-up |
|---|---|---|
| | Process | |
| Emotional intensity | -.05 | .20 |
| Working alliance | -.09 | .02 |
| Session evaluation | .01 | .15 |
| | Outcome | |
| Symptom checklist | .22 | -.03 |
| Depression items | .01 | .05 |
| Interpersonal distress | .05 | .05 |
| Presenting problem distress | .10 | .01 |

*Note.* N = 50–51. No *r* was statistically significant (all *p*s > .1).

Table 10 displays the results from a similar test, this time controlling for perceived therapist directiveness with client topic compliance, the other turn-by-turn client measure created for this study. Unfortunately, this model also failed to show any noteworthy relationships with the perceived therapist directiveness measure after controlling for

client compliance. Many of these correlations approached zero. The direction and size of these correlations presented no obvious patterns.

Table 10

*Partial Correlations of Perceived Therapist Directiveness and Client Topic Compliance with Therapy Process and Outcome*

| Therapy measure | Perceived therapist directiveness | Client topic compliance |
|---|---|---|
| | Process | |
| Emotional intensity | -.05 | -.02 |
| Working alliance | -.08 | .00 |
| Session evaluation | .02 | -.04 |
| | Outcome | |
| Symptom checklist | .25 | -.14 |
| Depression items | -.10 | .03 |
| Interpersonal distress | .09 | -.13 |
| Presenting problem distress | .15 | -.15 |

*Note.* N = 50–51. No *r* was statistically significant (all *p*s > .1).

Additional statistical tests were performed to control for client problem distress before the start of treatment. The first step was to identify process and outcome measures that significantly covaried with pretreatment problem distress, and two such measures were identified. There was one process measure, working alliance, $r(49) = .33$, $p = .02$, and one outcome measure, post-Session 3 presenting problem distress, $r(49) = .43$, $p <$

.01. A new set of models was created to identify the unique relationship between therapist directiveness and the appropriate therapy measures while controlling for pretreatment problem distress, and these results are shown in Table 11.

Table 11

*Partial Correlations of Therapist Directiveness Measures Controlling for Pretreatment Problem Distress*

| Therapy measure at Session 3 | Response restriction | Topic change | Perceived directiveness |
|---|---|---|---|
| Working alliance | -.18 | -.09 | -.12 |
| Presenting problem distress | -.11 | -.21 | .08 |

*Note.* N = 50–51. No *r* was statistically significant (all *p*s > .1).

Despite a plausible reason to control for pretreatment distress, this did not uncover any remarkable relationships. Therapist response restriction, topic change, and perceived directiveness were very weakly related with working alliance, as can be seen in the top row. Although there was a pattern—all three correlations were negative—even the strongest of these was too small for this pattern to be meaningful. The second row of Table 11 contains the unique correlations between the client's post-Session 3 presenting problem distress with the directiveness measures. The correlations with were small and without pattern. Therefore, this study did not find evidence for pretreatment symptom distress playing any role in the connection between therapist directiveness and therapy process or outcome.

The last series of models using the full dataset investigated whether the relationship between therapist directiveness and therapy process and outcome depended on client

compliance. This interaction can alternately be described as the matching of therapist use of directiveness with client use of compliance. The strength of this interaction was used as a predictor along with the individual directiveness and compliance measures used to create that interaction term.

The correlations in Table 12 indicate the size of the unique relationship of the interaction term with process and outcome, controlling for the individual measures. Each correlation represents the additional variance accounted for beyond what was found with only the measures used to create the interaction term in the model. Each column displays the name of a turn-by-turn directiveness measure, which was interacted with its corresponding client compliance measure. For example, the first column used therapist response restriction, client follow-up, and their interaction as predictors, and only the partial correlations unique to the interaction term are displayed. Not shown in the table, the unique relationships of the individual directiveness and compliance measures remained small, many near zero.

Even taking into account the varying ways directiveness could relate to therapy process for different levels of client compliance, there were no reliable relationships or patterns, as seen in the top half of Table 12. There was a trend in the relationships between the therapy outcome measures and the degree that therapist topic changes matched client topic compliance, and this can be seen on the bottom half of Table 12. This interaction was inversely linked with scores on the outcome measures; in other words, matching client compliance to therapist topic changes was related to better outcome. Reliable relationships were found with the Beck Depression items and the interpersonal distress items of the Outcome Questionnaire. The relationships were not significant for the Symptom Checklist items or presenting problem distress. It should be noted that Table 11 has 21 correlations, and only two reached statistical significance.

Therefore, perhaps this trend arose by chance, and these large correlations should not be over-interpreted.

Table 12

*Partial Correlations Assessing Degree Therapist Directiveness Relationships with Therapy Process and Outcome Varied Depending on Corresponding Client Compliance Measure*

| | Therapist directiveness measure | | |
|---|---|---|---|
| Therapy measure | Response restriction | Topic change | Word count |
| | Process | | |
| Emotional intensity | -.16 | .01 | -.01 |
| Working alliance | .02 | .13 | -.03 |
| Session evaluation | .00 | .15 | -.18 |
| | Outcome | | |
| Symptoms checklist | -.16 | -.18 | .19 |
| Depression items | .11 | -.32* | .05 |
| Interpersonal distress | -.14 | -.29* | .11 |
| Problem distress | -.12 | -.25 | .04 |

*Note.* N = 50–51. To create the interaction terms, standardized scores of the therapist measure displayed in the column headings were multiplied by standardized scores of the corresponding client measure. The displayed partial correlations come from models that controlled for the variance attributed to the therapist directiveness and client compliance measures.

*$p < .05$.

Table 13 contains the partial correlations unique to the interaction of perceived directiveness and client compliance[1]. The measures used to create these interaction terms were used as predictors in the model, but the partial correlations are not displayed; results were statistically nonsignificant, with most of them near zero.

Four follow-up analyses were conducted, each selecting a subset of data. The first follow-up analysis evaluated the models presented in Tables 4–13 using only the therapist directiveness and client compliance ratings from the fourth quarter of the therapy session. Because clients filled out the measures after the session, this analysis evaluated whether there was a stronger relationship between the process and outcome measures and the closing segment of the session. The pattern remained very similar to the results using all four quarters of the therapy session. There were occasional instances where correlations increased modestly, but these were matched with a comparable amount of instances in which correlations became smaller. The majority of the results consisted of very small correlations, most near 0.

