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**Therapist Report of Styles, Models and Practices:
Development and Validation of a Pre-Service Assessment Inventory**

David L. G. Robinson, M. A.

**A dissertation submitted to the Faculty of Graduate Studies
in partial fulfillment of the requirements for the Degree of
Doctor of Philosophy**

**Department of Psychology
Carleton University
Ottawa, Ontario**

September 1990

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The undersigned recommend to the Faculty of Graduate Studies
and Research acceptance of the thesis
submitted by
David. L.G. Robinson
in partial fulfilment of the requirements for
the degree of
Doctor of Philosophy

Thesis Supervisor

External Examiner

Chairman, Department of Psychology

Carleton University
October, 1990

ABSTRACT

The development and validation of a pre-service self-report instrument for the assessment of therapy-specific characteristics of therapists is described. The Therapist Report of Styles, Models, and Practices (TRSMP) consist of 23 rationally-derived scales reflecting major therapist variables in psychotherapy theory and research. The scales are composed of items from an existing battery of 265 therapist behaviours and attitudes. Psychometric analyses of the new TRSMP scales was based on a sample of 66 therapists from 11 Canadian Family Service Agencies. Sources of information on which scale validation efforts were based include: client reports on process and outcome for a sample of clients treated by the therapists; parallel supervisor scores on the TRSMP for a subsample of therapists; and treatment plans, client intake assessments, services delivered, and outcome assessments conducted by the therapists for a large sample of clients. The data showed a meaningful pattern of inter-correlation among the TRSMP scales, and there was evidence of predictive validity when the scales were examined in relation to therapist intake and closure assessments, planning and service delivery variables as well as the process and outcome measures based on client self-reports. The present study furnishes support for the use of pre-service self-report methods for the assessment of therapist characteristics.

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to Deb

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INTRODUCTION

The present research entails the development of a comprehensive therapist self-report instrument for the pre-service assessment of therapist styles, therapeutic models, and preferred practices. The Therapist Report of Styles, Models and Practices (TRSMP) is recommended as a multi-purpose instrument with potential applications in research, therapist self-evaluation, and clinical training. The content of the TRSMP is relevant to individual, group, and family therapies. The therapist variables surveyed by the instrument correspond to what Beutler, Crago, and Arizmendi (1986) have described as "therapy-specific characteristics" in their taxonomy of therapist influences.

The TRSMP scales survey attributes of the therapist's self-presentation, the particular foci and approaches employed in addressing client problems, the school or model of psychotherapy adopted, and the types of interventions and procedures applied to promote client change. The assumption is that therapist characteristics assessed prior to service may be linked to a variety of criteria: intake assessment of clients, the formulation of treatment plans, the selection of therapy targets, the specifics of therapy process, and outcome measures including client improvement and client satisfaction. The hypothesized links between pre-service therapist characteristics and other facets of the therapeutic process follow from recent models that have been advanced for conceptualizing the intervention process

in counselling and psychotherapy (Andrews and Kiessling, 1980; Hoge and Andrews, 1986; Orlinsky and Howard, 1978, 1986). These models posit a variety of variables including, setting, therapist, client, and program characteristics as antecedents of the processes and outcomes of therapy. With respect to therapist variables, Hoge and Andrews' (1986) model proposes that pre-service therapist attributes may impact upon the nature of therapeutic programs and in-therapy processes, which in turn, influence the intermediate and ultimate outcomes of therapy. The model also acknowledges that client and therapist characteristics may interact to affect other components of the intervention model.

The development of a pre-service therapist self-report instrument responds to the need for easily-administered and cost-efficient instruments that possess sound psychometric properties. The self-report strategy may be contrasted to more costly and time-consuming methods based on ratings of therapist attributes provided by independent observers, or from client accounts of the behaviour of their therapists. The principle advantage of a self-report instrument of the proposed type is that it employs a more accessible data source than alternative methods for measuring therapist variables in clinical settings. Moreover, the therapist obviously occupies a privileged vantage point in terms of providing information about his or her therapeutic behaviour. While the reliability and validity of

therapist self-report measures have been questioned (Fiske, 1977; Xenakis, Hoyt, Marmar and Horowitz, 1983; Orlinsky and Howard, 1986), such measures are, nevertheless, open to further psychometric investigation.

The TRSMP may be particularly useful in research applications where therapist variables must be taken into account, but may not be the primary focus of study. For example, a pre-service therapist self-report instrument would be of great utility in quasi-experimental evaluations of treatment programs or in multiple predictor studies which attempt to assess the impact of a variety of client and treatment variables on outcome. The self-report method may also be practical in preliminary selections of therapists for experimental studies that focus on particular therapist characteristics. Fiske (1977) has discussed the problem of external validity in psychotherapy research. One of the issues he raises is that we are often unable to make generalizations about our research findings because of uncertainty about the characteristics of the therapists comprising our samples. There is a need for descriptive information about therapists in all experimental and quasi-experimental studies of psychotherapy. However, this condition will not be met in the absence of convenient and inexpensive techniques for measuring therapist variables. The TRSMP self-report approach will, therefore, offer a practical method for describing therapist samples.

The use of the TRSMP as a pre-service measure does not preclude its potential function as a measure of in-therapy process. In this research context, the instrument could be used by therapists to document the styles and practices employed with individual cases. The TRSMP might also serve as a self-assessment tool, whereby therapists can describe and monitor their own therapeutic styles and practices. Beutler and McNabb (1981) have written about the increasing demands for therapist accountability and the need for therapists to employ self-evaluation techniques that allow them to critically assess the quality of their therapeutic endeavors. Although the TRSMP was tested as a self-report measure, the instrument may also furnish a standardized means for recording therapy process information collected by external observers in both research and training settings. Therapists could also be characterized by their peers or supervisors using the TRSMP in situations where such informants are familiar with the therapeutic behaviour of their co-workers.

The development of the TRSMP was based on extensive psychometric analyses of an existing inventory, the Preferred Practices Instrument (PPI) (Andrews, Hoge, Robinson, Faulkner, and Hollett, 1987). The inventory contains 265 items that tap in-therapy behaviours, and is comprised of 43 scales in its present form. There is considerable redundancy in these scales and the use of a large number of items has resulted in a rather cumbersome inventory. One of the objectives of the present

project was to reduce and refine the existing measures. This was achieved by identifying the constructs recognized as important in the psychotherapy literature, and arranging the items into scales that represent psychometrically robust measures of these constructs.

The psychometric properties of the new TRSMP scales are investigated using a large database collected from eleven family service agencies. The agencies were participants in the Family Service Assessment and Evaluation Project, a national project aimed at the development of assessment instruments for use in family service agencies (Andrews, Hoge, Robinson and Hollett, 1986; Hoge, Andrews, Robinson and Faulkner, 1987). The instruments were constructed to assess both client and therapist sources of variability in service planning, service delivery, and service outcomes. The data include PPI's completed by therapists, supervisor ratings of the therapists on the PPI, and intake assessments and treatment plans for a large sample of clients. In addition, subsamples containing client self-reported assessments, client feedback measures, and therapist closure assessments were available.

The wealth of data from multiple sources is a unique feature of this study. Previous attempts at constructing therapist self-report measures have typically relied on a small number of criterion variables such as therapist sex, experience, and professed models of practice. Hence, explorations of criterion

and construct validity have been extremely limited. Another strength of the current study is that intake assessment and therapy outcome data for a large sample of clients will be used. Intake measures for over 2600 clients and therapist-rated outcome measures for over 1400 clients have been collected. Sample sizes reported in the psychotherapy literature often do not exceed more than 100 clients. The present study also makes use of a sample of 66 therapists, which is considerably larger than samples reported in the majority of psychotherapy studies.

The Need for Measurement of Therapist Characteristics

Recent reviews (Beutler, Crago and Arizmendi, 1986; Garfield, 1983; Highlin and Hill, 1984; Orlinsky and Howard, 1986; Parloff, Waskow and Wolfe, 1978), highlight a growing interest in therapist variables. As we have seen, therapist variables have been identified as important determinants of processes and outcomes in models of psychotherapy and counseling (Hoge and Andrews, 1986; Orlinsky and Howard, 1986). Apart from this recognition that therapist variables have an impact on treatment plans, delivery and outcome, other theoretical currents in psychotherapy have drawn attention to the role of therapist variables and the need for the development of techniques for their assessment. The currents include the "specific versus non-specific" debate, the search for theoretical synthesis, the dramatic rise in eclectic practice, and hypotheses regarding

interactions among therapist variables and among therapist and client variables. We turn now to an examination of these issues.

The "Specific" Versus "Non-Specific" Debate

In large part the current interest in therapist characteristics can be understood as a shift of focus that has accompanied what many writers have referred to as the "specific versus non-specific" debate (Karasu, 1986; Schaffer, 1982; Strupp, 1978). In fact, Butler and Strupp (1985) have advanced that the debate has supplied the field with a guiding paradigm for the last three decades. The position that active ingredients of psychotherapy reside in "specific" techniques and practices prescribed by particular schools of psychotherapy (Telch, 1981) is pitted against the hypothesis that "non-specific" or "common" factors shared by a variety of schools account for the effectiveness of psychotherapy (Butler and Strupp, 1985; Frank, 1979, 1981; Strupp and Hadley, 1978; Strupp, 1978). In recent years the latter position has dominated the research scene.

Classic studies comparing the effectiveness of behavioural and psychoanalytic treatments (Sloane, Staples, Cristol, Yorkston and Whipple, 1975) and reviews of research on the relative merits of different types of therapies (Landman and Dawes, 1982; Loborsky, Singer and Luborsky, 1975; Smith, Glass and Miller, 1980; Smith and Glass, 1977) have been cited by adherents of the "non-specific" position (Butler and Strupp, 1986; Frank, 1979; Garfield, 1986). Reviewers have concluded that, while clients

who receive therapy are better off than clients who remain untreated, there is not sufficient evidence to conclude that certain psychotherapies are more effective than others. At the same time, others (Andrews, et. al., 1990, Lambert, 1986; Lambert, Shapiro and Bergin, 1986) have noted that findings from meta-analytic reviews are consistent with the conclusion that behavioural and cognitive therapies enjoy somewhat higher rates of success than less directive approaches such as dynamic and humanistic therapies. In addition, the question of whether or not particular treatments are more successful with certain types of clients still remains an important subject of inquiry (Andrews, 1990; Beutler, Crago and Arizmendi, 1986; Frank, 1979; Hoge and Andrews, 1986). When these issues are considered, it appears that we have not yet reached a reasonable conclusion regarding the differential effects of so-called "specific" factors. Nevertheless, the dominant mood within the field of psychotherapy is that the most fertile research efforts lie in the investigation of "non-specific" therapeutic factors.

The postulation of non-specific factors serves two functions (Kazdin, 1979). First, such factors might account for null findings in treatment comparisons. Secondly, differences in treatment effects might be explained by the correlation of non-specific factors with particular types of treatments. Non-Specific factors have not been limited to therapist variables. For example, non-specific factors have been equated

with client expectancies generated by the perceived power of certain techniques (e.g. systematic desensitization, Wilkins, 1979), and factors common to all therapies including the mere contact of clients with therapists (Kazdin, 1979). However, much of the scholarly activity stimulated by the non-specific hypothesis has involved a search for therapist variables that impact upon therapy outcome. For example, Frank (1973), a strong proponent of the non-specific hypothesis, has outlined several elements considered crucial to effective therapy: a confiding relationship, a therapeutic rationale acceptable to the client, provision of new information, a strengthening of the client's expectation for improvement, new experiences of success, and the arousal of emotions. All of these can be viewed as elements which, to a large extent, are under the control of the therapist.

Many variables that have gained empirical attention are relatively independent of the major models of psychotherapy. Therapist expertness, trustworthiness, and attractiveness are considered social influence variables (Strong, 1968), which, like the elements proposed by Frank (1973), are not linked directly to any particular school of therapy. Other therapist variables are recognized as defining tenets of particular models but are observed in therapists from diverse schools of therapy. Variants of the Rogerian constructs of therapist empathy, warmth and genuineness (Rogers, 1957) have been studied in therapists employing decidedly non-Rogerian therapies (Alexander, Barton, Schiavo and Parsons, 1976; Miller, Taylor and West, 1980). Truax

and Carkhuff (1967) have described the importance of therapist warmth, understanding and genuineness in the development of diverse psychotherapy models.

Theoretical Synthesis

Another major current that is shifting attention from therapy models to non-specific therapist factors, is an increasing interest in theoretical synthesis. Godfried (1980), Norcross (1986), and Prochaska and DiClemente (1982) have designated this trend as the Zeitgeist in psychotherapy. Parloff, London and Wolfe (1986) have also described psychotherapeutic integration as an active area of interest in the current field. One indication of theoretical rapprochement is that many theorists who were firmly committed to particular schools of psychotherapy have begun to acknowledge the need to borrow from alternative approaches (Godfried, 1980). A more concrete sign of rapprochement is the emergence of cognitive therapy, which some commentators (Masters, Burish, Hollon and Rimm, 1987; Parloff, London and Wolfe, 1986) have interpreted as an integration of the therapeutic concerns expressed by behavioural and psychoanalytic theories.

Contributors to the development of a synthesis have pointed to common agents of change that exist in all therapeutic approaches (Godfried, 1980; Karasu, 1986; Prochaska and DiClemente, 1982). Karasu (1986), whose approach is

illustrative, proposes that affective expressing, cognitive mastery, and behavioural regulation are the three agents of change common to most models of psychotherapy. This approach to synthesis requires that the hypothesized change agents are operationalized in terms of broader measures of therapist activity than implied in the research that compares psychotherapy models. The questions that follow from the theoretical work in this area include, which agents of change are essential and how does the effectiveness of the agents vary with different types of clients. In terms of therapist characteristics, one possibility is that therapist styles might be operationalized in terms of the extent to which they embody the hypothesized agents of change.

Eclectic Practice

The move away from an interest in traditional schools of therapy is nowhere more evident than in the actual practice of psychotherapy. Surveys of practitioners estimate that large numbers of psychotherapists and counseling psychologists do not align themselves with any particular school and prefer to be identified as "eclectic" (Garfield and Bergin, 1986, Smith, 1982; Wilkins, Lopez, Campbell and Himmell, 1986). The most recent national survey conducted in the United States found that 68% of mental health professionals endorsed eclecticism (Jensen, Bergin, and Greaves, 1990). Smith (1982) has also reported that a large majority of practitioners perceive the movement toward some type of eclecticism as the dominant mood in contemporary

psychotherapy. The rise of eclectic practice has been attributed to the goal of selecting the most appropriate treatments for clients who present with different types of complaints and personality characteristics (Highlin and Hill, 1984). However, an important question concerns the extent to which eclectic therapists display regular use of specific combinations of therapeutic techniques. Some researchers have begun to focus on the therapist variables associated with eclecticism (e.g. self-monitoring, Matthews and Marshall, 1988). There remains a need for research that will provide descriptions of the most common patterns of therapist behaviour that are associated with eclectic preferences (e.g., Norcross and Prochaska, 1988, Jensen, Bergin and Greaves, 1990).

For researchers attendant to issues in the "specific versus non-specific" debate, the search for theoretical synthesis, and the trend toward eclectic practices, there is a clear need for the development of procedures aimed at measuring multiple therapist characteristics.

Moderating Influences of Therapist Variables

In addition to these trends, hypotheses that therapist variables may interact to influence client outcome also point to the need for multiple therapist measures in research. In this context Schaffer (1982) has cogently presented the case for the development of multi-dimensional assessments of therapist characteristics. He observes that the majority of studies of

therapist variables have focused on unidimensional constructs with the result that few relationships between therapist behaviour and client outcome are discovered. Furthermore, when significant effects are reported for single therapist dimensions, the relationships are typically weak. Schaffer and others (Orlinsky and Howard, 1978; Jones, Cumming and Horowitz, 1988; Lambert and Bergin, 1983) argue that single therapist variables are not likely to capture the full complexity of therapy outcome. To overcome this problem Schaffer advocates the use of measures that are sensitive to types of therapeutic techniques employed, therapist skillfulness, and the quality of relationships therapists offer clients. The assumption on which his recommendation is based is that interactions between and within these classes of therapist behaviour are likely to occur. The few studies addressing the issue of interactive effects of therapist variables on client outcome do suggest that this may be a favorable direction for research. Mintz, Luborsky and Auerbach (1971) reported that therapist empathy interacted with therapist directiveness to effect client improvement. Therapist empathy was positively related to treatment outcome when therapists were non-directive, but negatively related when therapists were directive. In a correctional treatment study, Andrews (1980) reported a different type of interaction between counselor empathy and structuring. Counselor empathy had a positive impact on outcome under conditions of high counselor structuring and was associated with negative outcomes when low

structuring was present. In their study of group therapy Lieberman, Yalom and Miles (1973) found an interaction between the leadership dimensions of caring and providing meaning such that the latter variable had the most positive effects on outcome when combined with high levels of caring. Again, these studies underscore the fact that a fuller understanding of the therapist's influence on treatment outcome can be gained through examinations of multiple dimensions of therapist behaviour.

Another promising avenue of research concerns the interactive effects of therapist and client characteristics on therapeutic outcomes. Wolfe and Goldfried (1988) have suggested that therapist relationship variables may interact with client personality variables and problem severity. Beutler, Crago and Arizmendi (1986) have reviewed studies showing more positive effects of therapist directiveness for clients with internal as opposed to external attributions of control. In addition to personality variables, there is evidence that more global measures of client functioning may moderate the effects of therapist characteristics. Jones, Cumming and Horowitz (1988), for example, reported that more severely depressed clients responded better to therapist directiveness than less depressed clients, while the latter showed more gains when they received insight-oriented therapy. Research conducted by Andrews and his associates (Andrews, Kiessling, Robinson and Mickus, 1986; and Andrews, Robinson and Balla, 1986; Andrews, Hoge and Robinson, in preparation) on the "risk principle" have demonstrated that

clients who are at high risk of negative outcomes profit more from intensive treatments than lower risk clients. This research has identified the importance of the moderating influence of client risk level on treatment outcomes in family and childrens' services and in correctional treatment. One implication of these findings is that pre-service client risk level might also interact with therapist variables. The studies provide good reason for examining the moderating role of client factors in studies focusing on the relationship between therapist characteristics and treatment outcome.