The purpose of the second follow-up analysis was to detect if the relationship between therapist directiveness and the process and outcome of psychotherapy became stronger using only the sessions that had high or low therapist directiveness. These analyses used the statistical models presented in Tables 4–13, using cases at least one standard deviation above or below the mean for the therapist directiveness measure of the given model. The correlations were generally larger than the data using the full dataset, but the direction of these correlations was inconsistent within almost every model, and

---

[1] All reported analyses from Tables 1–13 were repeated at the therapist level, with each therapist's caseload aggregated into one unit of observation per therapist. These results consisted of small or modest correlations with no clear patterns, and occasional but isolated instances of statistical significance. Multi-level models, which simultaneously explained therapist and client variance, found that therapist differences were a redundant predictor, as they did not reliably account for variance in the dependent variables; therefore, results of the multi-level models were nearly identical to the reported results, which used each client as the unit of observation.

many correlations approached 0. Despite the modestly stronger effect sizes, statistical significance was rare and perhaps best explained by capitalizing on chance.

Table 13

*Partial Correlations Assessing Degree Perceived Therapist Directiveness Relationships with Therapy Process and Outcome Varied Depending on Client Compliance*

| | Client measure multiplied with perceived therapist directiveness | |
|---|---|---|
| | Follow-up | Topic compliance |
| | Process | |
| Emotional intensity | -.16 | -.16 |
| Working alliance | -.06 | .16 |
| Session evaluation | .12 | .15 |
| | Outcome | |
| Symptoms checklist | -.13 | -.29* |
| Depression items | -.10 | -.18 |
| Interpersonal distress | -.15 | -.15 |
| Problem distress | .02 | .07 |

*Note.* N = 50–51. Only the partial correlations unique to the interaction term are shown. These models controlled for the variance attributed to perceived therapist directiveness and the client compliance measure listed in each column heading.

*$p < .05$.

The third follow-up investigated whether the results varied depending on therapist training. The therapists were divided into two groups. One group consisted of directive therapists, defined as those trained in cognitive-behavioral therapy, the sole orientation which trained for directiveness in this dataset. The other group, the nondirective therapists, were trained in orientations that encouraged client self-direction. Therapists in the nondirective group received training in feminist, humanistic, client-centered, or constructivist orientations. Integrative, eclectic, and family systems therapists were not used in this follow-up analysis because these orientations lacked a clear stance on the use of directiveness. Statistical models evaluated whether relationships between the independent and dependent variable measures depended on the therapist being trained in a directive or nondirective orientation, herein referred to as *training type*. Interaction terms were created by multiplying the training type with the therapist directiveness and client compliance measures; these interaction terms were used as predictors in models that controlled for the variance attributed to the training type and the measure itself. With 49 tests total—four therapist directiveness measures and three client compliance measures each predicting three process measures and four outcome measures—there were only two statistically significant relationships. The relationship between client follow-up and Symptom Checklist items reliably varied by training type, $F$ (1, 35) = 4.29, $p$ = .05. Therapist word count had a significant relationship with presenting problem distress when moderated by training type, $F$ (1, 34) = 5.28, $p$ = .03. With only two of 49 tests showing reliable results, chance occurrence is perhaps the most parsimonious explanation.

As the fourth follow-up, the models presented in Tables 4–13 were repeated to assess whether Session 3 ratings of directiveness and compliance could predict therapy characteristics later in treatment. Session 6 was chosen as an appropriate second time point because, at 23 cases, it was the second most plentiful session that was linked with

client self-reports for the dependent variable measures. To summarize, the analyses predicting Session 6 process and outcome with the Session 3 ratings had no noteworthy trends. In the same vein as the analyses with the full dataset, the results consisted primarily of statistically nonsignificant effect sizes, many of them near zero. When looking for trends in these results, either with the size or direction of the correlations, no apparent patterns emerged. Although there were occasional instances of statistical significance, such instances were rare and not part of a bigger pattern. The possibility of these few reliable relationships arising from chance occurrence seems to be more parsimonious than any deeper interpretation. As the data from the follow-up tests showed no patterns or interpretable results different from those of the full analyses, the data are not displayed.

# CHAPTER 4

# DISCUSSION

The purpose of this study was to identify and interpret any potential relationships between therapist directiveness and the process and outcome of therapy by coding for directiveness using multiple measures similar, in concept, to those of other studies (e.g., Elliott et al., 1987; Karno & Longabaugh, 2005). Where the current effort differed was that it investigated therapy process and outcome from a within-study rather than between-study perspective. Unfortunately, the results consistently failed to indicate the reliability of such relationships.

Because of the lack of evidence for direct relationships, it was thought that perhaps directiveness was related to therapy process and outcome as a function of client compliance. Some authors (Peluso, Liebovitch, Gottman, Norman, & Su, 2012; Stiles, 2009) theorize that the psychotherapy relationship is an interactive process, where therapists and clients consistently respond in ways that depend on the context established by the directly preceding turn. Stiles (2009) named this construct *responsiveness* and suggested that results of treatment studies could be difficult to interpret as simple relationships between the dependent and independent variables. Words spoken by the therapist were theorized to affect the client's response, which would feed back into the therapist's next speech turn, therefore having the two speakers influencing each other in a feedback loop.

The fact that ratings were made for the therapist and client at each turn seemed to make responsiveness an applicable construct to interpret the results for this study. Based on the correlations between the therapist and client measures, there was a loose pattern of clients going along with discussion topics mentioned by the therapist, which aligns with previous literature (Peluso et al., 2012; Stiles, 2009). In addition to client compliance, the interaction between therapist directiveness attempts and client compliance was examined

for any connection to the therapy measures beyond what was already accounted for by the simple relationships. Although the theory was sound, the relationships were small. One possible theory linking the almost-complete prevalence of small effect sizes is that therapist directiveness does not relate to therapy process or outcome.

Although it would exceed the bounds of these findings to conclude that therapist directiveness truly has no effect on the process or outcome of therapy, it is interesting to speculate about the potential ramifications if there were truly no relationship. Psychotherapy research has a history of mixed findings about the causal factors of effective treatment (Lambert & Ogles, 2004) and covers such topics as the differential effectiveness of treatments (e.g., Luborsky, Singer, & Luborsky, 1975; Wampold, 2001) and therapist characteristics including age, race, and amount of training (Beutler et al, 2004). Such research has not reached a clear consensus about the most effective treatment, the best type of therapist training, or the most effective technique, and it appears that one ramification of this study is to place therapist directiveness into the list of constructs with no definitive relationship with therapy process and outcome.

It has been argued that the best predictors for treatment outcome are qualities common to most therapist–client relationships, including therapist kindness and the presence of a trusting relationship (Lambert & Ogles, 2004; Rosenzweig, 1936; Wampold, 2001). Regarding specific techniques, Lambert and Ogles (2004) stated, "These relationship factors are probably crucial even in the more technical therapies that generally ignore relationship factors and emphasize the importance of their techniques in their theory of change" (p. 181). Therapist directiveness varies across treatments and across therapists, and it is possible that directive techniques are among the techniques that do not adequately account for the variance in therapy process and outcome. This study did not look at specific techniques, instead treating directiveness as an ingredient that could vary in any therapist utterance. Therefore, the current findings do not contradict

therapist directiveness as an inert ingredient of therapy, and perhaps the causal factors of change are not linked with directiveness.

However, the lack of a reliable relationship can only be speculation because the design of this study had a number of limitations, including the use of responsiveness to interpret the results. Whereas responsiveness is characterized by speech turns continually changing the context for the next speaker, this study only coded for responsiveness one way, which was client compliance of the therapist. There were no dedicated measures for therapist compliance to client attempts at controlling the session, a construct sometimes known as client *agency* (Rennie, 2000; Williams & Levitt, 2007) or *locus of control* (Foon, 1987). With the sessions coded only for the ways clients responded to the therapist, this study is unable to make any definitive conclusions about responsiveness with regards to therapist directiveness.

Data collection started with the assumption that therapist directiveness was the major construct of interest. Client compliance and related constructs, such as client agency, received less development. Only after all the data had been collected and the analysis had begun, the lack of interesting simple correlations made it vital to control for client variables and use them in interactions. Consequently, the turn-by-turn directiveness measures had counterparts for client compliance, but the perceived directiveness measure did not have such a counterpart, which may be referred to as *perceived client compliance*. The analyses of perceived therapist directiveness that needed to control for or interact with client compliance had no choice but to use the measures for turn-by-turn client compliance. As-is, the current data do not allow for a clear understanding of how perceived directiveness may have behaved when associated with perceived client compliance.

The nature of the dependent variables in this dataset may have presented some coding incompatibilities. Whereas the directiveness and compliance measures coded each

speech turn, the clients filled out process and outcome measures directly after the session. Assuming that therapist directiveness truly did have a relationship with the ongoing qualities of those sessions, it is possible that differences in client perceptions of working alliance, session satisfaction, and other process-related constructs existed on a moment-by-moment level (Greenberg et al., 1993), but that scores filled out at the end of the session reflected only the client's perception of the final segment of the session. In support of this supposition, the construct of responsiveness (Stiles, 2009) suggests that session-wide generalizations may not appropriately reflect the changing emotions or discourse during that session. Therefore, assuming a robust relationship exists between therapist directiveness and client symptom distress, the lack of reliable relationships may be an artifact of the current effort to relate postsession ratings to predictors obtained turn by turn.

The analysis of the fourth quarter of the session's speech turns revealed no remarkable patterns in the relationship between therapist directiveness and client-reported process and outcome. The data largely consisted of small correlations, which resembles the data from the full analysis reported in the Results section. One possible interpretation is that the postsession questionnaires appropriately generalized to the whole session. However, the sessions in this dataset almost invariably concluded with a summary of the session, a negotiation for the date and time of the next session, goodbyes and wishes of good luck, and finally a request to fill out the postsession survey. It could be that the postsession ratings indeed generalized to the final segment of therapy, which followed a standard series of invariant, scripted procedural issues unrelated to treatment. Any powerfully experienced emotions or changes in symptom distress may therefore have been diluted by the time the clients began their self-report surveys.

The decision to conduct analyses at Session 3 presents issues needing discussion. Interpersonal dyads have been found to adapt to the other speaker (Kelley, 1968; Natale,

1975), which has been observed within a single-interview context (Gregory & Weber, 1996) and at a turn-by-turn level (Benus, Gravano, Hirschberg, 2011). Given the speed with which two individuals adapt to each other in discourse, perhaps the therapists and clients had already adapted to each other's interpersonal styles by Session 3. Sessions earlier in treatment may show greater variance in therapist directiveness and client compliance as both speakers would be beginning their relationship and adjusting to each other's styles.

Although Session 3 was used as the focal session because of the availability of the recordings, the Session 6 follow-up analyses using the Session 3 ratings as predictors also present certain limitations. This decision was primarily motivated by logistical practicality. Transcribing Session 1, Session 2, or Session 6 therapy sessions and then coding them for directiveness would have added months to the coding time. Using Session 3 ratings to predict Session 6 process and outcome limited the ability for this study to make meaningful statements about directiveness at various points in treatment. It would have been interesting to see if therapist use of directiveness changed from the beginning of treatment through later treatment, but the lack of early-treatment or follow-up directiveness ratings made such hypotheses impossible to evaluate.

Another issue with the design of the study was the reliability of the measures. The observers consistently coded for therapist response restriction and perceived therapist directiveness, but client follow-up, therapist topic change, and client topic compliance only displayed moderate reliability. The scores for each case, which were aggregated across observers, may have inherited error from the variance contributed by the observers. There were proactive efforts to maximize inter-rater reliability, but future studies should keep in mind that topic change, client follow-up, and client topic compliance may need more attention during training.

The dependent variable measures in the database inherited some issues from the original study. Not every client filled out every process or outcome measure. Additionally, clients were not obligated to respond to every item for the measures they chose to fill out. Some analyses could not use the full set of 52 observations because of missing data. At first it seemed logical to omit clients from analysis if they stood out as having too much missing data, but no particular client stood out as overly deficient. Clients who were missing data for certain measures often provided plentiful or complete responses for other measures. Another option was to use only cases that provided responses for the full dataset, but this would have been counterproductive, as it would have eliminated too many cases. In the interest of maximizing the number of observations, analyses used all available data. This incurred a cost, in that the number of observations for any given analysis ranged from 50 to 52, but analyses with less than 52 observations were inconsistent with which clients were missing.

If researchers would like to continue the topic of therapist directiveness in future studies, there are a number of ways to strengthen the design. Future researchers should avoid relegating client compliance into a subordinate role. Every measure for therapist directiveness should have a corresponding equivalent for client compliance. To address this issue in responsiveness, adding a measure for therapist compliance to the client's agency would provide a fuller picture of the contextual responsiveness of the therapy session. It would also be prudent to take additional proactive steps to enhance inter-rater reliability with the measures that were rated less consistently in this study.

A conceptual modification could be to reconsider the operational definition of directiveness, perhaps using a coding system based on two domains identified by experiential therapists (Elliott et al., 2004; Greenberg, Elliott, & Lietaer, 1994; Greenberg et al., 1993). *Process direction* refers to the degree that the therapist provides expertise on ways clients can ameliorate their problems. Its counterpart *content direction* refers to the

therapist behaving in a manner suggesting expertise about client emotions. Both of these domains seem adaptable into measures for therapist speech turns. The current measures do not discriminate between process or content direction, and it would be interesting to see if fine-graining directiveness into those dimensions could untangle relationships that may have been latent in the current effort.