Existing Measures of Therapist Characteristics

Most extant instruments fall into one of two broad categories. The first consists of measuring devices that are based on direct observations of the behaviour of therapists during therapy sessions. These measures will be referred to as process measures. Typically process measures rely on the judgments of trained observers who rate audio- or video-taped segments of therapy sessions. However, process measures of therapist characteristics can also be obtained from therapy participants, i.e., clients and therapists. Measures of process provided by therapy participants are normally based on client or therapist recall of events that occurred during therapy. The second category of measures refer to indices which are derived

independently of actual therapy processes between individual therapists and clients. These pre-service measures are predominantly based on therapist self-descriptions of usual therapeutic behaviour. Although there are some exceptions, most existing pre-service measures of therapist characteristics are of the self-report variety using multiple-item inventories of preferred practices and styles of interacting with clients.

Process Measures

The vast majority of studies of therapist characteristics have employed process-based ratings. Although numerous, the process measures usually focus on single therapist constructs. For example, there are a number of scales designed to rate the Rogerian relationship conditions. Popular measures of this type are the Truax Scales of Accurate Empathy, Non-possessive Warmth, and Genuineness (Truax and Carkhuff, 1967), and a revised version by Bergin and Solomon (1970). Audio-taped therapy sessions provide the content for judges' ratings of therapist relationship variables. Truax and Carkhuff (1967) have also designed a multiple-item client-report instrument that taps the therapist relationship variables. The Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962) is another multiple-item client-report questionnaire intended for measurement of the Rogerian constructs. Process measures of the therapist social influence variables of expertness, trustworthiness and

attractiveness, are also available. These measures are derived from the ratings of observers or client reports of therapist behaviour. The Counselor Rating Form (Barak and LaCrosse, 1975) and the Counselor Effectiveness Rating Scale (Atkinson and Carskaddon, 1975) are examples of instruments that measure therapist variables derived from the social influence model. These scales are based on multiple-item formats.

There are also therapy process ratings which provide multi-dimensional assessments of therapist characteristics. Most of these instruments include process ratings of both therapist and client behaviours. The ratings are usually made by external observers. The Vanderbilt Psychotherapy Process Scales (VPPS) is an example (Gomes-Schwartz, 1978). The VPPS have been widely used and provide measures of therapist exploration, warmth, directiveness, negative attitudes, as well as a number of client behaviours. Another process measure from the Vanderbilt Psychotherapy Project, the Vanderbilt Negative Indicators Scales (NNIS), provides judgments of therapist personal qualities and errors in technique (Sachs, 1983). The Lieberman, Yalom and Miles (1973) study of encounter groups employed observer-rating scales that characterized leaders in terms of caring, providing meaning, stimulating emotion, and performing executive functions. A measure designed specifically for characterizing the in-therapy behaviours of family therapists, the Family Therapist Rating Scale (Piercy, Laird and Mohammed, 1983), is used to rate therapists' relationship, structuring, and family structural/

process skills. Historical and experiential orientation scales are also included. A more recent innovation, the Psychotherapy Process Q-Sort, has been offered by Jones, Cumming and Horowitz (1988). This instrument is composed of 100 relatively orthogonal Q-sort items with a third of the items devoted to therapist attitudes and actions.

Taken together the existing process scales provide measures of a wide range of therapist characteristics. However, researchers who are interested in a comprehensive sampling of therapist variables are faced with the problem of combining a large assortment of scales that are based on diverse rating formats. Moreover, a large proportion of the scales were especially designed to assess single therapist dimensions. Other rating devices were designed with particular types of therapies in mind. The Vanderbilt scales were constructed for use in studies of psychodynamic therapy and the content of the Family Therapist Rating Scale is most appropriate for studying interactions between therapists and families. While some of the process instruments described above are less narrow in focus, many of the therapist characteristics identified in reviews of the literature and in theoretical contributions are not represented.

Pre-Service Therapist Self-Reports

Existing pre-service therapist self-report instruments possess much more breadth than the process-based methods. In

fact, the majority of these instruments were expressly designed to allow multi-dimensional assessments of therapist characteristics. Most therapist self-report inventories were constructed after extensive reviews of approaches and styles employed by therapists of differing theoretical orientations. This method has resulted in the development of scales that manifest a greater diversity of therapist characteristics.

There are a number of self-report instruments. Examples include: the Therapist Orientation Questionnaire (Sundland and Barker, 1962); the Active, Impersonal, Directive (AID) Scales (McNair and Lorr, 1964); the Usual Therapeutic Practices Scale (Wallach and Strupp, 1964; Wogan and Norcross, 1983); a therapist orientation and relationship instrument (Peterson and Bradley, 1980); a therapeutic style questionnaire (Rice, Fey and Kepecs, 1972; Rice, Gurman and Razin, 1974; Rice, Razin and Gurman, 1976); and a therapeutic activities questionnaire (Wogan and Norcross, 1985). The psychometric properties of the earliest therapist self-report measures have been described in some detail by Sundland (1977).

The multiple-item self-report inventories listed above range in length from 17 to 133 items which employ likert-type responses. The number of scales defined by these inventories ranges from three to thirteen. Most of the instruments permit assessment of therapist relationship factors along with a variety of other dimensions. Measures of therapist activity level,

directiveness, use of psychoanalytic techniques, flexibility, personal distance, goal setting, and the use of treatment planning are included in many of the instruments. The Peterson and Bradley (1980) instrument yields measures of therapist endorsement of behavioural, gestalt and rational-emotive techniques. The Wogan and Norcross (1985) inventory also includes scales that measure therapists' use of specific techniques such as flooding, education, and the use of psychometric tests.

In developing measures of therapist constructs from self-report inventories most scale developers have relied on factor analysis. The approach usually adopted has been to subject the inventory items to one or more factor analytic techniques that allow the therapist dimensions to emerge from the data. This method of empirically deriving scales can be contrasted with approaches that specify the constructs to be measured on an a priori basis. Items for the various constructs are then selected in a manner that maximizes the content validity of the individual scales. Only one of the self-report instruments described above (Bradley and Peterson, 1980) employed this method. The factor analytic strategy has many merits, especially when the constructs being investigated have not been theoretically elaborated or operationalized in previous studies.

Several therapist factors have been empirically-derived in separate analyses using different sets of self-report items. Therapist directiveness factors have been extracted in factor

analyses of three of the self-report inventories (McNair and Lorr, 1964; Rice, Gurman and Razin, 1974; Wogan and Norcross, 1985). Therapist flexibility was identified in two separate samples using the same inventory (Wallach and Strupp, 1964; Wogan and Norcross, 1983) and a similar factor labeled "rigid/mechanical" was extracted in a third study with a different inventory (Rice, Gurman and Razin, 1974). Therapist activity level was also identified in three studies (Rice, Gurman and Razin, 1974; Wallach and Strupp, 1964; Wogan and Norcross, 1983). Analytic or psychodynamic style factors emerged in three separate factor analyses (McNair and Lorr, 1964; Sundland and Barker, 1962; Wogan and Norcross, 1985) and a comparable factor, "traditional focus", was identified in another study (Rice, Gurman and Razin, 1974). Therapist relationship factors, variously labeled, have been reported in five separate factor analyses (McNair and Lorr, 1964; Rice, Gurman and Razin, 1974; Wallach and Strupp, 1964; Wogan and Norcross, 1983, 1985).

To a large extent it can be said that the work on self-report inventories has converged on a core number of empirically-derived therapist characteristic measures. Many therapist variables that have received attention in the psychotherapy literature are represented among the self-report factors. The factor analytic studies have also demonstrated that the self-report approach can yield therapist measures that are comparable to those designed for process-based research. Although the factor analyses have not provided an exhaustive battery of

all therapist variables considered relevant by contemporary theorists and researchers, measurement advances using self-report methods have been achieved.

The chief limitation of the work on self-report inventories is that construct validation efforts have been minimal. Fiske (1977) remarked that in general, "... the phrase construct validity is foreign to psychotherapy research ..." (p. 33). Apart from the factor analyses, the only evidence for the validity of the instruments involves correlations between some of the self-report scales and therapist demographic characteristics, professed theoretical orientation, and years of experience. Most of the self-report instruments were developed using samples of psychotherapy association members (Wogan and Norcross, 1983, 1985; Sundland and Barker, 1962; Wallach and Strupp, 1964) or psychotherapists affiliated with treatment centers (McNair and Lorr, 1964; Peterson and Bradley, 1980; Rice, Gurman and Razin, 1974). Data were not collected on clients who received treatment from the therapists in the various samples. Although some scale developers acknowledged the potential use of their instruments for exploring the relationship between therapist characteristics and therapeutic outcome (McNair and Lorr, 1964; Sundland and Barker, 1962; Wogan and Norcross, 1985), the appropriateness of the instruments for this purpose has not been demonstrated.

Another problem with the available self-report measures of therapist characteristics is that most of the instruments can no longer be regarded as comprehensive. Because of developments in

the field of psychotherapy in the last 20 years, many of the newer techniques are not represented in scales developed in the 1960's. For example, the popularity of paradoxical techniques and the use of relabeling are recent developments in the field. In addition, the Cognitive/Behavioural approach, which appeared only in the last 20 years, now represents a major psychotherapeutic orientation.

The existing self-report scales, particularly the earliest versions (Newman, Kopta, McGovern, Howard, and McNeilly, 1988), relied on attitudinal items to measure the various constructs. These types of items refer to what the therapist views as the major cause of client problems and the general approaches which are thought to be most ameliorative. Therefore, actual therapeutic behaviours are neglected in the content of some of the scales. However, it can be argued that items referencing more specific in-therapy behaviours are necessary to ensure that the therapist's self-reports bear a resemblance to the actual work they do when they see clients.

The existing measures of therapist characteristics reviewed above lay some of the groundwork for the development of a comprehensive assessment of therapy-relevant characteristics of therapists. Before proceeding to an elaboration of the therapist constructs measured in this study, some attention will be given to the methodological issues that have been raised in the psychotherapy literature regarding techniques for measuring therapist variables.

Methodological Issues in the Measurement of Therapist Characteristics

Two issues are of primary concern in designing measures of therapist characteristics. The first concerns the units on which measurements are to be based: segments of therapy sessions, overall ratings of therapy sessions or complete treatments with clients, and measures derived independently of the therapy process. The second issue pertains to the sources of measurement: clients, therapists, external observers. In the context of the present research these issues translate into questions about the utility of pre-service measures that are obtained using self-report techniques. The issues surrounding the assessment of therapist variables using pre-service self-report methods are particularly relevant when the intention is to study the associations between therapist characteristics and treatment outcome. These concerns will be examined in some detail in terms of current thinking on these matters in the psychotherapy literature, and empirical findings which directly address the issues.

Pre-Service Measures

As mentioned previously, pre-service assessments of therapist characteristics refer to measures obtained without reference to actual interactions that take place during therapy

between individual therapists and clients. A researcher adopting this method would characterize each of several therapists on a relevant therapist variable using some type of measurement instrument. Having also obtained a sample of clients who had completed a course of treatment with the therapists, the researcher would then examine correlations between therapist measures and the indicators of client outcome. An alternative approach would be to base the therapist measures on observations or reports of therapy process in which each individual therapist was engaged with one or more clients. The process-based therapist measures, normally aggregated for each client over one or more sessions or session segments, would then be correlated with client outcome measures.

The process-based measurement approach has been clearly preferred over pre-service assessments. In fact, with the exception of studies employing therapist demographic and personality variables derived from pre-service measurements, therapy-specific characteristics of the therapist are not normally operationalized independently of the therapy process. A number of writers have recommended that studies investigating the effects of therapist variables should pay close attention to the interactions that transpire between therapists and clients (Butler and Strupp, 1986; Fiske, 1977; Garfield, 1983; Highlin

and Hill, 1984; Lambert, DeJulio and Stein, 1978; Schaffer, 1983). Butler and Strupp (1986) called for intensive research on dyadic therapy processes and suggested that researchers refrain from the study of therapist factors that are disembodied from the interpersonal context of therapy. Fiske (1977) made a similar plea for research that is based on the observation of "molecular acts" in which the therapist's reactions to the client's specific behaviours are recorded on a moment-to-moment basis. Single therapist behaviours (e.g. providing an interpretation), are proposed by Schaffer (1982) as the best units for measuring therapist characteristics.

The recommendations that therapist characteristics be operationalized using process observations are rooted in the assumption that the behaviour of individual therapists is highly variable. Shaw and Dobson (1988) recently noted that outcome researchers have come to view therapist behaviour as "less traitlike" and more "statelike". It is argued that the behaviour of individual therapists varies across clients and across sessions with individual clients (Fiske, 1977; Schaffer, 1982). From this assumption it follows that pre-service assessments would fail to capture the full extent of the variance in therapist behaviours. Hence, the validity of pre-service measures of therapist variables are considered suspect. For example, the A-B therapist studies based on pre-service classification of therapist types are criticized by Fiske (1977) because the measures are perceived as too far removed from the

locus of treatment and cannot be presumed to represent what actually takes place in therapy. Another argument which favors the use of process measures is that different clients respond in different ways to the same therapist behaviours (Butler and Strupp, 1985). Thus, measures that are not sensitive to the interpersonal nature of psychotherapy will fail to identify the effects of therapist variables.

A study by Gurman (1973a) has frequently been cited as evidence of within therapist behavioural variability. Gurman plotted observer-rated therapist empathy derived from ongoing therapy sessions for six therapist/client dyads. The plots revealed fluctuations in empathic behaviour within sessions for each of the therapists and some variability in average empathy ratings across different sessions. Evidence of variability on characteristics other than empathy were not reported. However, in a study by Mintz and Luborsky (1971), correlations between segment-based and session-based ratings of empathy were lower than the correlations between segment-based and session-based ratings of other therapist variables (directiveness, cognitive approach, emphasis on the unconscious, activity level). The latter finding implies that, at least in terms of variability within single sessions, instability may apply more to empathy than to other therapist variables.

Although the results of Gurman's (1973a) study have reinforced the view that therapist characteristics are unstable, another important finding of the study has not received attention

in the literature. The six therapists were classified as high or low functioning therapists on the basis of earlier process-based ratings of empathy with a different sample of clients (Gurman, 1973b). Gurman's (1973a) data revealed that while there was within and across session variability, low empathy therapists rarely exhibited high empathy behaviour and high empathy therapists rarely functioned at low empathy levels. Thus, all of the therapists functioned at overall empathy levels that were predictable from their ratings based on a different sample of clients. While Gurman's (1973a) paper emphasizes the instability of therapeutic conditions, the data suggest that there is actually considerable stability in therapist behaviours within and across sessions and across clients. Objections to pre-service measurement that are predicated on the supposition that therapist behaviour is inherently unstable, may be less warranted than was previously thought.

There are also good illustrations that pre-service measures of therapist variables have some utility in predicting therapeutic outcome. Some of the more powerful effects of therapist characteristics have been discovered in studies which were not based on therapy process measures. In a study of a systems behavioural intervention with delinquents and their families, Alexander, Barton, Schiavo and Parsons (1976) used supervisor ratings of therapist behaviour. The ratings were derived from observations of the therapists in role-playing and group interaction situations that were entirely independent of

the treatments. However, Alexander and his associates found that pre-service measures of therapist relationship and structuring skills each made independent contributions to client outcome and accounted for almost 60% of the variance. The outcome criterion, improvement in family dynamics, was also associated with lower delinquent recidivism. Because the two therapist variables made relatively independent contributions to the explanation of outcome, concerns that the supervisor ratings may have constituted generalized halo effects that failed to represent the constructs can be ruled out.

Miller, Taylor and West (1980) used similar ratings of therapist empathy in an evaluation of behavioural therapies with alcoholics. The pre-service therapist empathy ratings accounted for 67% of the variance in client drinking behaviour after follow-up periods of six to eight months. The large magnitude of this effect was a serendipitous finding since the study was designed to evaluate the effectiveness of different behavioural treatments. Curiously, the significance of their finding has been questioned because the researchers had not specifically set out to test the relationship between therapist empathy and client outcome (Bergin and Lambert, 1983). However, Miller, Taylor and West (1980) used the Bergin-Solomon revision of the Truax Accurate Empathy Scale (Bergin and Solomon, 1970), a standard measure that has been employed in numerous psychotherapy studies.

Andrews and his associates (Andrews, 1980; Andrews and Kiessling, 1980) have reported on a series of studies of

correctional counseling in which pre-service measures of empathy were employed. In incarcerated samples they found that peer-ratings of the interpersonal skills of volunteer discussion group leaders were related to changes in offender criminal orientations. In a probation study involving volunteer and professional probation officers, these researchers also reported an interaction between pre-service levels of self-reported officer empathy and socialization. In this example the outcome criterion was the criminal recidivism of probationers who were seen by the officers.

Evidence of the stability of therapist characteristics and the predictive validity of measures derived independently of the therapy process provide support for the use of pre-service measurements of therapist variables. The evidence is in accord with Hoge and Andrews' (1986) conceptualization of interventions in human service settings. In their model pre-service therapist variables are regarded as an important source of influence on specific in-therapy processes. Just as pre-service characteristics of clients have been shown to be related to therapy outcome (Garfield, 1986), it is reasonable to expect that therapist attributes measured prior to the delivery of treatment will be associated with the actual process and outcomes of treatment.

Indications that links may exist between pre-service characteristics and therapy process do not imply that pre-service therapist variables are a replacement for more direct process

measures. On the contrary, in some research applications there will be the need to establish that pre-service measures of therapist variables serve as valid proxies of the conditions that occur in therapy. There is no question that process-based measures can provide rich insight into the contribution therapist variables make to client outcome. Therapist measures based on process observations are necessary to examine the dynamics that lead to what have been variously described as the "critical incidents" (Lambert and Bergin, 1983) or "good moments" in psychotherapy (Mahrer and Nadler, 1986). However, there are many research contexts requiring measurement of therapist characteristics in which the payoffs associated with process-based measures may not justify the time and costliness that are involved. In these situations, pre-service assessments will provide a feasible alternative method.

The usefulness of pre-service therapist measures need not be limited to their role as substitutes for process measures. There is a sense in which pre-service therapist variables should be regarded as relevant subjects of investigation in their own right. An obvious point is that inherent in the development of any professional training program is the assumption that therapist training in specific styles and modes of practice will produce effects on the outcomes of therapeutic interventions. Most practitioners in the human services would agree that some therapists are better than others and that particular characteristics and skills account for their success. The

attempt to identify these successful therapists at the pre-service level constitutes a very legitimate research enterprise. There are also clinical and research situations in which assignments of clients to treatments may need to be based on pre-service measures of therapist variables. For example, optimal matching of therapist characteristics with client characteristics as a means of enhancing outcome has emerged as an important theme in psychotherapy research (Berzins, 1977; Parloff, Waskow and Wolfe, 1978) and in the development of eclectic therapies (Beutler, 1983, 1986). In practical terms, the use of therapist-patient matching is dependent on the development of valid pre-service measures of therapist characteristics.

Self-Report Measures

Concerns about validity of measurement have also been raised with respect to self-report measures of therapist characteristics. There has been considerable discussion in the psychotherapy literature about the most appropriate source of information on which measures of therapist characteristics should be based (Fiske, 1977; Lambert, DeJulio and Stein, 1978; Mintz, Auerbach, Luborsky and Johnson, 1973; Wogan and Norcross, 1985). Uncertainty about whether therapists, clients or external observers provide the most valid information extends to other measurement problems involving therapy process and client

outcome. The uncertainty has been fueled by reports that therapists, clients, and observers possess divergent views regarding what happens in therapy (Lambert, DeJulio and Stein, 1978). The lack of consensus among different raters has been described as the "Rashamon" experience in psychotherapy (Mintz, Auerbach, Luborsky, and Johnson, 1973).

Most studies of therapist characteristics have relied on data supplied by clients or observers. Although the psychometric quality of client (Gurman and Razin in Fiske, 1977) and observer-based measures (Shaw and Dobson, 1988; Chinsky and Rappoport, 1970) have been questioned, more serious doubts have been raised about the ability of therapists to provide accurate self-descriptions. For example, Fiske's (1977) position is that ratings provided by therapists will be biased because therapists are too involved in the process of therapy. Self-reports are perceived as particularly suspect when they are related to indices of client outcome. Orlinsky and Howard (1986) commented on the finding that in 11 out of 11 studies there was a positive relationship between therapist self-reported affirmation of clients and client improvement: "This means that when therapists feel that they are being especially warm, they tend to be more satisfied with the outcome of their treatment. (p. 352)"

Reservations about the validity of therapist self-reports correspond to a general mistrust in the clinical literature about the information therapists provide with respect to client assessments and treatment outcomes (Newman, 1983). Many writers

have questioned the therapist's ability to provide objective assessment of the problems presented by their clients (Robins and Helzer, 1986; Houts, 1984; Auerbach, 1983). They draw attention to assessment errors associated with personal bias and theoretical presuppositions held by therapists. Ironically, it has been pointed out that the information supplied by therapists is valued to the extent that it is used routinely to inform management and policy-maker decisions (Caputo, 1985; Hoge, Andrews, Robinson and Hollett, 1988).

Skepticism about the validity of self-reports is not restricted to measures of therapist characteristics but pervades many areas of psychological research. Schrauger and Osberg (1981) have traced the skepticism to the psychoanalytic view that unconscious processes impede accurate self-appraisals and to the notion that social desirability motives produce biases. However, the latter researchers reviewed a number of studies in which predictive validity estimates for self-report measures were equal or superior to parallel ratings made by external observers. This finding was demonstrated in a variety of contexts. Shrauger and Osberg (1981) proposed that self-assessments may actually carry more predictive information because individuals have access to more information about themselves than external observers. Therapist self-reports may be useful for the same reasons. In this connection, Wogan and Norcross (1985) argued that the therapist's interpretation of his or her therapeutic behaviour may be more relevant than the interpretations imposed by external

observers. There are also a number of research findings indicating that valid measures can be derived from therapist self-reports.

Some evidence comes from studies which have examined correlates of therapist self-professed theoretical orientations. Luborsky, Woody, McLellan, O'Brien and Rosenzweig (1982) found that process ratings made by expert judges on a variety of criteria were appropriately correlated with therapists' intended use of three types of therapy for substance abusers. In 70 to 80 percent of the cases the researchers successfully identified the different therapies on the basis of observer ratings of in-therapy behaviour. Other investigators have found correlations between therapist theoretical orientation and self-reports of preferred techniques and practices. Peterson and Bradley (1980) found significant relationships between self-professed orientations among Gestalt, rational-emotive, and behavioural therapists and their responses to questionnaire items that operationalized the tenets of the respective orientations. Similar results for psychoanalytic, behavioural and humanistic therapists were reported by Heron, Ginot and Sitkowski (1987). These authors noted, however, that there was less evidence of the validity of therapist self-reports of allegiance to the humanistic orientation. Other support for the validity of therapist-professed orientation has been presented in psychometric analyses of the therapist self-report measures described earlier. Generally, expected correlations have been

obtained between therapist subscale scores and endorsements of psychotherapy models (Rice, Gurman and Razin, 1974; Sundland and Barker, 1962; Wallach and Strupp, 1964; Wogan and Norcross, 1985). These criterion-related validity studies suggest that there is consistency in the ways therapists describe the dimensions of their therapeutic behaviour.

The process literature contains some studies of the inter-correlations among ratings of therapy process variables provided by therapists, clients and external observers. Many of the process variables that have been examined relate to elements of therapist style, and therefore, shed light on the fit between therapist self-descriptions and their behaviour as reported by others. As such, the process literature provides data relevant to assessments of the concurrent validity of therapist self-reports.

Caskey, Barker and Elliott (1984) reported correlations that ranged from .17 to .45 between therapist and client ratings of six therapist behaviours. The two lowest and non-significant correlations were obtained for ratings of the therapist's communication of understanding and guiding the client. Therapist and client ratings of therapist explanations, gathering information, reassuring the client, and therapist "use of self" were significantly correlated. In an investigation of session impact, Dill-Stanford, Stiles and Rorer (1988) reported on therapist/client agreement regarding depth, smoothness, positiveness, and level of arousal experienced by both clients

and therapists. The majority of correlations between therapist and client ratings were in the .4 range. However, the researchers found that clients were less successful in predicting therapist self-reports than were therapists in predicting client reports.

A study by Hoyt, Marmar and Horowitz (1983) found moderate correlations between observer and therapist reports on 26 therapist behaviours exhibited during psychodynamic therapy sessions. The correlations ranged from $-.05$ to $.77$ with correlations falling below the $.2$ level for only six of the items. Most of the items referred to the use of specific psychodynamic practices. The use of two observers in this study allowed the researchers to compare inter-rater reliabilities with rater/therapist correlations. Not surprisingly, Hoyt, Marmer and Horowitz found that the inter-rater coefficients were considerably higher for most items than the correlations observed between therapist and observer ratings. Another study of psychodynamic therapy compared therapist self-reports of effectiveness with observer ratings of therapist exploration, warmth and negative attitudes (Rounsaville, Charon, Prusoff, Elkin, Imber, Stotsky and Watkins, 1987). Although the therapist self-report measure was not significantly correlated with ratings of negative attitudes, it was related to exploration ($r = .22$) and warmth ($.44$).

Carkhuff and Burstein (1970) reported therapist/client, therapist/observer, client/observer and inter-observer

correlations in a process study of therapist empathy, respect, genuineness, concreteness, and self-disclosure. Inter-observer correlations were very high, however, generally low and non-significant correlations emerged from the other comparisons. An exception to this trend involved more congruence between therapist and observer ratings among therapists who were rated by observers as high on empathy. It should be noted that except for therapist concreteness, the therapist variables were all concerned with therapist-offered relationship conditions in this study. The authors also acknowledged that the sample of therapists were below normative standards on the measure of empathy. The divergence of Carkhuff and Burstein's findings from other studies may have been due to the therapist sample employed and the domain of therapist variables examined.

Research involving a design resembling the Carkhuff and Burstein (1970) study was reported by Mintz, Auerbach, Luborsky, and Johnson (1973). Although this study is frequently cited to support the notion that therapists, clients and external observers possess discrepant views of the therapy process, the authors uncovered a "reasonable consensus" between the three views. The study was primarily concerned with client process variables but ratings of the therapist as "helpful and involved" were also solicited. The correlations for therapist helpfulness and involvement were in the .2 to .3 range and somewhat lower in magnitude than correlations for other scales. Perhaps the most important finding was that the level of correlations for the

different rater-pairs were not significantly different. An examination of the relationship between process ratings and evaluations of the quality of the psychotherapy sessions also demonstrated that the three types of raters all agree on what constitutes good sessions.

Interpreters of findings in the process literature have not been optimistic about the ability of therapists to accurately report on their therapeutic behaviour (Lambert, DeJulio and Stein, 1978; Xenakis, Hoyt, Marmar and Horowitz, 1983). However, a closer inspection of the findings reveals more overlap in the ratings provided by therapists and the observers of their behaviour than researchers' conclusions have conveyed. With the exception of therapist empathy, for which lower correlations have been observed, there were moderate levels of association between the self-reports of therapists and the ratings provided by clients and external observers. One possibility is that lower correlations between therapist self-reported empathy and ratings based on other sources have been perceived as evidence of the inaccuracy of therapist self-reports in general.

The psychometric meaning attributed to the levels of agreement between therapist self-reports and ratings made by clients and trained observers also has the effect of minimizing the perceived usefulness of therapist self-reports. Correlation coefficients have been interpreted as inter-rater reliability estimates (Dill-Stanford, Stiles and Rorer, 1988; Xenakis, Hoyt, Marmar and Horowitz, 1983), when concurrent validity would

actually be a more appropriate psychometric standard. Mintz (1977) described this situation as it relates to interpretations of correlations between therapist and observer ratings of client outcome. He notes that assessment of inter-rater reliability is based on the assumption that "randomly selected judges from a population of judges" provide the ratings. Yet this assumption cannot be met when client, therapist and observer ratings are evaluated. Clearly, the three types of raters are not comparable with respect to the nature of their involvement in the process of therapy. Furthermore, methods sometimes vary across different rater sources. In process studies external observers often rely on audio-tapes of sessions while clients and therapists form their impressions on the basis of session recall.

Mintz (1977) recommended that the internal consistency of multiple-item therapist reports should be used to evaluate the reliability of therapist-based scales. Correlations between therapist self-reports and client and observer ratings are typically in the range of .2 to .5. While coefficients of this magnitude suggest low inter-rater reliability, they do provide evidence of the concurrent validity of therapist self-reports.

Agreement between therapist self-reported characteristics and peer ratings have also demonstrated that there is concordance between therapist self-descriptions and actual in-therapy behaviour as reported by peers. Recent evidence of peer-rating agreement was reported by Fuquo, Newman, Scorr and Gade (1986), who used seven well-known counselor effectiveness rating scales

and examined the intercorrelations between self-report, peer, and supervisor ratings. All of the process ratings were based on video-taped role-playing sessions conducted during a therapist training program. Correlations between self-report and peer ratings ranged from .26 to .67 with a mean of .47. Mean differences between the two sets of ratings were not significant. When self-report and supervisor ratings were examined, Fuquo and his associates found that the mean differences were significant. However, a mean correlation of .38 indicated that moderate agreement existed between therapist and supervisor ratings for the seven scales. Rice, Gurman and Razin (1974) reported a mean correlation of .56 between therapist self-report and peer-based scores for ten therapist style factors. The peer ratings were based on a sample of co-therapists. The sample was selected to ensure that there was also variability in self-reported style among the therapist pairs. The authors concluded:

This finding indicates a highly significant relationship between the self-report of a therapist's behaviour and the independent description of that therapist's behaviour by someone who had worked with him/her in co-therapy. (p. 419)

There is also evidence that therapist self-reported characteristics possess predictive validity when evaluated against the criterion of client outcome. Findings from the recent review of process and outcome studies by Orlinsky and Howard (1986) are illustrative. Although these authors did not deal with the issue of the predictive validity of therapist-based measures directly, their extensive tabulations provided

information on the source of both process and outcome variables. Hence it was possible to compare the relative number of significant findings associated with process measures derived from therapists, clients, and external observers. Although the proportion of significant findings is only a crude index of the predictive validity of therapist self-reports, it provides a helpful method of summarizing the available research. A sample of 469 findings which were specifically concerned with the relationship between process measures of therapist characteristics and client outcome was available from Orlinsky and Howard's tabulations.

An initial comparison revealed that therapist process variables derived from therapist self-reports were less likely to be related to outcome than process measures based on client and observer reports of therapist behaviour. Therapist variables had significant effects on outcome in 45% of the findings using therapist self-reports, 63% using client reports and 48% using external observer ratings. A chi-square test conducted by the present authour indicated significant differences across the three process measurement sources ($p < .01$). Given the evidence in the literature that therapist self-reports of relationship offered conditions were less valid than other self-report variables, the analysis was repeated with a control for type of variable. When the 311 findings concerning therapist relationship variables were examined, the distributions were similar to those observed in the first crosstabulation. However,

in the subsample of 158 findings that were not concerned with therapist empathy (e.g. therapist styles, therapeutic techniques, social influence variables) source of measurement was unrelated to findings of significant effects on outcome. Therapist self-reports were related to client outcome in 55% of the findings, in 50% of the findings using observer ratings, and in 54% using client reports. The chi-square test indicated no significant differences in the distributions.

As Orlinsky and Howard (1986) have argued, the possibility exists that the predictive validity of therapist measures may be inflated when both process and outcome measures are based on therapist reports. The caution is particularly relevant when therapist empathy is measured. Alternatively, method variance attributable to findings involving both process and outcome measured from the client's perspective may have resulted in an underestimation of the predictive validity of therapist self-reports. Since Orlinsky and Howard (1986) categorized outcome measures in terms of therapist-based, client-based, independent clinical observations, and scores on psychometric tests, it was possible to examine the source of process and outcome ratings in relation to significant effects.

For this analysis there were 128 findings for which the outcome measures were derived independently of process measures and 30 findings involving process and outcome measured from the same perspective. Only the non-empathy therapist process measures were selected for the analysis. Among the findings

involving process and outcome measured by the same source, 68% of the findings regarding client-based measures of process and outcome were significant compared to 53% of the findings involving therapist reports on therapist process variables and client outcome. The difference was not significant. There were no findings in the Orlinsky and Howard sample in which process and outcome were both measured by external observers. In the sample of findings in which process and outcome were measured from different perspectives, 38% of the client measures, 56% of therapist self-report measures, and 50% of the observer measures showed significant effects. Again, the distributions were not significantly different. However, these results implied that if method bias was operating, the influence was greater for client reports than for therapist reports.

The meta-analyses demonstrate that for therapist characteristics other than empathy, therapist self-descriptions were not less likely to yield significant effects on client outcome than alternative measures. This finding was maintained when controls for dependence of process and outcome measures were introduced. Hence, sweeping evidence that the predictive validity of therapist self-reports is inferior to client or observer-based methods does not emerge from the data presented in Orlinsky and Howard's review (1986). Indications that therapist self-reports possess both concurrent and predictive validity lend credence to the claims of other authors (Mintz, 1977; Newman, 1983; Wogan and Norcross, 1985) that the psychometric quality of information provided by therapists has been underestimated.

We turn now to a discussion of the therapist constructs to be measured in the present study using the pre-service therapist self-report approach.

The TRSMP Scales

The rationally-derived TRSMP yield 23 pre-service therapist self-report scales. The scales are grouped according to the categories of therapist "styles", "models", and "practices". The 23 scales are listed in Table 1. The therapist constructs measured by the TRSMP will be defined and attention will be given to the types of indicators which are most suitable for scale construction.

The therapist constructs displayed in Table 1 were suggested by reviews of the literature on the relationship between therapist characteristics and client outcome (Parloff, Waskow and Wolfe, 1978; Beutler, Crago and Arizmendi, 1986), and more general studies of the relationship between therapy process and outcome (Howard and Orlinsky, 1986). Previous instrumentation attempts in this area have also influenced the selection of therapist constructs (Alexander, Barton, Schiavo and Parsons, 1976; Lieberman, Yalom and Miles, 1973; McNair and Lorr, 1964; Rice, Gurman and Razin 1972, 1974; Sundland and Barker, 1962; Wallach and Strupp, 1964; Wogan and Norcross, 1983, 1985). The 23 TRSMP scales include variables that have been consistently

Table 1

Therapist Report of Styles, Models, and Practices (TRSMP) Scales

Styles	Models	Practices
Openness/Warmth/ Understanding Direction Structuring Expertness Attractiveness Provides Meaning Focus on Feelings Activity Level Flexibility Goal Setting Emotional Distress	Psychodynamic	Paradoxical
		Interventions
	Behavioral	Skill-Training
	Cognitive	Role Playing
	Experiential	Relabeling
	Social Structure	Homework
		Social Networks
		Family Therapy

linked to particular outcome measures, as well as variables that possess theoretical promise.

Therapist Styles

Style refers to variables relating to the therapist's self-presentation in the context of therapy, as well as variables that concern the therapist's characteristic focus and approach in addressing the problems of clients. Examples of therapist styles include demonstrating openness, warmth and understanding, conducting directive interventions, having a tendency to elicit client expressions of emotion, and using flexibility in therapeutic procedures. Some style factors may emanate from the therapist's personality, while others may be traced to the therapeutic model or school with which the therapist identifies. However, the appeal to personality variables and therapeutic models in defining "therapist styles" does not take into account the greater generality of the concept as it will be applied here. Not all dimensions of therapist styles can be neatly placed within the categories of personality and therapeutic school. Some style factors, such as the therapist's relationship attitudes, may be linked to both personality dimensions and models of therapy. Moreover, therapists may exhibit a combination of styles that are associated with diverse theoretical orientations.

Some writers (Parloff, Waskow and Wolfe 1978; Pope, 1977) have used "style" to refer to nonlexical aspects of therapist speech. The present use of the term "style" is closer in meaning

to the term used by Beutler, Crago, and Arizmendi, which encompasses verbal and non-verbal communication, content of therapy, and elements of technical procedures and theoretical orientations. The wide range of in-therapy behaviours incorporated in studies of therapist style by Rice, Gurman and Razin (1974) and Lieberman, Yalom and Miles (1973) are also included in the present concept of therapist style.

A number of research applications for the therapist style factors are possible. Therapist styles have been linked to a variety of outcomes including client satisfaction with service and measures of behavioural change. The scales will provide a method of measuring therapist styles in studies of the link between therapist characteristics and outcome. As outlined above, there is a need to operationalize multiple style factors so that possible interactions between different styles can be investigated. There have been some efforts to identify client and therapist characteristics that interact to affect outcome. The therapist style scales may provide useful measures for research in the area of client-therapist matching. The style factors also provide measures for exploring other psychotherapy research questions aimed at clarifying the manner in which therapist characteristics relate to biases in clinical assessments, influence treatment planning, and determine the selection of criteria for evaluating treatment outcome.