Researchers who have the resources to manipulate therapist use of directiveness will be able to determine what happens to therapy clients as a result of therapist directiveness. Manipulating therapist directiveness may prove additionally useful if therapists are asked to use a wider range of directiveness, particularly on the high end. As can be seen in Appendix B, therapists in this study, on average, did not use high amounts of response restriction or topic change, with small deviations from the mean. Observer ratings of perceived directiveness were typically toward the middle of that scale. On the other hand, client follow-up and topic compliance received mean scores that were very near the highest possible value for those scales, with low variability between clients. It is possible that the current study was unable to detect the true relationship with therapist directiveness as the independent variable because the observed usage of directiveness did not fairly represent the whole scale of possible values, with noteworthy shortage of high directiveness scores. With a greater range and variance of directiveness, perhaps it will be more likely to detect reliable relationships with process and outcome.

The above recommendations may improve the internal validity and construct validity of future studies. Although this study used multiple measures, each assessing a different way to conceptualize directiveness as an ingredient that could be present in any speech turn, there was no reliable evidence of such relationships. It remains to be seen if additional research will yield clearer results about the relationship between therapist directiveness and the process and outcome of therapy.

REFERENCES

Barkham, M., & Shapiro, D.A. (1986). Counselor Verbal Response Modes and Experienced Empathy. *Journal of Counseling Psychology, 33,* 3–10.

Beck, A.T., Guth, D., Steer, R.A., & Ball, R. (1997). Screening for major depression disorders in medical inpatients with the Beck Depression Inventory for Primary Care. *Behavior Research and Therapy, 35,* 785–791.

Benus, S., Gravano, A., & Hirschberg, J. (2011). Pragmatic aspects of temporal accommodation in turn-taking. *Journal of Pragmatics*, *43*, 3001–3027.

Beutler, L.E., Engle, D., Mohr, D., Daldrup, R.J., Bergan, J., Meredith, K., Merry, W. (1991). Predictors of differential response to cognitive, experimental, and self-directed psychotherapeutic procedures. *Journal of Consulting and Clinical Psychology, 59,* 333–340.

Beutler, L.E., Harwood, T.M., Michelson, A., & Song, X. (2011). Resistance/reactance level. *Journal of Clinical Psychology: In Session*, *67*, 133–142. doi: 10.1002/jclp.20753.

Beutler, L.E., Malik, M., Alimohamed, S., Harwood, T.M., Talebi, H., Noble, S., & Wong, E. (2004). Therapist variables. In M.J. Lambert (Ed.). *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 227–306). New York: John Wiley & Sons, Inc.

Bischoff, M.M., & Tracey, T.J.G. (1995). Client resistance as predicted by therapist behavior: a study of sequential dependence. *Journal of Counseling Psychology, 42,* 487–495.

Bohart, A.C. (2003). Person-centered psychotherapy and related experiential approaches. In A.S. Gurman, & Messer, S.B. (Eds.), *Essential psychotherapies: Theory and practice* (pp. 107–148). New York: the Guilford Press.

Borkovec, T.D., & Costello, E. (1993). Efficacy of applied relaxation and cognitive-behavioral therapy in the treatment of generalized anxiety disorder. *Journal of Consulting and Clinical Psychology, 61,* 611–619.

Elliott, R., Barker, C.B., Caskey, N., & Pistrang, N. (1982). Differential helpfulness of counselor verbal response modes. *Journal of Counseling Psychology, 29,* 354–361.

Elliott, R., Greenberg, L.S., & Lietaer, G. (2004). Research on experiential psychotherapies. In M.J. Lambert (Ed.). *Bergin and Garfield's handbook of*

*psychotherapy and behavior change* (5th ed., pp. 492–539). New York: John Wiley & Sons, Inc.

Elliott, R., Hill, C.E., Stiles, W.B., Friedlander, M.L., Mahre, A.R., & Margison, F.R. (1987). Primary therapist response modes: Comparison of six rating systems. *Journal of Consulting and Clinical Psychology, 55,* 218–223.

Fisher, D., Karno, M.P., Sandowicz, M., Albanese, A., & Beutler, L.E. (1995). Systematic Treatment Selection Therapy Rating Scale manual. Unpublished manuscript, University of California, Santa Barbara.

Foon, A.E. (1987). Review: Locus of control as a predictor of outcome of psychotherapy. *British Journal of Medical Psychology*, *60*, 99–107.

Frank, J.D. (1973). *Persuasion and healing: A comparative study of psychotherapy* (Revised ed.). Baltimore, MD: Johns Hopkins University Press.

Friedlander, M.L. (1982). Counseling discourse as a speech event: Revision and extension of the Hill Counselor Verbal Response Category System. *Journal of Counseling Psychology, 29*, 425–429.

Greenberg, L.S., & Bolger, L. (2001). An emotion focused approach to the over-regulation of emotion and emotional pain. *Journal of Clinical Psychology: In Session*, *57*, 197–212.

Greenberg, L.S., Elliott, R., & Lietaer, G. (1994). Research on experimental psychotherapies. In A.E. Bergin & Garfield, S.L. (Eds.). *Handbook of psychotherapy and behavior change* (4th ed., pp. 492–539). New York: John Wiley & Sons, Inc.

Greenberg, L.S., Rice, L.N., & Elliott, R. (1993). *Facilitating emotional change: The moment-by-moment process.* New York, NY: The Guilford Press.

Gregory, S.W., & Weber, S. (1996). A nonverbal signal in voices of interview partners effectively predicts communication accommodation and social status perceptions. *Journal of Personality and Social Psychology, 6*, 1231–1240.

Hadley, H.D. (1953). Applied psychology in action: The non-directive approach in advertising appeals. *The Journal of Applied Psychology, 37,* 496–498.

Karno, M.P., Beutler, L.E., & Harwood, T.M. (2002). Interactions between psychotherapy procedures and client attributes that predict alcohol treatment effectiveness: A preliminary report. *Addictive Behaviors, 27,* 779–797.

Karno, M.P., & Longabaugh, R. (2005). Less directiveness by therapists improves drinking outcomes of reactant clients in alcoholism treatment. *Journal of Consulting and Clinical Psychology, 73,* 262–267.

Kelley, H.H. (1968). Interpersonal accommodation. *American Psychologist*, *23*, 399–410.

Klausner, E.J., Clarkin, J.F., Spielman, L., Pupo, C., Abrams, R., & Alexopoulos, G.S. (1998). Late-life depression and functional disability: The role of goal-focused group psychotherapy. *International Journal of Geriatric Psychiatry, 13,* 707–716.

Lambert, M.J., Hansen, N.B., Umpress, V., Lunnen, K., Okiishi, J., & Burlingame, G.M. (1996). *Administration and scoring manual for the OQ-45.2.* Stevenson, MD: American Professional Credentialing Services.