A description of the style factors to be measured follows.

Openness, Warmth, and Understanding. The most frequently investigated style factors are therapist relationship variables. Generally, process studies examining these variables have presented evidence that the therapist's ability to form a quality relationship with the client promotes better outcomes (Patterson, 1984; Howard and Orlinsky, 1986; Lambert and Bergin, 1983; Truax and Carkhuff, 1967). The original impetus for research on relationship attitudes came from Roger's (1957) proposal that the therapist attitudes of empathy, unpossessive warmth, unconditional positive regard, and congruence, were necessary and sufficient conditions of positive therapeutic outcome. Rogers maintained that the therapist's authentic demonstration of these relationship qualities would allow the client to engage in the self-exploratory behaviour that is necessary for achieving positive change. The well-known work of Truax and Carkhuff (1967) also embraced the view that therapist relationship conditions were a primary agent of therapeutic effectiveness and extended Rogers's conceptualization. In addition to the promotion of self-exploration, they hypothesized that the therapist relationship variables facilitate positive client outcome by reinforcing effective human relating, eliminating fears and anxiety, and promoting positive self-valuations. The therapist's relationship skills are said to be directly facilitative of client change in these areas through effective reinforcement, and indirectly to the extent that the therapist's

warmth, understanding and genuineness produce positive affect in the client.

Although much of the research in this area employs separate measures of the four Rogerian conditions, there is some evidence that these variables represent a unidimensional construct (Lambert, DeJulio and Stein, 1978; Mintz and Luborsky, 1971; Ponterotto and Furlong, 1985). In practice, many studies have employed single scales to measure therapist relationship variables. For example, Gurman (1973) combined indicators of the Rogerian conditions and described the resulting scale as a measure of the therapist's facilitative behaviour. Another group of investigators combined the components, affect-behaviour integration, warmth, and humour to form a relationship skills measure (Alexander, Barton, Schiavo and Parsons, 1976).

Lieberman, Yalom and Miles (1973) studied the effectiveness of encounter group leaders in terms of their demonstration of a "caring" leadership style. The attributes of a caring leader consisted of offering friendship, love, affection, and encouraging participants to seek positive feedback.

The Openness/Warmth/Understanding scale being proposed to tap therapist relationship attitudes is modeled after the Rogerian constructs. Although this scale combines three facets of therapist relationship skills, a factor analysis will be performed on the items to determine whether or not separate dimensions should be retained. Elements of openness include the therapist's attempt to show unconditional positive regard toward

the client, warmth refers to expression of affection and friendliness, and understanding is defined as the therapist's use of empathy.

Direction and Structuring. The use of the terms direction and structuring to refer to therapist styles is ambiguous in the psychotherapy literature. Generally, both terms have been used to describe therapeutic styles that are based on a preference for a learning model of therapy. Hence, structuring and directing refer to the therapist's attempts to identify specific client problems and suggest concrete courses of action aimed at their resolution.

Although the term direction is employed more frequently, structure and direction are often used interchangeably. Alexander et al. (1976) refer to therapist directiveness and self-confidence as indicators of structuring skills. Rice, Gurman and Razin (1974) identified a style factor labeled "directed focus" which was composed of a focus on relationships, employing challenging behaviour, being interpretive, and guiding. In their review of the process and outcome literature, Howard and Orlinsky (1986) equate directiveness with therapists who exhibit authoritative styles in their establishment of the therapist-client relationship. The latter are contrasted with therapists who invite the client to collaborate in setting the therapeutic conditions. The concept of the directive therapist as one who takes a decisive lead in therapy is analogous to the description of the "executive function" of group therapy leaders proposed in

the factor-analytic study of Lieberman, Yalom and Miles (1973). Leaders characterized as high on the executive function engaged in behaviours aimed at setting rules and limits, establishing goals, and managing time.

The notions of executive function and authoritative style may represent a construct that is distinct from directiveness. In the scales being proposed, potential directiveness items that emphasize the therapist's use of guiding behaviour in relation to the client would be appropriate. For example, giving advice and instructions, offering explanations, setting goals and specifying concrete ways of acting are among the possible indicators. Structuring, on the other hand, will refer to a more authoritative stance associated with the executive function. Indicators of structuring might include taking responsibility for setting treatment goals, confronting the client, being in charge, and imposing firm leadership. A factor analysis of the pooled direction and structuring items will be performed to assess the potential utility of using separate scales.

The separation of the constructs of direction and structure may help explain some of the contradictory research findings regarding the construct of directiveness which have been identified in reviews of the literature (Beutler, Crago and Arizmendi, 1986; Howard and Orlinsky, 1986). While there have been positive, negative, and null findings, it has been concluded that directiveness is negatively correlated with outcome. More careful specification of the constructs of direction and

structure may reveal that these variables are related to outcome in different ways, or that optimum levels on both variables may be necessary to produce positive change. One possibility is that therapist direction, defined in terms of guiding the client and giving advice may be positively related to outcome. Structuring, to the extent that it reflects an authoritative stance, may be negatively related to outcome.

Expertness. The interpersonal influence model of counseling proposed by Strong (1968) has stimulated a great deal of research on clients' perceptions of therapist's expertness, trustworthiness, and attractiveness (Corrigan, Dell, Lewis and Schmidt, (1980). Using a cluster analysis of citation patterns in a counseling periodical, Wampold and White (1985) found that interpersonal influence represents the most dominant contemporary theme in counseling research. Strong (1968) outlined a two-phase interpersonal influence process in which it is necessary for the therapist to demonstrate expertness, trustworthiness, and attractiveness before techniques aimed at client change can be effective. The psychometric studies of interpersonal influence scales summarized by Ponterotto and Furlong (1985) imply that the three scales may be unidimensional. In particular, factor analyses have provided poor evidence that trustworthiness represents a separate dimension.

The expertness scale taps behaviours that are likely to increase the client's confidence in the therapist's expertise. Possible indicators include the projection of confidence,

explanation of therapeutic actions, and promotion of positive expectancies regarding therapeutic outcomes.

Attractiveness. Elements that refer to interpersonal liking behaviours would be most appropriate for the measurement of attractiveness. Examples include the therapist's demonstration of enthusiasm, joking, smiling, and the avoidance of behaviours such as shouting, anger, and unpleasant physical contact. A number of indicators of this type were used by Wilner et al (1977) in a study of therapist behaviours that were liked and disliked by youth who were being treated in a residential setting. It is likely that the attractiveness scale will overlap to a considerable degree with Openness/Warmth/Understanding.

Provides Meaning. One of the four leadership styles identified in the Lieberman, Yalom and Miles (1973) study related to the encounter group leaders' use of "cognitizing" behaviour. Leaders high in meaning-attribution provided group members with concepts, clarified experiences, and made interpretations of behaviour. Other writers have also pointed to the importance of this construct. A key ingredient in Frank's (1973) model of therapeutic change is the therapist's ability to present plausible explanations for the client's distress. In their review, Howard and Orlinsky (1986) concluded that therapists' employment of interpretive techniques was frequently related to positive outcomes. Garfield (1983) has suggested that the therapeutic function of providing the client with explanations of his or her disturbance may be an effective ingredient common to

most psychotherapies. Variations of the construct of providing meaning have also been proposed by other theorists in their efforts to identify the principle agents of change in psychotherapy (Karasu, 1986; Prochaska and DiClemente, 1982).

The measurement of this construct would rely on items referring to the therapist's use of explanations, offering interpretations, and promoting the integration of behaviour and affective realms. It can be hypothesized that these items will share variance with the social-influence construct of expertness. This follows from Frank's (1973) thesis that the ability to formulate explanations of clients' problems may give the therapist some professional credibility.

Focus on Feelings. Focus on feelings is another therapist style extracted in the factor-analytic study by Lieberman, Yalom, and Miles (1973). Group leaders high on the "emotional stimulation" factor were challenging, provocative, encouraged expression of feelings, and the release of emotions. Karasu (1986) postulated that affective expressing is a major agent of change used by therapists across diverse psychotherapy schools. Howard and Orlinsky (1986) reported that most process studies of affective expression or catharsis, found that client experience of emotional discharge is related to positive outcomes.

In terms of potential indicators, focus on feelings could be operationalized using items that stress attendance to the emotional experience of their clients. Examples include the

therapist's encouragement of discussions of feelings and the use of ventilation.

Activity Level. Rice, Gurman and Razin (1972, 1974) identified a strong factor described as "activity level" in their factor analysis of therapist self-reported in-therapy behaviours. Therapists high on activity level were talkative, impassive, and unlikely to use cautious, premeditated interventions. While this therapist style factor has been under-investigated in relation to process and outcome variables (Parloff, Waskow, and Wolfe, 1978; Beutler, Crago and Arizmendi, 1986), activity level may be an important correlate of outcome and may interact with client variables. For example, the work of Linn, Klett and Caffey (1980, 1982) indicates that activity level may have differential impact on the treatment outcomes of schizophrenic and depressed patients. There is evidence from research in family therapy (Shapiro & Budman, 1973) that clients expect relatively active behaviour from their therapists, and therefore, a passive approach may be negatively correlated with client satisfaction.

Possible components of an activity scale could be drawn from the indicators previously used by Rice, Gurman and Razin in the study mentioned above. There are other therapist characteristics such as spontaneity, enthusiasm, and eccentricity that would also contribute to an animated style. There is reason to suspect that activity level will correlate with therapist directiveness since these two styles have been combined in earlier measurement attempts (McNair and Lorr, 1964).

Flexibility. There is a lack of studies on therapist flexibility. However, Parloff, Waskow and Wolfe (1978) note that flexibility in the application of therapeutic procedures may be an advantage in working with some types of clients. They suggest that flexibility may be particularly beneficial in the treatment of lower class clients. Evidence for the flexibility construct has also been presented in the Rice, Gurman and Razin (1972, 1974) studies. One of the style factors derived from their factor analyses reflected a rigid/mechanical approach. Wallach and Strupp (1964) and Wogan and Norcross (1983) also extracted flexibility factors in their factor analyses of seventeen self-reported therapist behaviours.

Improvising, avoiding consistency during sessions, reviewing and evaluating alternative courses of action, and revising plans on the basis of progress, are possible flexibility items. An issue to be explored is the degree of variance that this scale may share with level of therapist activity. For example, items defining activity level, such as spontaneity, are likely to correlate with flexibility.

Goal Setting. Sundland and Barker (1962) reported considerable variability in the extent to which therapists formulate treatment goals and a preference for goal-limited therapy emerged in a factor analysis by Wogan and Norcross (1983). Although goal setting may be highly related to other therapist styles, the feasibility of treating this construct as a distinct style will be assessed. In measuring this construct,

emphasis will be placed on the specificity of the therapist's formulation of treatment goals. Possible elements include the therapist's report that therapy is directed toward definite goals, explicit goal formulation, and the specification of desired outcomes in terms of objective and measurable goals. It is possible that Goal Setting may be an integral component of the direction or structuring styles.

Emotional Distress. Reviews of the literature have concluded that therapist mental health or emotional well-being is correlated with positive client outcomes (Beutler, Crago and Arizmendi, 1986; Lambert and Bergin, 1983; Parloff, Maskow and Wolfe, 1978). Recently, Guy, Poelstra and Stark (1989) found that of the psychotherapists in their sample who reported experiencing personal distress during the previous three year period, close to 40% felt that their distress resulted in a decrease in the quality of treatment extended to their clients. Strictly speaking, emotional well-being might be considered a personality variable rather than a therapist style variable. Beutler, Crago and Arizmendi (1986) referred to therapist emotional well-being as an "extra-therapy" characteristic of the therapist. Emotional Distress is being proposed as a therapist style in the sense that the mental health of the therapist will affect his or her self-presentation in the therapeutic context. Items tapping the therapist's lack of security, discontentedness, anxiety, are potential indicators of the absence of emotional well-being.

Openness/Warmth/Understanding, Direction, Expertness, Attractiveness, and Activity Level are style factors that are likely to be negatively correlated with poor emotional well-being. The magnitude of the associations between the Emotional Well-Being scale and other style factors will determine the utility of retaining this construct as a measure of style. Given the hypothesized correlations, emotional well-being is an obviously strong measure for exploring the validity of other style factors.

Psychotherapy Models

The psychotherapy model scales provide measures of the extent to which therapists identify with particular schools of psychotherapy or broad orientations toward therapeutic practice. Psychotherapy models can also be conceived as therapist styles according to the broad definition delineated above. However, psychotherapy models are regarded as the accepted categories or labels that make it possible to distinguish between various approaches in the field of psychotherapy. For this reason, the model scales are posed as a separate class of therapist variables. As distinct from therapist styles, models are directly related to well-recognized theoretical principles which are unique to particular theorists or schools of therapy. Psychotherapy models furnish a systematic understanding of the causes of clients' problems and prescribe the specific therapeutic actions necessary to facilitate client adjustment.

The models encompass broad groupings of therapeutic approaches and are not being designed with the intention of providing an exhaustive classification of therapists into therapeutic schools. However, previous research has demonstrated that it is possible to construct indices of psychotherapeutic models that correlate with therapists' professed models of practice (Peterson and Bradley, 1980). Only models of therapy currently in popular use are represented in the scales.

There are a number of reasons for including measures of psychotherapy models in a comprehensive assessment of therapist styles and practices. In some settings researchers and administrators may desire a means for describing therapists in terms of their relative endorsement of particular models. The scales also have potential utility for exploring the validity of therapist self-designated orientations, similar to the data reported by Heron, Ginot and Sitkowski (1987). Apart from questions about the relative effectiveness of different psychotherapy models raised in the discussion of "specific" versus "non-specific" factors, models may also interact with style factors to affect outcome. Psychotherapy models may also help account for some of the variance in client assessments, targets of intervention, and other treatment planning variables which cannot be explained by therapist styles.

The model scales include psychodynamic, behavioural, cognitive and experiential models. While most therapists define their approaches as "eclectic", recent surveys of counseling

psychologists (Zook II and Walton, 1989; Wilkins, Lopez, Campbell and Himmell, 1986; Smith, 1982), psychotherapists (Garfield and Bergin, 1986) and mental health professionals (Jensen, Bergin, and Greaves, 1990) found that the models enumerated above were most frequently reported, both singly and in combinations. To increase the utility of the instrument for applications in social work agencies and mental health centres that serve a large proportion of economically disadvantaged clients, a Social Structure scale will also measure the extent to which therapists attribute client problems to social and political-economic structures.

Psychodynamic. This scale includes a number of items that indicate the adoption of a psychodynamic interpretation of clients' problems. Examples include an interest in client histories, linking personal problems to individual psychodynamics, and identifying and dealing with resistance.

Behavioural. The behavioural scale is composed of items concerned with behavioural assessments and procedures. Included are the therapist's isolation of behavioural targets, linking problems to personal habits and skill deficits, use of behavioural contracting, contingency management, time-out procedures, and token economy techniques.

Cognitive. Focus on attitudes and values and the use of techniques that promote cognitive change are included in the cognitive scale. Indicators include linking client problems to attitudes, values, and beliefs, encouraging discussion of

beliefs and values, giving clients new ways of viewing relationships, and the use of values clarification and cognitive control methods.

Experiential. The number of experiential therapies in contemporary practice poses difficulties for identifying a single set of indicators that will adequately represent the diversity of approaches. Research indicates that therapist measures poorly discriminate between experiential and other types of therapists (Heron, Ginot and Sitkowski, 1987; Wogan and Norcross, 1985). However, an attempt will be made to select items which have been associated with experiential therapies. Potential indicators can be drawn from Rogerian themes since this school appears to be the most popular. The scale will be comprised of items such as therapist patience and willingness to wait, requesting clarifications, paraphrasing content, and reflecting feelings.

Social Structure. Therapists employing a social structural model may be characterized by the use of social and political-economic explanations of the problems presented by their clients. The collection of papers edited by Bailey and Brake (1975) illustrate some of the tenets and practices endorsed by therapists who take a structural approach to treatment. Items composing this scale will include the therapist's endorsement of the view that personal problems are caused by political-economic and gender structures, an emphasis on legal and civil rights, and linking clients to community resources.

Ideally, the measures of psychotherapy models will be somewhat independent of the therapist style scales. Nevertheless, there should be meaningful patterns of intercorrelation between some of the therapist styles and models. Beutler (1983) has reviewed the literature on studies of the differences and similarities among therapists employing the major models of therapy. Beutler's comparisons have aided in the formulation of a number of hypotheses about the relationships between therapeutic models and the therapist constructs which have been referred to as "styles". According to the data presented by Beutler, the Direction and Structuring scales should be positively correlated with the Behavioural and Cognitive models, and negatively correlated with the Psychodynamic and Experiential models. Similarly, the therapist Activity Level scale should be positively correlated with the Behavioural and Cognitive scales and inversely related to the Psychodynamic and Experiential scales. It is also possible to predict that the relationship between Goal Setting and the psychotherapy model scales will follow a similar pattern. Openness/ Warmth/ Understanding and Focus on Feelings are likely to be associated with an experiential orientation. The Provides Meaning scale, to the extent that it taps the therapist's use of interpretive techniques, should be associated with the Psychodynamic scale. Although there is no evidence from Beutler's (1983) review of the research in this area, the Provides Meaning scale might also be related to the Cognitive scale.

Therapist Practices

The third class of therapist variables, therapist practices, refers to specific techniques and procedures that therapists employ in the treatment of clients. As opposed to the general categories of styles and models developed above, the practice constructs assess the therapist's use of particular types of interventions such as role-playing, homework assignments, and relabeling. Only practices not implied in the major models of psychotherapy will be examined. For example, contingency management techniques are implied in behavioural therapies and free association and dream analysis are associated with analytic therapies. Such practices are not defined as separate practice scales.

The practice variables being proposed are meant to reflect the types of practices that are common to a variety of therapeutic models, and would quite easily fit within the armamentarium of techniques of an eclectic psychotherapist who does not draw exclusively from any one particular school. While an attempt was made to include contemporary therapeutic practices that are not intimately tied to any of the major therapy models, the practice constructs will overlap in varying degrees with the style and model constructs already defined. Most of the practice scales, for example, reflect relatively directive interventions.

Paradoxical Interventions. Paradoxical interventions have increased in popularity in recent years as evidenced by two reviews that summarize the research on the effectiveness of these

techniques (Hill, 1987; Shoham-Solomon and Rosenthal, 1987). The use of paradox has been particularly associated with strategic family therapy (Stanton, 1981), although Hill (1987) notes that such techniques are practiced by therapists from diverse persuasions. Paradox can be described as "prescribing the symptom", whereby the therapist typically instructs the client to continue or repeat problematic behaviour. Brehm and Smith (1986) explain that the therapist might appear to be advocating the "bad" or opposing the "good" in executing a paradoxical intervention. Although there is a lack of agreement about the psychological processes that operate to promote client change through paradox, Brehm and Smith (1986) propose that client reactance may operate to halt the problem behaviour which the therapist prescribes. In this view, the client rebels against the directive because compliance to the symptom prescription threatens his or her freedom. Indicators of the use of paradoxical techniques are numerous. The willingness of therapists to request that clients do not change, direct assignments of paradoxical tasks, and the use of paradoxical interpretations are among the possible indicators.

The use of paradoxical techniques reflect very conscious attempts to manage the behaviour of clients, and therefore, should be associated with the directive therapeutic style. There may also be a component of structuring involved to the extent that the success of such techniques implies that the therapist must convey the message that the client's compliance to the

paradoxical instructions are important. Since paradoxical techniques have been described by some of the dominant family system schools (Goldenberg and Goldenberg, 1985), a relationship between the use of paradox and endorsement of a family systems approach is also expected. However, it is not clear how paradoxical techniques might be related to the other style and model constructs that have been proposed.

Skill Training. In their factor analyses of therapist techniques, Wogan and Norcross (1985) identified a skill-training factor which they labeled "education". The factor included items that reflected the provision of information, and providing training in skill deficits. A number of prominent psychotherapists have advocated the use of direct skill-training in teaching clients to cope with stress (Meichenbaum, 1985) and directly addressing skill deficits which are regarded as precipitants of specific problems or obstacles to client fulfillment (Carkhuff and Berenson, 1976). Carkhuff (1971) elaborated on the notion of "training" as a preferred mode of treatment. Goldstein (1973) proposed Structured Learning Therapy as an approach to personal and interpersonal skill-training that was particularly suited to addressing the needs of working-class clients. An important characteristic of Goldstein's skill-training approach is that it emphasizes active and directive therapeutic procedures while avoiding introspective and symbolic activities. Various techniques such as modeling, role-playing,

and social reinforcement are appropriate within a skill-training approach (Goldstein, 1973).

One method of measuring the therapist's reliance on skill-training as a therapeutic agent is to assess the number of different behavioural targets which are identified as foci of skill-training efforts. Assertiveness, physical and mental relaxation, decision-making, listening, and negotiating are among the targets of skill training efforts. The use of skill-training has obvious links to more broader therapeutic styles such as directiveness, level of activity, and to the general models of behavioural and cognitive psychotherapy. It is unlikely that skill-training would be a major focus among therapists who endorse experiential and psychodynamic models.

Role Playing. The involvement of clients in role playing exercises appears to be popular among therapists, although the effectiveness of these procedures is under-investigated. It also appears that role playing is a common therapeutic practice applied by therapists across different therapeutic schools. At the same time, role playing may be used for different therapeutic objectives, depending on the psychotherapeutic model that guides the therapist. For example, Karasu (1977) notes the use of role playing as a method of rehearsing new behaviours in behavioural therapy, while it might be introduced to promote client self-expression or affective experiencing by therapists who use experiential orientations. Apart from the more specific objectives associated with the use of role playing, additional

power may be inherent in this technique simply because of its ability to involve the patient in the therapeutic process.

Measuring the therapist's use of role playing exercises is straight-forward and can be achieved with a simple frequency of use rating. In terms of the relationship between role playing techniques and other therapist variables, one possibility is that role playing may be used by therapists who are fairly active in their therapeutic approaches. There also may be a tendency for therapists who are more directive to use role playing.

Relabeling. Relabeling, or reframing, is an interpretive technique used by therapists to encourage clients to view their problems or situations in a new perspective. Normally relabeling replaces the client's definition of the problem with a more positive interpretation. For example, a troublesome behaviour might be described in terms of other adaptive functions it serves in the client's attempts to cope. Goldenberg and Goldenberg (1985) have discussed the role of reframing in family systems theory and suggest that when clients are able to reframe their problems, new options and alternatives for action become available. For example, when particular family disturbances are viewed in a more positive or sympathetic light, family members may become aware that changes in family dynamics are possible.

The relabeling scale measures the therapist's frequency of use of techniques designed to relabel client problems. Since relabeling operates at the level of changing cognitions, use of such techniques are likely to be associated with the endorsement

of a cognitive model of psychotherapy. Relabeling might also be correlated with the therapist construct of Provides Meaning since therapists who use relabeling attempt to give their clients new ways of perceiving their situation. Beutler (1983) has also suggested that the use of reframing is often used by experiential therapists.

Homework. The use of homework assignments can be an important component of the therapist's attempt to facilitate the transfer and maintenance of therapeutic outcomes (Galassi and Galassi, 1984). Homework techniques are used by behavioural therapists as a method of behavioural rehearsal, but may also be used by analytic therapists in assisting the client with the "working through" stage of therapy (Karasu, 1977). Although not enough research has been conducted on the effectiveness of specific homework assignments (Galassi and Galassi, 1984), in general homework is likely to enhance the client's involvement in therapy and may be a relatively effective means of promoting the generalization of in-therapy learning to other situations.

The homework construct can be measured by items that tap the therapist's use of homework techniques in addressing various behavioural targets. Endorsement of behavioural and cognitive models of psychotherapy should be positively related to the use of homework. In addition, therapists who assign homework are likely to be characterized by directive and active therapeutic styles.

Social Networks. The contribution of social support to the maintenance and enhancement of emotional and physical health has emerged as a dominant theme in health psychology. Gotlieb (1983) has drawn attention to the potential applications of social support models in the mental health field. He has described a number of psychotherapy approaches which are based on the mobilization of social support resources through the involvement of clients' social networks. Efforts to increase social support might also be sought in more formal support services available through community agencies.

Indicators of the use of social networks include the therapist's attempt to involve the client's family and friends in the treatment process and efforts to link the client with community resources. Social network techniques are likely to be applied by therapists who are active and directive. It can also be predicted that the endorsement of a family systems model will be correlated with the use of interventions that draw upon social networks.

Family Therapy Techniques. The family systems model represents a number of different approaches to conceptualizing and treating family problems. Therapists employing diverse psychotherapeutic models have contributed to family systems theory and research (Gurman and Kniskern, 1981). However, there is some evidence that more agreement on therapeutic techniques than on conceptualization of family problems exists among the various strains of family systems theory (Rohrbaugh, 1986).

The strategy for constructing this scale involves a factor analysis of numerous family therapy techniques. The emergence of a single factor or multiple weak factors will be taken as evidence that family therapy techniques are not too diverse to justify the use of a single scale. Elements of the family therapy technique scale will include the therapist's attribution of individual problems to family dynamics, identifying contracts in family relations, uncovering "scripts" and "rules of the game", and adopting the family's symbols and manner of communication.

Assessing the Validity of the TRSMP Scales

After the scales have been formed to operationalize the 23 therapist constructs and satisfactory estimates of their reliability have been obtained, the task becomes one of furnishing evidence of the validity of the new scales. The overall strategy adopted in the current research is that of construct validation. The establishment of construct validity is a psychometric goal when information is desired about the extent to which a set of operations actually measure the construct of interest (Ghiselli, Campbell and Zedeck, 1981). Construct validation, in the classical sense advanced by Cronbach and Meehl (1955), involves empirical tests of a network of hypotheses concerning the relationships between the construct being validated and other constructs. These authors have argued that

construct validity investigations are "not essentially different from the general scientific procedures for developing and confirming theories" (Cronbach and Meehl, 1955, p. 300). This definition invokes a deductive interpretation of construct validity. However, as Ghiselli, Campbell and Zedeck (1981) have argued, inductive strategies can also contribute to construct validation. In the latter case, unhypothesized correlations that are observed between a particular construct and other measures may provide evidence of construct validity, and may help clarify the meaning of the construct. The present validation method which is described in detail below, draws from both deductive and inductive approaches.

A network of hypotheses have been implied in the definitions of the constructs to be assessed by the TRSMP scales. These hypotheses provide a point of departure for assessing the construct validity of the scales in a deductive fashion. A number of criterion variables will also be examined in relation to the TRSMP scales. Hypotheses concerning the relationship between the TRSMP scales and specific criterion variables will be proposed. More exploratory analyses will also focus on the relationship between the TRSMP scales and other criteria about which no specific hypotheses are advanced.

A number of predictions have been made regarding the inter-relationships between the various TRSMP scales. For example, the use of Goal Setting should be positively related to Direction; Openness/Warmth/Understanding is likely to be

negatively associated with therapist Emotional Distress; and attempts to provide clients with meaning may be correlated with cognitive orientations. Hence, some support for the construct validity of the measures will be evident from a pattern of interconnections among the constructs which concurs with the logical predictions that have been advanced. The expected correlations among the TRSMP scales are outlined in Table 2.

A priori propositions can also be advanced regarding expected relationships between the therapist constructs and therapeutic outcomes. Many of the therapist style constructs have been traced to theories of behavioural change or behavioural influence. Empirical evidence that some of the constructs are linked to positive outcomes has also been reviewed. Theoretical and empirical work suggests that openness/warmth/understanding, directiveness, expertness, attractiveness, providing meaning, focus on feeling, and Emotional Distress are among the therapist characteristics that should have positive impacts on treatment outcome. Therefore, correlations between the TRSMP scales and outcomes of therapy judged by therapists and clients supply further data against which the construct validity of the scales can be assessed. Outcome measures include therapist judgments about whether or not positive treatment outcomes have occurred, and client reports of cognitive gain, behavioural change, satisfaction with service, and reasons for terminations.

A major assumption involved in the development of preservice assessments of therapist variables is that therapist descriptions

Table 2

Predicted Correlations Among TRSMP Scales

TRSMP Scales	Correlates
Openness/Warmth/ Understanding	Attractiveness, Emotional Distress (-)*, Experiential
Direction	Activity, Goal Setting, Psychodynamic (-), Behavioral, Cognitive, Experiential (-) Paradox, Skill Training, Homework, Social Networks
Structuring	Attractiveness (-), Activity, Goal Setting, Psychodynamic (-), Experiential (-), Paradox
Expertness	Attractiveness, Direction, Provides Meaning, Emotional Distress (-)
Attractiveness	Attractiveness, Openness/Warmth/ Understanding, Emotional Distress (-)
Provides Meaning	Expertness, Psychodynamic, Cognitive, Relabeling
Focus on Feelings	Experiential
Activity Level	Direction, Structuring, Flexibility, Emotional Distress (-), Behavioral, Cognitive, Skill-Training, Role Playing, Homework, Social Networks
Flexibility	Activity Level
Goal Setting	Direction, Structuring, Psychodynamic (-), Experiential (-), Cognitive, Skill-Training
Emotional Distress	Openness/Warmth/Understanding (-), Direction (-), Expertness (-), Attractiveness (-), Activity (-)
Psychodynamic	Direction (-) Structuring (-), Provides Meaning, Activity (-), Goal Setting (-)

Table 2 Continued

Predicted Correlations Among TRSMP Scales

TRSMP Scales	Correlates
Behavioral	Direction, Structuring, Activity, Goal Setting, Skill-Training, Role Playing, Homework
Cognitive	Direction, Provides Meaning, Goal Setting, Skill-Training, Role Playing, Homework
Experiential	Openness/Warmth/Understanding, Direction (-), Structuring (-), Focus on Feelings, Activity (-), Goal Setting (-) Role Playing, Relabeling
Social Structure	Social Networks
Paradox	Direction, Structuring, Homework, Family Therapy
Skill-Training	Direction, Activity, Goal Setting, Behavioral, Cognitive
Role Playing	Direction, Activity, Behavioral, Cognitive, Experiential
Relabeling	Provides Meaning, Cognitive, Experiential
Homework	Direction, Activity, Goal Setting, Behavioral, Cognitive
Social Networks	Direction, Activity, Family Therapy, Social Structural
Family Therapy	Paradox, Relabeling, Social Networks

* Expected negative correlations are denoted by "(-)" following the scale.

of their styles and practices will be predictive of therapy processes with individual clients. The absence of relationships between the TRSMP scales and relevant process variables would reflect poorly on the construct validity of the scales. One source of process information available for these analyses entails client evaluations of their therapists' behaviour. Following termination of service, clients provided information on the extent to which the therapists were understanding and supportive, had a capacity for encouraging exploration, assisted with problem-solving, and used assessment and directive methods. These process variables should be correlated with similar TRSMP measures. The predicted correlations among the client process and TRSMP scales are summarized in Table 3.

A second source of information about treatment process pertains to the techniques therapists plan to employ with their clients. Strictly speaking, planned techniques do not provide direct assessments of treatment processes. However, information about treatment plans based on individual cases are closer to the treatment process than the pre-service therapist self-descriptions. It is hypothesized that therapists' pre-service descriptions of their styles, models, and preferred practices will be predictive of the types of techniques they identify in their treatment plans for individual cases. An attempt is made to construct indices based on case planning narratives in such a manner as to provide parallel measures for a number of the TRSMP scales. For example, an index representing plans to utilize

Table 3

Predicted Correlations between Client Process Measures and TRSMP Scales

TRSMP Scales	Predicted Process Correlates
Openness/Warmth/Understanding	Basic Support
	Active Understanding
Direction	Explicit Problem-Solving
	Active Assessment/Structuring
Structuring	Explicit Problem-Solving
	Active Assessment/Structuring
Attractiveness	Basic Support
	Active Understanding
Focus On Feelings	Encourage Exploration
Goal Setting	Explicit Problem-Solving
	Active Assessment/Structuring
Emotional Distress	Basic Support (-) *
	Active Understanding (-)
Behavioural	Explicit Problem-Solving
Experiential	Encourage Exploration

* Expected negative correlations are denoted by "(-)" following scales.

directive techniques is compared with TRSMP directiveness scores. It is assumed that correlations observed between the parallel pre-service and case-planning variables are an additional source of support for the validity of the TRSMP scales.

Further tests of construct validity involve an examination of the relationship between therapist self-reports and expert observer accounts of therapist behaviour. In the latter case, supervisors' TRSMP ratings of their therapists' behaviour are compared with therapist self-report scores. In using these data it is assumed that supervisors have sufficient knowledge of the behaviour of their therapists to provide accurate descriptions. The use of supervisor ratings also provides an assessment of the potential utility of the TRSMP as a pre-service assessment device completed by expert observers. The supervisor scales can also be evaluated against client reports of process, and therapist and client assessments of outcome.

The validation efforts outlined up to this point focus on expected relationships between the TRSMP scales and a number of criterion variables. However, more exploratory efforts to validate the scales can also be pursued. It is possible that pre-service therapist characteristics may be related to assessment practices. There have been frequent references in the psychotherapy literature (Newman, 1983) to biases that are perceived to exist in the clinical assessments conducted by therapists. For example, the identification of client conflicts

and stressors may vary as a function of therapist styles, models, and practices. This issue will be explored by examining the correlations between the TRSMP scales and intake assessments of several areas of client functioning. Another area which can be explored pertains to the number of client problems that therapists select to serve as targets of their therapeutic interventions. Other treatment planning and treatment delivery variables which may provide further criteria for exploring the usefulness of the scales include the number of interviews planned at intake and the actual number of interviews delivered during the course of treatment.

Exploratory analyses will also address the issue of therapist characteristics as moderating variables. For example, certain therapist characteristics may have little impact on treatment outcome in the absence of other important therapist attributes. In particular, the possible moderating impacts that Openness/ Warmth/ Understanding may have on other therapist variables will be examined. The exploratory analyses will also direct attention to the moderating effects of client variables. Compared to low risk cases, clients at high risk of poorer outcomes may respond differently to treatment when certain therapist conditions are present. The influence of therapist characteristics on client outcome may be masked by interactive effects of this nature. Hence, the identification of such effects through exploratory analyses will provide further

information for evaluating the construct validity of the TRSMP scales.

In summary, the construct validation of the TRSMP will proceed along both deductive and inductive lines. Initial analyses focus on the extent to which the observed pattern of inter-correlations among the scales conforms with a priori predictions. Secondly, supervisor ratings of therapist behaviour are compared with the therapist self-report measures. Evidence of the construct validity of the scales will then be sought in examinations of the correlations between the TRSMP scales and a number of criterion variables. The criteria consist of client-based process measures, techniques planned by therapists in formulations of treatment plans for individuals cases, therapist assessment and targeting patterns, and number of interviews planned and delivered. Finally, the extent to which the TRSMP scales forecast treatment outcome as assessed by clients and therapists will be examined. Exploratory analyses will also investigate the potential interactive effects on outcome that may be operative through combinations of therapist variables and joint effects of therapist and client variables.

METHOD

Background

The Family Service Assessment and Evaluation Project (Andrews, Hoge, Robinson & Hollett, 1986; Hoge, Andrews, Robinson, & Faulkner, 1987) was a large-scale research endeavour funded by Health and Welfare Canada and sponsored by Family Service Canada. The project provided the opportunity for the development of the instruments and the collection of data that were analyzed in this study. The overall goal of the project was the development of a package of assessment instruments for use in family service agencies. The instruments were designed to survey both client and therapist sources of variability in service planning, service delivery, and service outcomes. The scope of the project allowed for the collection of data pertaining to both clients and therapists. The information gathered was based on therapists and client reports. In addition, family service supervisors were used as a data collection source. As such, the project produced a strong database for exploring the construct validity of the various instruments that were developed.

The Family Service Assessment and Evaluation Project involved a total of eleven Canadian family service agencies representing various regions of the country. The first phase of the data collection, which began with a pilot in 1984, was conducted in four agencies in Eastern Ontario. The second phase

began in 1986 and extended the project to two agencies in Nova Scotia, one in New Brunswick, three in Saskatchewan, and one in British Columbia. Data collection terminated in 1988 after a total of over 2600 family service cases had been entered in the databank.

Sample

Therapists

One hundred and three therapist/counsellors from the eleven family service agencies were asked to provide pre-service descriptions of their therapeutic behaviour. The present sample consists of the 66 therapists (64%) who agreed to participate in this component of the project.

The therapists had a mean age of 42.3 years ($SD = 9.9$) and 68% were female. In terms of their professional composition, 68% had received training in social work and 10% had backgrounds in psychology. A variety of academic backgrounds were represented among the remainder. While 65% of the therapists reported having graduate training, only two (3%) of the therapists held doctoral degrees. On average, the therapists had been involved in the human service field for 12.6 ($S.D. = 8.4$) years. They were involved in the provision of individual, marital, and family therapy. Sixty-nine percent of the therapists described their therapeutic orientation as "eclectic". Interestingly, the major psychotherapy models were not well-represented in this sample.