Lambert, M.J., & Ogles, B.M. (2004). The efficacy and effectiveness of psychotherapy. In M.J. Lambert (Ed.). *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139–193). New York: John Wiley & Sons, Inc.

Littauer, H., Sexton, H., & Wynn, R. (2005). Qualities clients wish for in their therapists. *Scandinavian Journal of Caring Sciences, 19,* 28–31.

Luborsky, L., Singer, J., & Luborsky, L. (1975). Comparative studies of psychotherapy. *Archives of General Psychiatry*, *32*, 995–1008.

McLean, P.D., & Hakstian, A.R. (1990). Relative endurance of unipolar depression treatment effects: longitudinal follow-up. *Journal of Consulting and Clinical Psychology, 58,* 482–488.

Miller, W.R., Benefield, G., & Tonigan, J.S. (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology, 61,* 455–461.

Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford.

Natale, M. (1975). Convergence of mean vocal intensity in dyadic communication as a function of social desirability. *Journal of Personality and Social Psychology*, *5*, 790–804.

Patterson, G.R., & Forgatch, M.S. (1985). Therapist behavior as a determinant for client noncompliance: A paradox for the behavior modifier. *Journal of Consulting and Clinical Psychology, 53,* 846–851.

Peluso, P.R., Liebovitch, L.S., Gottman, J.M., Norman, M.D., & Su, J. (2012). A mathematical model of psychotherapy: An investigation using dynamic non-linear equations to model the therapeutic relationship. *Psychotherapy Research*, *22*, 40–55. doi: 10.1080/10503307.2011.622314.

Rennie, D.L. (2000). Aspects of the client's conscious control of the psychotherapeutic process. *Journal of Psychotherapy Integration*, *10*, 151–167.

Rogers, C.R. (1951). *Client-centered therapy.* Boston: Houghton Mifflin.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, *6*, 412–415.

Sabatelli, R.M., Buck, R., & Dreyer, A. (1983). Locus of control, interpersonal trust, and nonverbal communication accuracy. *Journal of Personality and Social Psychology, 44,* 399–409.

Sadler, P., Ethier, N., Gunn, G.R., Duong, D., & Woody, E. (2009). Are we on the same wavelength? Interpersonal complementarity as shared cyclical patterns during interactions. *Journal of Personality and Social Psychology, 97*, 1005–1020.

Sexton, T.L., Alexander, J.F., & Mease, A.L. (2004). Levels of evidence for the models and mechanisms of therapeutic change in family and couple therapy. In M.J. Lambert (Ed.). *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 227–306). New York: John Wiley & Sons, Inc.

Shapiro, D.A., Rees, A., Barkham, M., Hardy, G., Reynolds, S., & Startup, M. (1995). Effects of treatment duration and severity of depression on the maintenance of gains after cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting and Clinical Psychology, 63,* 378–387.

Shaw, B.F., Olmsted, M., Dobson, K.S., Sotsky, S.M., Elkin, I., Yamaguchi, J., … Imber, S.D. (1999*). Journal of Consulting and Clinical Psychology, 67,* 837–846.

Snyder, W.U. (1945). Short Articles and Notes: Dr. Thorne's critique of nondirective psychotherapy. *The Journal of Abnormal and Social Psychology, 40,* 336–339.

Sommers-Flanagan, J., & Sommers-Flanagan, R. (2009). *Clinical interviewing* (4th ed.). Hoboken, NJ: John Wiley & Sons, Inc.

Stiles, W.B. (2009). Responsiveness as an obstacle for psychotherapy outcome research: It's worse than you think. *Clinical Psychology: Science and Practice*, *16*, 86–91.

Stiles, W.B., & Shapiro, D.A. (1994). Disabuse of the drug metaphor: Psychotherapy Process-Outcome Correlations. *Journal of Consulting and Clinical Psychology, 62,* 942–948.

Tambs, K., & Moum, T. (1993). How well can a few questionnaire items indicate anxiety and depression? *Acta Psychiatrica Scandinavica, 87,* 364–367.

Thorne, F.C. (1944). A critique of nondirective methods of psychotherapy. *The Journal of Abnormal and Social Psychology, 39,* 459–470.

Tiedens, L.Z., & Fragale, A.R. (2003). Power moves: Complementarity in dominant and submissive nonverbal behavior. *Journal of Personality and Social Psychology, 84,* 558–568.

Tracey, T.J. (1986). Interactional correlates of premature termination. *Journal of Consulting and Clinical Psychology, 54,* 784–788.

Tracey, T.J., & Kokotovic, A.M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 1,* 107–210.

Wampold, B.E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.

Warwar, S., & Greenberg, L. (2002). *Emotional arousal session report measure.* Unpublished manuscript, York University, Toronto, Ontario, Canada.

Wenegrat, A. (1976). Linguistic variables of therapist speech and accurate empathy ratings. *Psychotherapy: Theory, Research, and Practice, 13,* 30–33.

Williams, D.C., & Levitt, H.M. (2007). Principles for facilitating agency in psychotherapy. *Psychotherapy Research*, *17*, 66–82.

# APPENDIX A

## FORMS USED IN THE STUDY

Appendix Page

# Appendix A.1

## Coding Instructions for Observer Measures

### CODING INSTRUCTIONS

**PROCEDURE**
Label the speech turn measure with your name and the transcript ID. For your assigned transcript segment, rate each therapist speech turn, which is any instance the therapist speaks. Each speech turn is separated by a pause during which the client speaks. Do not code for brief utterances such as, "Uh-huh" or "Mm-hmm." Immediately after you have filled out the speech turn measure, fill out the perceived directiveness measure.

**MEASURES**
**1. Words (therapist)**
Mark down number of words from the therapist's turn.

**2. Response Restriction**
Response restriction refers to the therapist narrowing down the possible ways the client can speak afterwards. Because a therapist speech turn can have many sentences and ideas, focus on the end of that turn.

- Scores range from 0-4: 0=low, 2=moderate, 4=high.
- Give a lower score if the therapist sets up the client to respond using a nearly-unlimited number of ways. Example—Client: "I felt so angry." **Therapist: "Tell me more."**
- Give a higher score if the therapist's turn sets up the client to select from a limited number of options. Example—Client: "I had a pretty busy weekend." **Therapist: "Oh, did you go to the basketball game?"**

**3. Therapist Topic**
A topic change occurs when the therapist attempts to shift the conversation onto a different issue or event than the one(s) discussed in the immediately preceding client turn. Focus on the end of the turn.

- Scores can be 0 or 1.
- Give a 0 if, by the end of the speech turn, the therapist has not introduced a topic change.
- Give a 1 if, by the end of the speech turn, the therapist has introduced a topic change.