For example, only 4.5% endorsed the Psychodynamic model, and only one therapist preferred the Behavioural model.

Clients

Intake data were available on 2140 cases which were seen by the 66 therapists for at least one interview. The cases were consecutive intakes who approached the agencies for help during the data collection phases of the project. The client sample includes married/attached individuals (57%), single parents (22%), and unattached individuals (21%). Slightly over half of the cases presented as individuals (51.7%). The remaining cases were client groups: married or unmarried couples (31.7%); couples or individual parents seen with one or more children (16.6%).

Measures

The Core Instruments

The measures were derived from five core instruments: Preferred Practices Inventory (PPI); Family Service Assessment Inventory - Intake (FSAI - Intake); Family Service Assessment Inventory - Client (FSAI - Client); Family Service Assessment Inventory - Closure (FSAI - Closure); Client Feedback Questionnaire (CFQ). Each of these instruments will be described in terms of its major purpose, general composition, and administration procedures. The general overview of the

instruments precedes a more detailed description of the specific measures that were employed in the validation of the TRSMP scales.

Preferred Practices Inventory

The PPI is a 265 item inventory designed to survey characteristics of therapists/counsellors which are believed to be linked to service process (Andrews, Hoge, Robinson, Faulkner, Hollett, 1987). The content of the PPI was selected after broad reviews of the literature on therapist characteristics and therapy process. The general handbooks on psychotherapy edited by Garfield and Bergin (1966, 1978) and Gurman and Kniskern's (1981) work on family therapy research and practice served as important sources of item content for the PPI. The employment counseling (Peavy, 1981; Bezanson, DeCoff & Stewart, 1982), correctional counseling (Andrews, 1983; Andrews and Kiessling, 1980; Gendreau & Ross, 1979) and general social work practice (Fisher, 1978) literatures were also consulted. Items from existing scales were also adapted and incorporated in the battery of items (Alexander, Barton, Parsons and Schiavo, 1976; Rice, Gurman and Razin, 1974; Willner, Braukman, Kirigin, Fixen, Phillips & Wolfe, 1977). Although the PPI was first introduced in a family service setting, the research and theory on which the content of the instrument is based ensured that the instrument would apply to a variety of psychotherapy and counseling settings.

FSAI - Intake

The Family Service Assessment Inventory - Intake (FSAI - Intake) is a comprehensive assessment instrument completed by therapists after the first intake interview with clients. A manual provides detailed instructions for completing the FSAI - Intake protocols (Hoge, Andrews, Robinson & Hollett, in press). An FSAI - Intake specimen form appears in Appendix C.

The first section of the FSAI - Intake provides for the recording of information on the demographic characteristics of clients and details of the referral. The second section is a 25-item checklist of problems that have been experienced by the client and his or her family in the past. An expanded checklist consisting of 131 items, forming the bulk of the FSAI - Intake protocols, was designed for the assessment of problems and conflicts that are currently experienced by clients. The Current Situations Checklist items are distributed across twelve problem types (e.g., marital conflict, substance abuse, emotional well-being). Each item requires a check to signify the presence or absence of the problem. The therapist also indicates, by means of a simple coding procedure, the primary family members involved in the particular problem. Subscale scores are calculated by simple summation of dichotomous items within each problem area. A total score based on all 131 items provides an overall indicator of the level of problems exhibited by the clients. Each of the twelve problem areas are also rated with respect to the severity of stress associated with the problem.

A resolution test chart featuring various patterns of horizontal and vertical lines of different thicknesses. Numerical values are placed next to the patterns, indicating resolution levels. The values include 1.0, 1.1, 1.25, 1.4, 1.6, 1.8, 2.0, 2.2, 2.5, 2.8, 3.2, 3.6, 4.0, 4.5, 5.0, 5.6, 6.3, 7.1, 8.0, 9.0, 10, 11.2, 12.5, 14, 16, 18, 20, 22.4, 25, 28, 31.5, 36, 40, 45, 50, 56, 63, 71, 80, 90, 100, 112, 125, 140, 160, 180, 200, 224, 250, 280, 315, 360, 400, 450, 500, 560, 630, 710, 800, 900, 1000, 1120, 1250, 1400, 1600, 1800, 2000, 2240, 2500, 2800, 3150, 3600, 4000, 4500, 5000, 5600, 6300, 7100, 8000, 9000, 10000.

●

Following reviews of the literature, a first draft of the PPI was completed and distributed to members of the project's research advisory committee. The committee included supervisory personnel from the four Eastern Ontario agencies involved in the first phase of the project. After the instrument received approval from the advisory committee, further consultations were held with a working committee of therapists from the agencies. These consultations were viewed as important in ensuring that the instrument would be accepted by respondents, and to gain further input on the appropriateness of the content. The therapists agreed to complete the draft anonymously and to propose improvements based on their viewpoints as practitioners. While the initial draft of the instrument was not revised in a major way, the therapists aided in clarifying some of the terms used to define the items.

A specimen of the PPI is displayed in Appendix A. Each of the 265 items takes the form of a statement describing therapeutic behaviour (e.g., encourage ventilation, expression of feelings, linking personal/familial problems to personal attitudes, values, beliefs). The response format follows a 6-point scale ranging from "definitely not, never, not at all descriptive of worker" to "definitely yes, always, very descriptive of worker", with an additional response category reserved for "cannot say". Based on the earlier approach adopted by Rice, Gurman and Razin (1974) in their development of a therapist self-report instrument, the PPI instructions request

therapists to describe their "style in general". The instructions explain that the self-descriptions should correspond to "that picture which a panel of observing therapists would get from watching you work, over time, with a variety of cases."

A face sheet requesting demographic information is also attached to the PPI. Therapist age, gender, education, professional experience, and number of years employed with the agency are included. Therapists are also asked to indicate the primary model which they rely upon in conducting their work.

The PPI was distributed to all therapists employed in the participating agencies. Therapists received the necessary forms from their supervisors and were notified that their completion of the PPI was strictly voluntary. A four-page statement of the principles of confidentiality guiding all facets of data collection in the project was also distributed to therapists (Appendix B). The confidentiality of therapist responses were again underscored in the instructions for completing the PPI. Therapists were also told that they would be permitted to examine their PPI scale scores if they wished.

Therapist supervisors were also asked to complete the PPI for each therapist under their supervision. The item content and administration instructions were the same for both therapist and supervisors, although supervisors were asked to use the PPI items to describe the therapists they supervised. Supervisor versions of the PPI were completed for 35 (53%) of the 66 therapists.

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The psychometric properties of the Current Situations Checklist have been described (Hoge, Andrews, and Robinson, 1990a; Hoge, Andrews, and Robinson, 1990b; Hoge, Andrews, Faulkner, and Robinson, 1989; Hoge, Andrews, Robinson & Hollett, 1988; Robinson, 1987). Global ratings of family/individual strength, stress, need for service, and motivation are also made by the therapist.

After the completion of the assessment, the therapist follows a structured format to record information concerning treatment plans. The problems targeted for treatment are indicated using the current situations checklist. The therapist then specifies the goals of treatment and the therapeutic techniques to be applied. The latter are recorded in an open-ended section that permits narrative summaries of the treatment plan. In the final section of the FSAI - Intake, the therapist designates the level of service to be extended, and estimates the number of interviews to be employed in providing service to clients. Referrals planned, and the type of interviews to be employed are also noted.

The FSAI - Intake was completed by therapists for each new case registered by the agencies during the designated data collection periods. An attempt was made to obtain FSAI - Intake data on the full population of clients who approached the agencies. Intake data collection proceeded for a period of approximately twelve months in the first phase of the project and for approximately 6 months in the second phase. A sample of 2140

FSAI - Intakes completed by the 66 therapists in the present sample were available for analyses.

FSAI - Client

The FSAI - Client is a client self-report version of the FSAI - Intake Current Situations Checklist (Appendix D). This instrument was designed to serve as a source for validating the latter instrument completed by therapists (Hoge, Andrews, Robinson, and Hollett, 1988). A subset of 42 items from the FSAI - Intake are contained in the client version and seven subscales from the larger instrument are represented. The FSAI - Client was self-administered to sub-samples of clients immediately before the first intake interview with the therapist. Therapists had no knowledge of client scores on this instrument when FSAI - Intake assessments were conducted. FSAI - Client forms were completed by 180 of the clients who were treated by the present sample of therapists.

FSAI - Closure

The FSAI - Closure was designed to provide information regarding treatment delivery and treatment outcome. It is completed by the therapist at the time of case closure. The protocols for the FSAI - Closure are presented in Appendix E. Instructions for completing this instrument are available and norms for the various measures have been reported (Hoge, Andrews, Robinson, & Hollett, 1987).

In the first section the therapist records the reason for service termination using a checklist. The second section

requests data concerning the type of interviews employed, an enumeration of the members of the client group who received treatment, number of interviews attended by clients, number of agency hours devoted to the case, and any referrals that were made during the course of treatment. The third part of the FSAI - Closure involves a reassessment of the client's current situations. The reassessment at case closure involves the same format as outlined for the FSAI - Intake including the Current Situations Checklist, severity ratings for the twelve problem areas, and global ratings of client functioning. The 66 therapists completed FSAI - Closures for 1105 of their cases.

CFQ

The Client Feedback Questionnaire (CFQ) was developed to assess the perceptions of clients relevant to treatment process, outcome of service, and overall consumer satisfaction. This instrument was adapted from an earlier measure of client satisfaction in family service agencies (Gandy & Lambert, 1983). Scoring procedures and the results of psychometric analyses have been reported for the CFQ scales (Andrews, Hoge, Robinson & Hollett, 1987). A CFQ specimen form appears in Appendix F. The CFQ includes five sections that deal with evaluations of therapy process, hassles or inconveniences experienced during service, ratings of change in ten major problem areas, reasons for treatment termination, and overall consumer satisfaction. The questionnaire is self-administered by clients after case closure.

Letters from the respective agencies requesting client cooperation and promising confidentiality were mailed to clients along with the CFQ forms. When couples or families were involved in treatment, CFQ's were provided for all individuals who had participated in therapy. The CFQ's were returned to the agencies by mail using pre-stamped envelopes. In the second phase of the project, some therapists distributed the CFQ at the closing interview and clients were instructed to return the forms by mail. Completed CFQ's are available for a total of 324 cases.

TRSMP Scales and the Validation Measures

We turn now to the procedures employed in constructing the TRSMP scales, and a description of the various validation measures derived from the core instruments. It will be recalled from the discussion in the previous chapter that the primary validation measures include the TRSMP scales derived from supervisor reports, treatment techniques elaborated by therapists, indicators of therapy process reported by clients, treatment outcome reported by clients and therapists, patterns of client assessment adopted by therapists in describing client problems, level of service plans, and treatment delivery.

TRSMP Scales

The TRSMP scales measure the therapist constructs elaborated earlier and summarized in Table 1 of the previous chapter. The 23 scales were operationalized using indicators selected from the

pool of 265 PPI items. Sixty-four items were eliminated from the battery prior to the construction of the scales, leaving a total of 201 items. The deletions involved items judged to be irrelevant to the constructs being measured and items that would be rarely endorsed by therapists (e.g., unpleasant physical contact).

Scale items were selected on the basis of their face validity by a team of three judges. The present author and two registered psychologists served as judges. Each judge independently selected PPI items to compose the 23 TRSMP scales. Judges were instructed to make no attempt to incorporate all 201 PPI items in the new scales. In an effort to limit overlap, assignment of any item to more than one scale was not permitted. After the selection procedures were completed, the three judges met to review their levels of agreement and to reach consensus regarding discrepancies in their assignments. Final decisions on the composition of the scales were guided by internal consistency and factor analyses using data from the sample of 66 therapists.

TRSMP Supervisor Version

The TRSMP Supervisor Version scales were formed using the PPI data completed by supervisors. The supervisor scales are identical in content to the TRSMP scales based on the therapist self-reports.

FSAI Technique Scales

The FSAI Technique Scales were used to characterize therapists according to the types of techniques they specify in

the development of treatment plans for individual cases. In the treatment planning section of the FSAI - Intake, therapists identify treatment goals in terms of the expected outcomes of their interventions. The techniques to be used in pursuing each goal are then listed. Space is provided for the specification of three major goals and multiple techniques may be indicated for each goal. In the total sample of 2620 FSAI - Intakes completed by therapists in the family service project, close to 600 different goals and 532 separate techniques were mentioned. To preserve the original detail of the treatment plans, each goal and technique was assigned a unique numerical code. This approach was adopted so that the goals and techniques could be collapsed into more general categories at a later time.

In the present study, techniques planned at intake were categorized in terms of the extent to which they manifest the styles, models, and practices tapped by the pre-service TRSMP scales. The 23 TRSMP dimensions furnished the technique categories used to classify planned techniques. Each recorded technique was assigned to the categories on the basis of how well it corresponded to the definitions of the TRSMP dimensions. For example, the technique "Rational Emotive Therapy" would be assigned to the category of "Cognitive". On the other hand, "Client-Centered Therapy" would be classified under the "Experiential" category. The TRSMP categories Attractiveness, Expertness, Activity Level, Flexibility and Emotional Distress, were excluded from the assignment procedures. It was considered

unlikely that these constructs would be typified by any of the techniques that therapists listed in their treatment plans.

The techniques were assigned to the system of categories by the present investigator. Inter-rater reliability for the categories was assessed using assignments made by a second rater. After the assignments were finalized, FSAI Technique scores were calculated for individual therapists by counting the number of techniques that fell within each of the technique categories. An individual therapist's score was based on the techniques listed in the treatment plans for a sample of clients seen by that therapist. FSAI Technique scores were then divided by the total number of techniques mentioned by each therapist in their treatment plans. The latter adjustment corrects for the tendency of some therapists to provide more detailed treatment plans than others.

CFQ Process Scales

Clients evaluated their therapists in terms of relationship skills and the ability to provide the kind of assistance expected by individuals who seek counseling. The CFQ process scales consist of statements about therapists to which clients respond using a true/false format. There are five process scales.

Active Understanding. This measure refers to the therapist's understanding of client feelings and problems ($\alpha = .55$ $n = 157$), Hoge, Andrews, Robinson, and Faulkner, 1987).

Basic Support. The Basic Support scale consists of items evaluating the therapist's ability to listen, provide emotional support, and show respect toward the client ($\alpha = .57$).

Encourage Exploration. This scale taps the therapist's ability to promote client expression and exploration of emotionally sensitive material ($\alpha = .38$).

Explicit Problem-Solving. This scale is primarily concerned with the therapist's assistance in setting goals and suggesting solutions to problems ($\alpha = .53$).

Active Assessment/Structuring. Items relating to the therapist's assessment of treatment progress and initiation of referral action are included in this scale ($\alpha = .34$).

Each of the scales are composed of two true/false items with the exception of the Basic Support scale, which involves four items.

Therapy Outcome

As indicated in the overview of the family service instruments, measures of both client and therapist evaluations of outcome were collected. Several client self-report outcome scales are derived from the CFQ, and an index of outcome is drawn from the FSAI - Closure reported by therapists.

CFQ Cognitive Gain. A scale designed to assess cognitive gain is scored on the basis of two true/false items. High scores indicate that clients felt that they had learned how to solve their problems and that a new understanding of their situations had been achieved.

CFQ Positive Termination. Positive termination is a three level measure that taps the client's perception about why therapy was terminated. The CFQ requests clients to indicate the reasons for case closure using a checklist. The highest score of "2" is reserved for reasons that signify a positive outcome (e.g., "I no longer needed help."), while a score of "0" denotes more negative reasons (e.g., "I was not receiving the help I wanted"). The intermediate level on the positive termination scale refers to more neutral reasons for case closure (e.g., "I moved", "I was unable to get other family members involved"). In some cases clients may indicate more than one reason and, therefore, it is possible that both positive and negative reasons for termination may be identified. In such cases, the more positive reason is given the priority code.

CFQ Positive Behaviour Change. The CFQ provides client ratings of change in ten areas of functioning. The areas of functioning refer to problems or difficulties that clients experienced at the time they presented for treatment. These include emotional problems, substance abuse, marital conflict, parenting problems, family conflict, conflict with relatives and friends, physical or sexual abuse, financial difficulties, problems dealing with schools or governments, and problems associated with being single. Clients rate their current status in these areas by indicating "better", "worse", or "no change". Clients rate only the areas of functioning that constituted problems at the time help was sought from the agency. In

addition to the ten scores, a summary measure of positive behaviour change is also obtained. This measure is a dichotomous index with positive change referring to cases in which the number of problems rated "better" exceeded the number of problems rated "no change" or "worse".

CFO Consumer Satisfaction. Three satisfaction items scored in a dichotomous fashion are summed to provide an index of consumer satisfaction. Clients are asked to indicate whether or not they would return to the agency if they needed help in the future, and whether or not they would recommend the service to relatives or friends. Clients also rate their overall satisfaction with their counselling experience by "taking all things into consideration".

CFO Overall Outcome. The overall outcome measure is a composite scale based on the four outcome measures already described. Binary versions of cognitive gain, positive termination, positive behaviour change, and consumer satisfaction are added to form this overall outcome measure.

FSAI Positive Termination. The FSAI - Closure instrument solicits the therapists judgment about the reason for case closure using a format similar to the CFQ. Therapists indicate the reason for case closure using a checklist. A three-level positive termination scale is computed using the checklist responses. As in the CFQ positive termination scale, a score of "0" indicates a negative reason for termination, "1" signifies a neutral reason, and the highest value of "2" is reserved for

positive reasons for termination of service. When both positive and negative reasons are listed, the most positive reason is given priority coding on the scale.

Patterns of Client Assessment

The patterns of client assessment to be examined will be derived from the Current Situations Checklist of the FSAI - Intake. As explained earlier, the principle assessment component of the FSAI - Intake involves a 131 item checklist of current situations. The items are distributed across twelve problem areas and subscale scores are calculated by simple summation of the respective dichotomous items for each problem area. The twelve current situation subscale scores include: Marital Conflict, Problems of Separation/Divorce, Problems with Ex-Partners, Problems with Children, Family Conflict, Family Violence, Problems of Singles, Substance Abuse, Health Problems, External Stressors, Emotional Distress, and Personal Resource Deficits. The subscale scores have demonstrated moderate to high reliability when assessed using test-retest, inter-rater (Hoge, Andrews, Robinson, and Hollett, 1988), and internal consistency criteria (Hoge, Andrews, Robinson and Faulkner, 1987). Total current situations scores are also calculated by adding the number of items checked by the therapist for the entire battery of 131 items. The latter measure provides a summary measure of the levels of problems exhibited by the clients.

FSAI - Risk. The latter scale is a composite index designed to assess the extent to which an individual or client group

exhibits characteristics that are predictive of poorer outcomes. The FSAI Risk scale is based on the sum of the global ratings of Motivation for Service, Level of Strength, and Level of Stress (scored in reverse). Each of the above components are rated on 5-point scales.

General Indicators of Service Plans and Services Delivered

In addition to the narrative descriptions of treatment goals and techniques, the FSAI - Intake provides for more structured recording of treatment plans, including targets of treatment, level of service, and type of interview planned. Information regarding the services delivered to clients is recorded using the FSAI - Closure.

Targets Planned. The Current Situations Checklist of the FSAI - Intake is used to identify the particular problems that will become the targets of the therapist's interventions. All current situation items checked at the stage of assessing the client's problems become potential targets of treatment. The instructions for specifying targets require that the therapist review each of the problems that were checked and then circle the problems that have been selected for explicit focus during treatment. Target scores for each of the twelve FSAI problem categories are obtained by summing the number of items targeted within each problem area. The twelve target subscales are then added to form a total targets score.

Level of Service Planned. Two indices of level of service are included in the treatment planning section of the FSAI - Intake. The first, overall level of service, is a 4-level ordinal scale designed to classify cases in terms of "no additional service", "short term", "medium term", and "long term". The second index is an estimate of the number of interviews to be completed before the case is closed.

Number of Interviews Delivered. The number of interviews delivered is recorded by the therapist on the FSAI - Closure form.

RESULTS

The reliability of the TRSMP scales will be first examined in terms of agreement among judges on the composition of the scales, and then the estimates of internal consistency will be reviewed. The dimensionality of selected scales will also be investigated. Following these analyses, evidence respecting the construct validity of the scales will be described in detail. This will include an examination of the intercorrelation among the TRSMP scales, and the convergent and divergent validity estimates using the parallel supervisor versions of the scales will be presented. The scales will next be examined in relation to client reports of therapy process and therapist reports on the use of particular therapeutic techniques with individual clients. The criterion-related validity of the TRSMP will also be explored using indices of therapist assessment practices and service delivery. Finally, the relationship between the TRSMP scales and therapeutic outcomes will be reported.

Reliability of the TRSMP Scales

Inter-judge agreement rates for the first round of item assignments are presented in Table 4. The "number of items assigned" refers to the total number of unique items selected by the three judges for each TRSMP scale. Agreement rates for any

Table 4

Inter-Judge Agreement on Item Assignments

TRSMP Scales	1st Round Assignments				Final Assignments		
	Number of Items Assigned	% Item Agreement			Number of Items	% Item Agreement	
		3 Judges	2 Judges	1 Judge		3 Judges	2 Judges
Styles							
Openness/Warmth	15	46.7	33.3	20.0	12	58.3	41.7
Direction/Understanding	25	12.0	32.0	56.0	14	42.9	57.1
Structure	21	9.5	9.5	81.0	10	80.0	20.0
Expertness	27	0.0	22.2	77.8	6		100.0
Attractiveness	17	17.6	47.1	35.3	12	33.3	66.7
Provides Meaning	13	30.8	15.4	53.8	9	77.8	22.2
Focus on Feelings	5	80.0	0.0	20.0	4	100.0	
Activity Level	7	28.6	14.3	57.1	5	80.0	20.0
Flexibility	12	0.0	33.3	67.7	7	42.9	57.1
Goal Setting	11	18.2	27.3	54.5	9	66.7	33.3
Emotional Distress	14	35.7	7.1	57.1	6	83.3	16.7
Psychotherapy Models							
Behavioural	18	33.3	22.2	44.4	10	60.0	40.0
Psychodynamic	14	35.7	21.4	42.9	9	66.7	33.3
Cognitive	12	16.7	25.0	58.3	6	50.0	50.0
Experiential	13	15.4	46.2	38.5	11	45.5	54.5
Social Structure	10	80.0	0.0	20.0	8	100.0	

Table 4 Continued

TRSMP Scales	1st Round Assignments				Final Assignments		
	Number of Items Assigned	% Item Agreement			Number of Items	% Item Agreement	
		3 Judges	2 Judges	1 Judge		3 Judges	2 Judges
Practices							
Paradoxical Interventions	6	50.0	16.7	33.3	4	75.0	25.0
Role Playing	2	100.0	0.0	0.0	2	100.0	
Skill Training	9	55.6	33.3	11.1	8	62.5	37.5
Relabeling	6	83.3	16.7	0.0	6	83.3	16.7
Homework	9	88.9	11.1	0.0	9	88.9	11.1
Social Networks	10	30.0	50.0	20.0	8	37.5	62.5
Family Systems	22	45.5	27.3	27.3	18	66.7	33.3

given scale are expressed in terms of the percentage of items selected by all three judges, by two judges, and by only one judge. Considering the large number of items and scales involved in the selection exercise, agreement on the composition of the scales is encouraging. At least two judges agreed on more than 50% of the item assignments for 14 of the 23 scales. Substantial convergence in the judges' assignment patterns was also apparent at the item level. Working independently, all three judges were in agreement on the scale assignments of 91 of the 201 items. An additional 73 items were assigned to the same TRSMP scales by two judges. In other words, two or more judges agreed on the scale assignments of 81% of all items.

The highest levels of agreement were associated with the practice scales. To a less extent, there was consistency in item assignments to the psychotherapy models. A notable exception was the poorer level of agreement for the cognitive scale. Fifty-eight percent of the 12 items that were assigned received endorsement by only one judge. Overall, the poorest agreement rates were evident for items comprising the style scales. The openness/warmth/ understanding, attractiveness, and focus on feelings scales were the only scales in this group that displayed reasonable consistency across judges. Agreement on items for the structure, expertness, and flexibility scales was particularly poor. Over 60% of the item assignments to these scales were made by only one judge.

In total, 164 items had been assigned to the same scales by two or three of the judges. It was decided to retain these items as components of the TRSMP scales. The remaining 37 items that had been assigned to the various scales by only one judge were reconsidered for inclusion. After discussion among the three judges, 8 of the items were eliminated and 29 were reassigned. Agreement rates for the final item assignments are reported in the last two columns of Table 4. The percentage of items for which there was agreement by three judges include items retained from the first round of assignments, as well as items that received the consensus of all three judges after discussion. The final column refers to the percentage of items retained from the first round of assignments that received consensus from only two judges.

Reliability as assessed by means of the Cronbach alpha indicated adequate levels of internal consistency for the majority of the scales. The mean alpha, based on the data from the sample of 66 therapists, was .70 (s.d. = .14) with alphas for 17 of the 23 scales (74%) reaching .6 or above. The lowest coefficients ($\alpha < .6$) were associated with the psychodynamic, experiential, relabeling, expertness, flexibility, and cognitive scales. As reported above, poor inter-judge agreement was also found for the three latter scales.

Supplementary analysis indicated that internal consistencies could be augmented by elimination of selected items. By sequentially removing each item from its respective scale and

recomputing alpha, items contributing to poor internal consistency were identified. This procedure was conducted for all 23 scales. A separate factor analysis using principle components with varimax rotation was also performed on each set of scale items in an effort to corroborate the alpha analyses. The results of the factor analyses were inspected to determine whether or not items that contributed to poor internal consistency formed single-item factors within the factor solutions. The factor analyses were also used to identify items or clusters of items within the scale sets that referred to constructs that were conceptually distinct from the major constructs being measured.

A detailed account of the outcomes of these analyses and the scale revisions that followed is contained in Appendix G for the interested reader. Generally, the results of the alpha and factor analyses were in agreement. For example, items that suppressed internal consistency according to the alpha criterion often loaded on separate factors, or failed to load highly on the main factors that were extracted for a given set of scale items. The factor analyses led to additional revisions to the item compositions for a number of scales. Some of the factor solutions drew attention to items that possessed low content validity with respect to the constructs being operationalized.

Table 5 compares alpha coefficients based on the item compositions recommended by the three judges with coefficients obtained after the scales were revised. The means and standard

Table 5
TRSMP Scale Alpha Coefficients, Means, Standard Deviations

TRSMP Scales	Number of Items	Alpha	After Scale Revisions			
			Number of Items	Alpha	Mean	S.D.
Openness/Warmth	12	.83	12	.83	51.70	4.86
/Understanding						
Direction	14	.81	13	.85	43.98	6.85
Structure	10	.60	8	.72	27.18	4.34
Expertness	6	.52	5	.67	20.16	2.19
Attractiveness	12	.72	12	.72	47.27	4.76
Provides Meaning	9	.65	8	.68	27.53	3.76
Focus on Feelings	4	.78	4	.78	17.15	2.35
Activity Level	5	.55	4	.60	15.20	1.92
Flexibility	7	.43	4	.58	14.63	2.32
Goal Setting	9	.81	9	.81	32.48	5.13
Emotional Distress	6	.69	5	.72	8.61	2.11
Behavioural	10	.73	10	.73	30.23	5.08
Psychodynamic	9	.39	4	.66	13.15	2.97
Cognitive	6	.55	5	.61	17.86	2.75
Experiential	11	.54	8	.63	29.98	3.63
Social Structure	8	.93	8	.93	27.50	6.67
Paradoxical	4	.79	4	.79	10.42	2.96
Interventions						
Role Playing	2	.85	2	.85	5.36	1.64
Skill Training	8	.77	8	.77	28.80	3.95
Relabeling	6	.53	2	.73	7.97	1.21
Homework	9	.78	9	.78	27.50	5.09
Social Networks	8	.82	6	.89	23.71	4.04
Family Therapy	18	.83	18	.83	63.75	8.33

n = 66.

deviations for the new versions of the 23 scales are also tabulated. Table 5 shows that item deletions produced increases in internal consistency for 11 scales. In total, the scale refinements resulted in the elimination of 24 items. Only one scale, flexibility ($\alpha=.58$), has an internal consistency estimate below the level of .6. The mean alpha for the revised scales is .75 (s.d. = .09). The final item composition of the 23 scales is presented in Appendix H.

Dimensionality of Selected Scales

The TRSMP scales include constructs that are viewed as multi-dimensional. These include the Openness/Warmth/Understanding scale, the Direction and Structuring scales, and the Family Therapy scale. Dimensionality was investigated using the results of the factor analyses described above.

Therapist relationship attitudes, measured by the Openness/Warmth/Understanding scale, have been defined in the literature in terms of Rogers' (1957) necessary and sufficient conditions of therapeutic gain. As Table 6 shows, the 12 items comprising the Openness/ Warmth/ Understanding scale produced a three-factor solution. The highest loadings on the first factor correspond to items that tap demonstrations of interpersonal warmth. Attitudes reflecting openness and respect for clients are also included in this factor. Eight of the twelve items in the scale had loadings above .59 on the first factor and it accounted for 37.1%

Table 6

Rotated Factor Loadings: Openness/Warmth/Understanding

Items	Factors		
	1	2	3
89. Unconditional warmth, liking, respect	.80	.27	.10
33. Demonstrating interpersonal warmth	.77	.09	-.02
80. Patient, tolerant	.73	.05	-.06
23. Open, warm, understanding	.69	.03	.27
79. Kind, loving, caring	.64	.10	.16
5. Supportive, reassuring	.60	-.27	.04
87. Attentive: eye contact, open posture	.59	.14	.48
88. Genuine: authentic, congruent	.59	.24	.44
110. Express understanding of client's behaviour	.16	.86	-.00
111. Express understanding of client's feelings	.08	.83	.18
47.* Lack of understanding	-.16	.31	.77
31. Being non-blaming	.33	-.23	.53
Eignevalues	4.45	1.78	1.03
Percent of Variance Explained	37.1	14.8	8.7

* Indicates reverse scoring.

of the variance in the correlation matrix. Two items relating to expression of understanding of clients' feelings and behaviour anchored the second factor. The third factor, which is difficult to interpret, incorporates the items, "lack of understanding"¹ and "being non-blaming". It should be noted that items referring to similar content are also represented in the first two factors.

The factor analysis provides some evidence that more than one dimension may be present in the Openness/ Warmth/ Understanding scale. However, given the overall strength of the first factor and the high internal consistency estimate for the scale ($\alpha=.83$), the use of a single measure to operationalize therapist relationship attitudes appears feasible.

The Direction and Structuring scales were intended to provide a distinction between guiding, advice-giving behaviour, and authoritative behaviour associated with the executive function of therapy. A factor analysis was conducted on the combined pool of items assigned to the Direction and Structuring scales. The purpose of the analysis was to assess the extent to which the two set of items would distinguish between the two constructs. To simplify the analysis, the number of factors extracted was limited to two. The factor solution for this analysis is reported in Table 7.

¹ This item is scored in reverse so that a low score indicates lack of understanding.

Table 7

Rotated Factor Loadings: Direction and Structuring

Items	Factors	
	1	2
64. Give lots of examples	.65	.28
37. Using oneself as source of information and model through self-disclosure	.64	-.02
94.* Withhold direct suggestions/advice	.62	.05
91. Confrontation: telling it like it is	.61	.12
48. Explanation of how or what to do	.61	.20
112. Report a personal experience as an example	.60	.05
93. Offer direct suggestions/give advice	.60	.30
223. Providing firm leadership, authoritative guidance	.57	.23
92. Concreteness: being specific	.56	.33
34. Being directive (giving instructions, prompting verbal participation, etc.)	.46	.26
25. Firm but fair	.44	.31
58. Getting right to the point	.44	.19
39. Offering or providing help	.42	.09
253.* No therapeutic action without mutual agreement on problems	-.27	-.06
8. Guiding, directing obliquely	.16	.03
137. Negotiating contract	.03	.82
138. Re-negotiating contract	.17	.77
245. Takes responsibility for setting treatment goals	-.41	.51
128. Willing to confront if contract not followed	.17	.50
24. Active, directive, structured interaction	.29	.50
156. Identifying possible post-treatment problems and appropriate responses	.29	.48
36. Being clear and specific (not vague)	.04	.43
235. Willing to make further therapy contingent upon compliance with instructions	.35	.43
4. Businesslike, "in charge"	.09	.23
Eigenvalues	6.1	2.0
Percent of Variance Explained	25.4	8.6

The pattern of factor loadings indicated that the majority of items assigned to the Direction scale loaded on the first factor while the Structuring items tended to load on the second factor. The items comprising the Direction factor are primarily concerned with giving advice, being concrete, and providing examples. The Structuring items emphasize the establishment of treatment contracts and the structuring of therapeutic exchanges in a manner that implements the agreement between therapist and client. While concordance between the item assignments by the judges and the factor loadings is not perfect, the factor solution produced a satisfactory separation of the two constructs. For this reason, the results of the factor analysis was used to determine the composition of the two scales.

A number of family therapy models are represented among the items used to define the Family Therapy scale. Five factors were extracted from the Family Therapy technique items (Table 8). Items comprising the first factor suggest a focus on the development of family negotiation and contracting skills. Items referring to more general principles of the family systems approach also loaded on this factor (e.g. advocate for all family members, relational ethics, and promote interaction). The remaining four factors are difficult to interpret. Items referring to "rules" and the "distribution of power" received the highest loadings on the second factor. These issues are emphasized in most systems approaches to the family. The third and fourth factors contain items that refer to the family of

Table 8

Rotated Factor Loadings: Family Therapy Techniques

Items	Factors				
	1	2	3	4	5
220. Helping couples/families arrive at mutually agreed upon contracts	.82	.20	-.12	.02	.04
222. Teaching family members to negotiate with each other	.81	-.01	.05	.12	.22
233. An advocate for all members	.63	.16	.11	-.14	.09
219. Try to uncover personal "contracts" in family relationships	.61	.14	.24	.37	-.17
221. Working on "interactional scripts" or "rules of the game"	.59	.34	.10	.14	.02
232. Focus on relational ethics, a balance of equitable fairness	.54	-.11	.07	.28	.50
135. Encourage reciprocal negotiations	.50	.40	-.03	-.19	.17
142. Promoting interaction between family and worker	.48	.43	.24	-.11	-.23
179. Distinction between rules and requests	.03	.78	-.02	.18	.04
198. Linking personal/familial problems to interpersonal distribution of power	.17	.68	.12	.02	.29
139. Encouraging interaction among family members	.32	.63	.09	.15	-.09
197. Linking personal/familial problems to family of origin	.16	.02	.71	.02	-.18
20. Focusing upon relationship(s)	-.07	.02	.66	.10	.19
236. Adopting family's language, symbols, and manner of communication	.06	.08	.55	.09	.23
141. Involving family of origin	-.05	.09	.33	.79	-.05
140. Involving extended family	.25	.29	-.03	.69	.07
196. Linking personal/familial problems to faulty communication	.36	.28	.41	-.42	-.18
241. Sometimes join with one person who's in conflict with other family members	.14	.18	.16	-.06	.82
Eigenvalues	4.99	1.75	1.45	1.36	1.2
Percent of Variance Explained	27.8	9.8	8.1	7.6	6.7

origin, a theme that is emphasized in family therapy approaches that draw on the psychodynamic model. However, other items which would not be associated with this approach also load on the factor. The fifth factor relates to the technique of joining with the person in conflict with other family members. A focus on relational ethics also loads on this factor.

The factors derived from the family systems items are not easily interpreted relative to the major schools represented in family therapy. While items corresponding to particular themes within the family therapy literature were combined in some instances, none of the factors were homogeneous with respect to those themes. In summary, the factor solution provides little evidence of the potential usefulness of dividing the family systems scale into separate components.

Inter-relationships Among the TRSMP Scales

The inter-correlation among the 23 TRSMP scales furnishes some evidence of construct validity. The inter-correlation matrix is displayed in Table 9. Underscored coefficients in the table indicate the pairs of scales for which specific hypotheses were proposed. With some exceptions, the statistically significant ($p < .01$) correlations conformed to the pattern that had been predicted (see Table 2). Generally, positive correlations were observed for pairs of scales for which hypotheses of positive correlations had been advanced.