**4. Words (client)**
Mark down the number of words from the client's immediately following turn.

**5. Client Follow-Up**
Client follow-up refers to the degree that the client's response continues from any restrictions set up by the therapist's previous turn. A turn can have many sentences and ideas, and your task is to rate the degree that the whole turn addressed the therapist's previous turn.

- Scores range from 0-4: 0=low, 2=moderate, 4=high
- Give a lower score if the client's turn either does not or barely addresses the therapist's direction. Example—Client: "There are so many things bothering me." Therapist: "Tell me about the most important one." **Client: "No, I can't. They're all important."**

- Give a higher score if the client addresses the therapist's direction. Example—Therapist: "What was that like for you?" **Client: "It was horrible. I started crying."**

**6. Client Topic**

Client topic refers to whether or not the client continues speaking about the issue(s) or event(s) discussed in the immediately preceding therapist turn.

- Scores can be 0 or 1.
- Give a 0 if the client's speech turn is primarily unfocused on topics from the therapist's last turn.
- Give a 1 if the client's speech turn primarily focuses on topics from the therapist's last turn.

**7. Perceived Directiveness Measure**

You are rating the appropriateness of each item as it characterizes the feeling of the session and not a count or frequency of any behavior. Therefore, if certain behaviors occurred infrequently but had a profound impact on your perception of the session, give a higher score. If certain behaviors occurred frequently but were not the focus of the session, give a lower score. Do not skip any items, and only circle whole numbers.

Appendix A.2

Speech Turn Measure (one-page sample)

| Observer's Name: | Transcript ID: |
|---|---|
| | |

— Speech Turn Measure —

| Speech turn | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Words (therapist) | | | | |
| Response restriction | | | | |
| Therapist topic | | | | |
| Words (client) | | | | |
| Client follow-up | | | | |
| Client topic | | | | |

| Speech turn | 5 | 6 | 7 | 8 |
|---|---|---|---|---|
| Words (therapist) | | | | |
| Response restriction | | | | |
| Therapist topic | | | | |
| Words (client) | | | | |
| Client follow-up | | | | |
| Client topic | | | | |

| Speech turn | 9 | 10 | 11 | 12 |
|---|---|---|---|---|
| Words (therapist) | | | | |
| Response restriction | | | | |
| Therapist topic | | | | |
| Words (client) | | | | |
| Client follow-up | | | | |
| Client topic | | | | |

# Appendix A.3

## Perceived Directiveness Measure

| Observer's Name: | Transcript ID: |
|---|---|
| | |

— Perceived Directiveness Measure —

Immediately after you have filled out the speech turn measure, fill out the perceived directiveness measure based on your subjective impressions of the session. Make sure your name and the transcript ID are clearly labeled. Do not skip any items, and only circle whole numbers.

| | Not at all | | Moder-ately | | Very much |
|---|---|---|---|---|---|
| 1. The therapist was assertive. | 1 | 2 | 3 | 4 | 5 |
| 2. The therapist introduced topics for the client to follow. | 1 | 2 | 3 | 4 | 5 |
| 3. The therapist was a teacher to the client. | 1 | 2 | 3 | 4 | 5 |
| 4. The client thought of his or her own solutions. | 1 | 2 | 3 | 4 | 5 |
| 5. The therapist provided important advice. | 1 | 2 | 3 | 4 | 5 |
| 6. The therapist followed topics that the client introduced. | 1 | 2 | 3 | 4 | 5 |
| 7. The therapist was confrontational. | 1 | 2 | 3 | 4 | 5 |
| 8. The therapist was in control of the session. | 1 | 2 | 3 | 4 | 5 |
| 9. The therapist reflected the client's feelings and cognitions. | 1 | 2 | 3 | 4 | 5 |
| 10. The therapist had a clear plan for the structure of the session. | 1 | 2 | 3 | 4 | 5 |

# Appendix A.4

## Postsession Reflection Questionnaire

**POST-SESSION REFLECTION QUESTIONNAIRE**

It can be useful to reflect upon your experience in therapy, to consider what therapy is like for you, and to set goals for yourself. By completing this form, you can take the time to do this as well as supporting the research that is ongoing in our center.

Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work and so forth.

| | Never | Rarely | Sometimes | Frequently | Almost Always |
|---|---|---|---|---|---|
| 1. I get along well with others. | 1 | 2 | 3 | 4 | 5 |
| 2. I tire quickly. | 1 | 2 | 3 | 4 | 5 |
| 3. I feel no interest in things. | 1 | 2 | 3 | 4 | 5 |
| 4. I feel stressed at work/school. | 1 | 2 | 3 | 4 | 5 |
| 5. I blame myself for things. | 1 | 2 | 3 | 4 | 5 |
| 6. I feel irritated. | 1 | 2 | 3 | 4 | 5 |
| 7. I feel unhappy in my marriage/significant relationship. | 1 | 2 | 3 | 4 | 5 |
| 8. I have thoughts of ending my life. | 1 | 2 | 3 | 4 | 5 |
| 9. I feel weak. | 1 | 2 | 3 | 4 | 5 |
| 10. I feel fearful. | 1 | 2 | 3 | 4 | 5 |
| 11. After heavy drinking, I need a drink the next morning to get going (If you do not drink, mark 'never'). | 1 | 2 | 3 | 4 | 5 |
| 12. I find my work/school satisfying. | 1 | 2 | 3 | 4 | 5 |
| 13. I am a happy person. | 1 | 2 | 3 | 4 | 5 |
| 14. I work/study too much. | 1 | 2 | 3 | 4 | 5 |
| 15. I feel worthless. | 1 | 2 | 3 | 4 | 5 |
| 16. I am concerned about family troubles. | 1 | 2 | 3 | 4 | 5 |
| 17. I have an unfulfilling sex life. | 1 | 2 | 3 | 4 | 5 |
| 18. I feel lonely. | 1 | 2 | 3 | 4 | 5 |
| 19. I have frequent arguments. | 1 | 2 | 3 | 4 | 5 |
| 20. I feel loved and wanted. | 1 | 2 | 3 | 4 | 5 |
| 21. I enjoy my spare time. | 1 | 2 | 3 | 4 | 5 |
| 22. I have difficulty concentrating. | 1 | 2 | 3 | 4 | 5 |
| 23. I feel hopeless about the future. | 1 | 2 | 3 | 4 | 5 |
| 24. I like myself. | 1 | 2 | 3 | 4 | 5 |
| 25. Disturbing thoughts come into my mind that I cannot get rid of. | 1 | 2 | 3 | 4 | 5 |
| 26. I feel annoyed by people who criticize my drinking (or drug use) (if not applicable, mark 'never'). | 1 | 2 | 3 | 4 | 5 |
| 27. I have an upset stomach. | 1 | 2 | 3 | 4 | 5 |
| 28. I am not working/studying as well as I used to. | 1 | 2 | 3 | 4 | 5 |
| 29. My heart pounds too much. | 1 | 2 | 3 | 4 | 5 |
| 30. I have trouble getting along with friends and close acquaintances. | 1 | 2 | 3 | 4 | 5 |
| 31. I am satisfied with my life. | 1 | 2 | 3 | 4 | 5 |
| 32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark 'never') | 1 | 2 | 3 | 4 | 5 |

| | Never | Rarely | Sometimes | Frequently | Almost Always |
|---|---|---|---|---|---|
| 33. I feel that something bad is going to happen. | 1 | 2 | 3 | 4 | 5 |
| 34. I have sore muscles. | 1 | 2 | 3 | 4 | 5 |
| 35. I feel afraid of open spaces, of driving or being on buses, subways, and so forth. | 1 | 2 | 3 | 4 | 5 |
| 36. I feel nervous. | 1 | 2 | 3 | 4 | 5 |
| 37. I feel my love relationships are full and complete. | 1 | 2 | 3 | 4 | 5 |
| 38. I feel that I am not doing well at work/school. | 1 | 2 | 3 | 4 | 5 |
| 39. I have too many disagreements at work/school. | 1 | 2 | 3 | 4 | 5 |
| 40. I feel something is wrong with my mind. | 1 | 2 | 3 | 4 | 5 |
| 41. I have trouble falling asleep or staying asleep. | 1 | 2 | 3 | 4 | 5 |
| 42. I feel blue. | 1 | 2 | 3 | 4 | 5 |
| 43. I am satisfied with my relationships with others. | 1 | 2 | 3 | 4 | 5 |
| 44. I feel angry enough at work/school to do something I might regret. | 1 | 2 | 3 | 4 | 5 |
| 45. I have headaches. | 1 | 2 | 3 | 4 | 5 |

Instructions: Below is a list of problems people sometimes have. Please read each one carefully and circle the number to the right that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Circle only one number for each problem and do not skip any items. If you change your mind, please erase your first mark carefully.

| **How much were you distressed by**: | Not At all | A Little | Quite a bit | Extremely |
|---|---|---|---|---|
| 1. Nervousness or shakiness inside | 1 | 2 | 3 | 4 |
| 2. Feeling blue | 1 | 2 | 3 | 4 |
| 3. Worrying too much about things | 1 | 2 | 3 | 4 |
| 4. Feeling fearful | 1 | 2 | 3 | 4 |
| 5. Feeling hopeless about the future | 1 | 2 | 3 | 4 |

**Please indicate the extent to which you <u>felt</u> these emotions *<u>during your session</u>*.**

| | Not At All | | Somewhat | | Moderately | | Very Much |
|---|---|---|---|---|---|---|---|
| Emotional Pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Sadness | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Anger/Resentment | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Grief/Loss | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Helplessness | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Hopelessness | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Loneliness | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Fear | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Tension/Jitters | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Joy/Excitement | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Contentment/Relief | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Shame/Guilt | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Forgiveness | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Pride/Self-Confidence | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Which, if any, of these emotions experienced in your session do you think was most helpful to you, and why?

Which, if any, of these emotions experienced in your session do you think changed the most as a result of this session, and how did it change?

Would you describe this session as an emotional one for you? **Yes___ No___**

Did you feel like some particular aspect of the session triggered you to "get emotional" e.g., a thought or feeling you had, or something the therapist did? **Yes___ No ___** Please indicate what the emotion was:_____

If so, what was it that the therapist did?

**For the following three questions, please mark how you are feeling *at the end of your session* using the following scales.**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **1. How much progress do you feel you made in dealing with your problems this session?** | A great deal of progress | Considerable progress | Moderate progress | Some progress | A little progress | No Progress | In some ways my problems seem to have gotten worse |
| **2. How helpful do you feel your therapist was to you this session?** | Completely helpful | Very helpful | Pretty helpful | Somewhat helpful | Slightly helpful | Not at all helpful | Made things worse |
| **3. How do you feel about the session that you have just completed?** | Perfect | Excellent | Very good | Pretty good | Fair | Pretty poor | Very poor |

1. How much did you hold back feelings or thoughts from your therapist during this session? (If you answer "not at all," skip numbers 2 and 3)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Not at all | | | Somewhat | | | Very much |

2. To what extent did you feel that holding back feelings or thoughts from your therapist was due to differences in perspective that might exist between you and your therapist?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Not at all | | | Somewhat | | | Very much |

3. To what extent do you think that holding back feelings or thoughts from your therapist was due to your reluctance to explore something that might feel difficult emotionally?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Not at all | | | Somewhat | | | Very much |

Appendix A.4 (Continued)

**Please circle one of the following responses:**

| | Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |
|---|---|---|---|---|---|---|---|
| 1. My therapist and I agree about the things I need to do in therapy to help improve my situation. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. What I do in therapy gives me new ways of looking at my problems. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. I believe my therapist likes me | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. My therapist does not understand what I am trying to accomplish in therapy. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. I am confident in my therapist's ability to help me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. My therapist and I are working toward mutually agreed upon goals. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. I feel that my therapist appreciates me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. We agree on what is important for me to work on. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. My therapist and I trust one another. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. My therapist and I have different ideas on what my problems are. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. We have established a good under-standing between us of the kind of changes that would be good for me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. I believe the way we are working with my problem is correct. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**After readings each group of statements carefully, check the blank next to the one statement in each group that best describes the way you have been feeling the past week, including today. Be sure to read all the statements in each group before making your choice.**

| | | | |
|---|---|---|---|
| 1. __I do not feel sad. | __I feel sad. | __I am sad all the time and I can't snap out of it. | __I am so sad or unhappy that I can't stand it. |
| 2. __I am not particularly discouraged about the future. | __I feel discouraged about the future. | __I feel I have nothing to look forward to. | __I feel that the future is hopeless and that things cannot improve. |
| 3. __I do not feel like a failure. | __I feel I have failed more than the average person. | __As I look back on my life, all I can see is a lot of failures. | __I feel I am a complete failure as a person. |
| 4. __ I get as much satisfaction out of things as I used to. | __I don't enjoy things the way I used to. | __I don't get real satisfaction out of anything anymore. | __I am dissatisfied or bored with everything. |
| 5. __ I don't feel disappointed in myself. | __I am disappointed in myself. | __I am disgusted with myself. | __I hate myself. |
| 6. I don't feel I am any worse than anybody else. | I am critical of myself for my weaknesses or mistakes. | I blame myself all the time for my faults. | I blame myself for everything bad that happens. |
| 7. __I don't have any thoughts of killing myself. | __I have thoughts of killing myself, but I would not carry them out. | __I would like to kill myself. | __I would kill myself if I had the chance. |

**Would you be willing to be contacted about participating in an interview about your session?**

# APPENDIX B

## ADDITIONAL DATA

Appendix Page

Appendix B.1

*Descriptive Statistics for Therapist Directiveness and Client Compliance Measures*

| Measure | Mean | SD | Minimum | Maximum |
|---|---|---|---|---|
| Therapist directiveness | | | | |
| Response restriction | 2.16 | .33 | 1.43 | 2.81 |
| Topic change | .22 | .05 | .14 | .35 |
| Perceived directiveness | 2.88 | .40 | 2.09 | 3.93 |
| Word count | 29.57 | 12.44 | 9.59 | 84.05 |
| Client compliance | | | | |
| Follow-up | 3.15 | .14 | 2.83 | 3.44 |
| Topic compliance | .95 | .03 | .89 | .99 |
| Word count | 71.21 | 39.96 | 16.89 | 222.86 |

*Note.* N = 52. Therapist response restriction client follow-up were scored 0–4. Perceived directiveness was scored 1–5. Therapist topic change and client topic compliance had possible values of 0 and 1.

Appendix B.2

*Therapist Means for Directiveness Measures*

| Therapist | Clients seen | Measure: Response restriction | Measure: Topic change | Measure: Perceived directiveness | Measure: Word count |
|---|---|---|---|---|---|
| 1 | 11 | 2.20 | .25 | 2.85 | 34.19 |
| 2 | 5 | 2.24 | .21 | 3.28 | 42.29 |
| 3 | 2 | 1.75 | .16 | 2.22 | 18.37 |
| 4 | 5 | 2.08 | .23 | 2.40 | 32.55 |
| 5 | 1 | 2.55 | .24 | 2.64 | 16.57 |
| 6 | 4 | 2.31 | .23 | 2.91 | 34.88 |
| 7 | 2 | 1.68 | .16 | 3.24 | 20.53 |
| 8 | 2 | 2.30 | .20 | 2.70 | 25.36 |
| 9 | 4 | 2.37 | .27 | 3.06 | 21.83 |
| 10 | 4 | 2.31 | .19 | 2.88 | 18.83 |
| 11 | 2 | 2.01 | .21 | 2.51 | 36.59 |
| 12 | 6 | 2.27 | .26 | 3.28 | 23.11 |
| 13 | 1 | 1.43 | .16 | 2.65 | 38.74 |
| 14 | 1 | 1.93 | .14 | 2.43 | 20.39 |
| 15 | 1 | 2.01 | .22 | 2.73 | 28.04 |
| 16 | 1 | 1.61 | .17 | 3.35 | 40.88 |
| Mean | 3.25 | 2.16 | .22 | 2.88 | 29.57 |
| SD | 2.67 | .33 | .05 | .40 | 12.44 |

*Note.* N = 52. Therapist response restriction client follow-up were scored 0–4. Perceived directiveness was scored 1–5. Therapist topic change and client topic compliance had possible values of 0 and 1.

Appendix B.3

*Therapist Means for Process Measures*

| | | Measure | | |
|---|---|---|---|---|
| Therapist | Clients seen | Emotional intensity | Working alliance | Session evaluation |
| 1 | 11 | 3.14 | 5.78 | 3.64 |
| 2 | 5 | 2.93 | 5.85 | 3.78 |
| 3 | 2 | 2.46 | 6.00 | 3.25 |
| 4 | 5 | 2.26 | 5.73 | 3.28 |
| 5 | 1 | 2.93 | 4.73 | 3.50 |
| 6 | 4 | 2.64 | 5.43 | 3.88 |
| 7 | 2 | 5.92 | 6.23 | 2.38 |
| 8 | 2 | 4.54 | 6.50 | 3.13 |
| 9 | 4 | 3.43 | 5.64 | 3.00 |
| 10 | 4 | 2.75 | 5.67 | 2.91 |
| 11 | 2 | 2.44 | 5.86 | 2.23 |
| 12 | 6 | 2.56 | 5.65 | 2.87 |
| 13 | 1 | 3.00 | 6.73 | 3.40 |
| 14 | 1 | 2.86 | 6.91 | 2.75 |
| 15 | 1 | 7.00 | 6.64 | 4.00 |
| 16 | 1 | 2.00 | 4.60 | 2.40 |
| Mean | 3.25 | 3.02 | 5.79 | 3.25 |
| SD | 2.67 | 1.05 | 1.03 | .83 |

*Note.* N = 52. Items were scored 1–7. Higher scores indicate better process.

Appendix B.4

*Therapist Means for Outcome Measures*

| | | Measure | | | |
|---|---|---|---|---|---|
| Therapist | Clients seen | Symptom checklist | Depression items | Interpersonal distress | Problem distress |
| 1 | 11 | 2.43 | 1.85 | 2.60 | 4.79 |
| 2 | 5 | 2.20 | 1.54 | 2.75 | 4.60 |
| 3 | 2 | 2.00 | 1.36 | 2.24 | 2.83 |
| 4 | 5 | 2.00 | 1.74 | 2.45 | 4.20 |
| 5 | 1 | 1.60 | 1.14 | 2.73 | 4.33 |
| 6 | 4 | 2.25 | 1.50 | 2.48 | 5.56 |
| 7 | 2 | 4.00 | 2.07 | 3.11 | 7.00 |
| 8 | 2 | 3.00 | 2.41 | 3.04 | 6.33 |
| 9 | 4 | 2.55 | 1.82 | 2.52 | 4.29 |
| 10 | 4 | 2.20 | 1.66 | 2.69 | 5.00 |
| 11 | 2 | 1.60 | 1.50 | 2.59 | 5.50 |
| 12 | 6 | 2.37 | 1.57 | 2.44 | 4.61 |
| 13 | 1 | 2.20 | 2.00 | 1.82 | 5.67 |
| 14 | 1 | 2.40 | 1.86 | 3.55 | 5.00 |
| 15 | 1 | 1.60 | 1.43 | 2.09 | 5.33 |
| 16 | 1 | 2.60 | 2.57 | 3.00 | 7.00 |
| Mean | 3.25 | 2.31 | 1.73 | 2.59 | 4.84 |
| SD | 2.67 | .67 | .54 | .61 | 1.43 |

*Note.* N = 52. Items from the Symptom Checklist and Beck Depression Inventory were scored 1–4. Interpersonal distress was scored 1–5. Problem distress was scored 1–7. Higher scores indicate higher degrees of distress.