Table 9

Inter-correlation Matrix of TRSMP Scales

TRSMP Scales	1	2	3	4	5	6	7	8
1. Openness/Warmth Understanding								
2. Direction	.16							
3. Structuring	.14	<u>.45*</u>						
4. Expertness	.48*	<u>.13</u>	<u>.18</u>					
5. Attractiveness	<u>.60*</u>	<u>.40*</u>	.12	<u>.36*</u>				
6. Provides Meaning	.34*	.65*	.50*	<u>.19</u>	.30*			
7. Focus on Feeling	.51*	.19	-.00	.22	.42*	.34*		
8. Activity Level	.37*	<u>.39*</u>	<u>.39*</u>	<u>.38*</u>	.50*	.27	.22	
9. Flexibility	.38*	.19	.04	.39*	.50*	.22	.42*	<u>.21</u>
10. Goal Setting	.16	<u>.35*</u>	<u>.55*</u>	.11	.16	.43*	-.00	.26
11. Emotional Distress	-.45*	<u>.01</u>	-.03	-.50*	-.21	-.16	-.27	-.13
12. Behavioural	.18	<u>.43*</u>	<u>.47*</u>	.18	.28*	.45*	.01	<u>.43*</u>
13. Psychodynamic	.18	<u>.05</u>	<u>.03</u>	.12	.13	<u>.16</u>	.45*	<u>.11</u>
14. Cognitive	.32*	<u>.47*</u>	.42*	.37*	.25	<u>.58*</u>	.29*	<u>.26</u>
15. Experiential	<u>.60*</u>	<u>.24</u>	<u>.10</u>	.31*	.45*	.31*	<u>.38*</u>	<u>.14</u>
16. Social Structure	.15	.51*	.34*	.15	.20	.58*	.12	.22
17. Paradoxical Interventions	-.07	<u>.36*</u>	<u>.22</u>	.17	.18	.16	-.19	.17
18. Role Playing	.18	<u>.36*</u>	.40*	.16	.31*	.41*	.14	<u>.39*</u>
19. Skill Training	.17	.41*	.32*	.31*	.28	.44*	.06	<u>.33*</u>
20. Relabeling	.19	.26	.17	.11	.20	<u>.36*</u>	.25	.33*
21. Homework	.18	<u>.25</u>	.48*	.24	.24	.36*	.02	<u>.34*</u>
22. Social Networks	.21	<u>.30*</u>	.11	.11	.12	.53*	.14	<u>.12</u>
23. Family Therapy	.21	.43*	.61*	.30*	.32*	.56*	.19	.40*

Table 9 Continued

TRSMP Scales	9	10	11	12	13	14	15	16
9. Flexibility								
10. Goal Setting	.05							
11. Emotional Distress	-.12	-.12						
12. Behavioural	.14	<u>.52*</u>	-.03					
13. Psychodynamic	.17	-.03	-.09	<u>.12</u>				
14. Cognitive	.27	<u>.37*</u>	-.15	<u>.54*</u>	.28*			
15. Experiential	.35*	.18	-.37*	.08	.06	.43*		
16. Social Structure	.14	.32*	-.01	.38*	-.02	.38*	.15	
17. Paradoxical Interventions	.19	.28*	.03	.25	-.21	.30*	.21	.17
18. Role Playing	.32*	.46*	-.09	<u>.53*</u>	.09	<u>.34*</u>	<u>.10</u>	.33*
19. Skill Training	.43*	.40*	-.11	<u>.63*</u>	.06	<u>.56*</u>	.16	.38*
20. Relabeling	.24	.20	-.13	.15	-.09	<u>.06</u>	<u>.05</u>	.25
21. Homework	.36*	.50*	-.20	<u>.40*</u>	-.12	<u>.42*</u>	.37*	.31*
22. Social Networks	.15	.21	-.13	.10	.13	.19	.06	<u>.52*</u>
23. Family Therapy	.32*	.51*	-.03	.49*	.25	.64*	.18	.50*

Table 9 Continued

	17	18	19	20	21	22
17. Paradoxical Interventions						
18. Role Playing	.25					
19. Skill Training	.27	<u>.57*</u>				
20. Relabeling	.02	.31*	.15			
21. Homework	<u>.53*</u>	<u>.52*</u>	<u>.52*</u>	.16		
22. Social Networks	-.05	.33*	.27	.30*	.02	
23. Family Therapy	.44*	.54*	.54*	.25	.52*	<u>.36*</u>

* $p < .01$

Generally, coefficients at the .4 level or above were significant at the .001 level, while coefficients below .2 failed to reach conventional significance levels ($p < .05$). Underscored coefficients correspond to the pairs of scales about which specific hypotheses were made (Table 2).

For hypotheses involving negative correlations, the observed coefficients also tended to be positive. However, in most cases these coefficients approached zero in magnitude and were statistically insignificant.

There were also unanticipated significant correlations in the matrix. In post hoc terms, many of these correlations are consistent with the definitions of the constructs. Although the correlation matrix contains a large number of significant coefficients, the highest was .65. Therefore, none of the measures were so highly correlated as to suggest excessive redundancy.

To a large extent the correlations between the 11 "style" scales and other TRSMP scales were congruent with expectations. The relationship attitude measure (Openness/Warmth/Understanding), the social influence scales (Expertness and Attractiveness) and the Emotional Distress scale were intercorrelated in appropriate ways. As hypothesized, Openness/Warmth/ Understanding also correlated with Experiential, the psychotherapy model scale. Although not all of the predicted correlations between Emotional Distress and other scales were significant, the direction of the coefficients followed expectations in that they were almost invariably negative. Contrary to predictions, Expertness was not significantly correlated with Direction and Provides Meaning, and the correlation between Attractiveness and Emotional Distress also failed to reach significant levels.

The Direction and Structuring scales were moderately correlated ($r = .45$), and in turn, these measures were correlated with other style scales in appropriate ways (Activity Level, and Goal Setting). The set of four style scales which suggest a directive therapeutic focus (i.e., Direction, Structuring, Activity Level, and Goal Setting) also related to the more directive psychotherapy models (Behavioural and Cognitive) and techniques (Skill Training, Homework). Contrary to the hypotheses, Direction and Structuring were not inversely related to the Psychodynamic and Experiential model scales. The coefficients in question were positive, but statistically insignificant.

The correlation matrix was scrutinized for evidence that the Direction and Structuring scales were effectively assessing two distinct therapeutic style constructs. As described above, Direction and Structuring correlated with many of the same TRSMP scales in the battery. Although it had been predicted that Structuring and Attractiveness would be inversely related, the coefficient for the two scales was insignificant. Moreover, while the use of Paradoxical Interventions was described as an example of the Structuring style, the former scale was more highly correlated with Direction ($r = .36$) than with Structuring ($r = .22$). On the other hand, Goal Setting, which characterizes the executive function associated with Structuring, was more strongly related to Structuring ($r = .55$) than to Direction

($r = .35$). In summary, the data do not provide strong evidence that the two scales measure separate constructs.

While the Provides Meaning scale was unrelated to Expertness and Psychodynamic, it was significantly related to both the Cognitive and Relabeling. Provides Meaning also correlated with the more directive styles and models (Direction, Structuring, Goal Setting, Behavioural). An unanticipated finding was that Provides Meaning was associated with the Social Structure, Social Networks, and Family Therapy scales. In fact, Provides Meaning was as highly correlated with these scales ($r > .5$) as it was with scales that are viewed as more closely approximating the construct.

Focus on Feelings was significantly related to the Experiential scale, as hypothesized. The Psychodynamic scale also correlated with Focus on Feelings. This finding is understandable given that the constructs represented by both scales refer to the use of evocative therapeutic practices.

Flexibility was unrelated to Activity level. This was the only hypothesis advanced for this scale. However, significant correlations between Flexibility and other TRSMP scales suggest that the scale may be referencing the intended construct. Not surprisingly, Flexibility was correlated with the Openness/ Warmth/ Understanding and Attractiveness scales. The Flexibility scale was also associated with the Experiential scale, and it is quite plausible to expect that therapists who endorse the latter psychotherapy model might be more flexible in their approaches.

In addition, correlations between Flexibility and the technique scales (Role Playing, Skill Training, and Homework), support the notion that flexible therapists rely on a variety of therapeutic practices.

All of the hypotheses regarding the Behavioural and Cognitive scales were supported by the data. Consistent with the fact that Behavioural theorists have been active in the formulation of Cognitive therapies, the two scales were correlated ($r = .54$) and showed a similar pattern of relationship to other TRSMP scales. Nevertheless, on a few key criteria the two scales demonstrated appropriate divergence. The Provides Meaning scale was more highly correlated with the Cognitive scale ($r = .58$) than it was with the Behavioural scale ($r = .45$). Although it was not predicted, the Cognitive scale was also related to Focus on Feelings and the Experiential scale. It is not surprising that therapists endorsing items assigned to these styles and models would also make use of some of the techniques which have been popularized by the Cognitive movement in psychotherapy.

None of the predicted correlations between the Psychodynamic scale and other TRSMP scales were statistically significant. It had been predicted that this scale would be inversely related to the more directive styles. The data revealed that the Psychodynamic scale was correlated positively, albeit not significantly, with the majority of scales referring to directive approaches. There was some post hoc evidence of the

validity of this scale. As noted previously, the Psychodynamic scale was related to Focus on Feelings ($r = .48$).

Several predictions had been made about the relationships between the Experiential scale and other TRSMP scales. Both Openness/Warmth/Understanding and Focus on Feelings were significantly related to the Experiential scale as expected. Contrary to predictions, Role Playing and Relabeling were not correlated with this scale. In addition the hypotheses that Direction, Structuring, Activity, and Goal Setting would be inversely correlated with the Experiential scale, were not confirmed.

The Social Structure scale was significantly correlated with the Social Network scale, as predicted. Although it had not been predicted, Social Structure was also correlated with the Provides Meaning scale. The Social Structure scale was significantly related to scales indicative of directive approaches (Direction, Structuring, Goal Setting, Behavioural, and Cognitive). These latter findings were also unanticipated. In fact, it might have been predicted that therapists who used a social structural model of therapy would draw upon non-directive interventions. Perhaps the advocacy function associated with this model explains why therapists who endorsed the Social Structure items, also endorsed the more directive items.

Much of the evidence concerning the construct validity of the technique scales has already been touched upon in relation to the TRSMP style and model scales. Skill Training, Role

Playing and Homework were inter-correlated, and these scales demonstrated similar patterns of association with other TRSMP scales that manifest directive components. With only one exception, support for all of the predictions concerning these three scales was evident in the correlation matrix. Contrary to predictions, Role Playing and Experiential were unrelated.

The Paradoxical Interventions scale also exhibited construct validity. It was related to the Direction, Homework, and Family Therapy scales as predicted. As elaborated earlier, Paradoxical Interventions was not significantly correlated with Structuring.

Consistent with predictions, Relabeling was correlated with Provides Meaning. However, this scale was unrelated to the Cognitive, Experiential, and Family Therapy scales.

The Social Networks and Family therapy scales were significantly correlated, as hypothesized. Family Therapy correlated with the majority of scales that are defined by directive approaches. Although it was hypothesized that Social Networks and Activity level, and Family Therapy and Relabeling would be related, the coefficients for these pairs of scales did not reach significance.

In an attempt to summarize the inter-correlations observed, a factor analysis was performed on the 23 TRSMP scales. Since the ratio of number of cases to number of variables (66:23) is below conventional standards for factor analyses, the results must be regarded as exploratory. Nevertheless, as the rotated factor loadings in Table 10 illustrate, the factor solution is

Table 10

Rotated Factor Loadings for TRSMP Scales

TRSMP Scales	Factors						
	1	2	3	4	5	6	7
Behavioural	.782						
Structure	.780						
Family Therapy	.721						
Goal Setting	.709						
Cognitive	.639			.419			
Skill Training	.618					.538	
Homework	.617					.367	-.347
Role Playing	.572					.411	
Social Networks		.853					
Social Structure	.379	.681					
Provides Meaning	.495	.640		.342			
Emotional Distress			-.881				
Distress							
Expertness			.652				
Openness/Warmth			.607	.407	.381		
/Understanding							
Experiential			.455	.744			
Direction	.468	.390		.469	.305		
Activity Level	.432				.737		
Attractiveness	.115			.462	.604	.328	
Relabeling		.497			.582		
Flexibility						.806	
Psychodynamic							.881
Focus on Feelings				.368	.319		.572
Paradoxical	.425			.375			-.493
Interventions							
Eigenvalues	7.411	2.791	1.792	1.341	1.224	1.151	1.052
% of Variance	32.2	12.1	7.8	5.8	5.3	5.0	4.6

helpful in providing an overall picture of the pattern of inter-correlation among the scales.

The first factor, which explains almost one third of the variance in the correlation matrix, is defined by the scales which have been described as directive: Behavioural, Structuring, Goal Setting, Cognitive, Skill Training, Homework, and Role Playing. The Family Therapy scale also belonged to this factor. All scales had loadings above .5 on this factor.

The second factor, although less interpretable, consisted of the Social Networks, Social Structure and Provides Meaning Scale. The loading of Provides Meaning on this factor was not expected.

The next factor contains Emotional Distress, Expertness, and Openness/Warmth/Understanding. These scales imply a "relationships skills" or "self presentation factor". It is interesting that Attractiveness did not load on this factor.

The fourth factor appears to be defined almost exclusively by the Experiential scale. Although the Direction and Attractiveness scales also loaded on this factor, the loadings were not high.

The last three factors together accounted for less than 15% of the total variance and were more difficult to interpret. The fifth factor, which includes Activity, Attractiveness and Relabeling, is difficult to interpret. None of these scales had been linked together in the hypotheses formulated earlier. The Flexibility scale anchored the sixth factor which also included Skill Training, Homework, Role Playing, and Attractiveness. The

last factor, composed of the Psychodynamic and Focus on Feelings scales, is interpretable given the hypothesis made about these scales.

The correlation matrix and the results of the factor analysis generally supported the hypotheses regarding the inter-correlations among the TRSMP scales. Less evidence of the construct validity of the Psychodynamic and Experiential scales was present, at least in terms of the hypotheses advanced. There also appeared to be little support for hypotheses regarding the distinction between Direction and Structuring.

Therapist Demographic Characteristics

Age, years of therapeutic experience, and gender were examined in relation to the TRSMP scores. Since Master of Social Work degrees were reported by about 50% of the therapists and the "eclectic" orientation was the modal therapeutic preference in the sample, TRSMP scores were also compared on these latter two variables.

Table 11 summarizes the findings of the analyses. Age and experience were correlated in similar ways with a number of TRSMP scales. Consistent with recent findings (Wogan and Norcross, 1985), experience was inversely correlated with the TRSMP scales that manifest directive approaches (e.g. Direction, Behavioural, Skill Training). Social Structure, which represents a relatively new approach was also negatively correlated with years of

Table 11
TRSMF Scales by Demographic Characteristics

	Age Experience		Gender ¹		Degree		Eclectic	
	$\bar{r}$	$\bar{r}$	$\bar{x}$		$\bar{x}$		$\bar{x}$	
			F	M	MSW	Other	Yes	No
			(45)	(21)	(33)	(33)	(44)	(22)
Openness/Warmth	.16	-.15	52.4	50.0	51.8	51.6	51.8	51.3
Understanding								
Direction	-.29*	-.31**	42.9	46.3	44.2	43.7	43.6	44.7
Structuring	-.14	-.07	27.1	27.3	27.5	26.8	26.7	28.0
Expertness	.15	.03	20.3	19.8	20.6	19.6	20.3	19.8
Attractiveness	-.08	-.28*	47.3	47.3	47.3	47.2	47.7	46.2
Provides Meaning	-.12	-.31**	27.5	27.5	28.4	26.6	27.6	27.4
Focus on Feelings	.15	-.13	17.5	16.3	17.0	17.3	17.5	16.4
Activity Level	-.09	-.05	15.3	14.9	15.3	15.1	15.1	15.3
Flexibility	.08	-.18	14.7	14.5	14.7	14.6	15.1	13.8*
Goal Setting	-.03	-.18	31.9	33.8	32.4	32.6	32.4	32.7
Emotional Distress	-.13	-.12	8.2	9.4*	9.2	8.0*	8.7	8.4
Behavioural	-.21*	-.27*	30.1	30.7	29.9	30.5	29.8	31.1
Psychodynamic	-.12	.05	13.3	12.8	12.8	13.5	13.6	12.3
Cognitive	.06	-.07	17.7	18.2	18.1	17.6	17.8	17.9
Experiential	.01	-.17	30.0	30.0	30.2	29.7	30.0	39.9
Social Structure	-.06	-.29*	28.1	26.3	28.5	26.5	27.9	26.6
Paradoxical	-.26*	-.02	9.7	11.9*	10.6	10.2	10.2	10.8
Interventions								
Role Playing	-.01	-.14	5.2	5.8	5.4	5.3	5.4	5.3
Skill Training	.03	-.27*	28.7	29.0	28.5	29.1	29.1	28.1
Relabeling	-.22*	-.07	7.9	8.0	8.2	7.7	8.1	7.8
Homework	.03	-.13	27.3	27.9	27.8	27.1	27.3	27.8
Social Networks	.11	-.15	24.0	23.1	24.1	23.3	24.7	21.7*
Family Therapy	.05	-.06	63.1	65.3	64.5	62.9	64.6	62.0

* $p < .05$ ** $p < .01$, n (therapists) = 66).

¹ T-tests were used to test differences between means.

experience. Paradoxical Interventions and Relabeling, both more recent developments in psychotherapy, were more frequently endorsed by younger therapists. Male therapists reported higher levels of emotional distress and were more likely than female therapists to use paradoxical techniques.

For the most part, the training and orientation variables were unrelated to the TRSMP scales. Eclectic therapists had higher scores on the Flexibility scale, a finding which is consistent with the definition of this construct. It should also be noted that eclectic therapists reported more use of Social Networks than therapists who did not define themselves as eclectic.

Correlations Between Therapists and Supervisor Scales

TRSMP scores based on supervisor reports were available for 35 of the 66 therapists in the sample. Before comparing the supervisor scores with therapist self-report scores, the 35 therapists were compared with the remaining 31 therapists for which no supervisor assessment was completed. Using the 23 therapist-reported TRSMP scales, the two groups were found to differ on two of the psychotherapy model scales. The group for which supervisor data were complete had lower scores ($M = 12.47$, $SD = 2.9$) on the Psychodynamic scale than therapists who were not rated by their supervisors ($M = 14.07$, $SD = 2.8$) ($t(64) = 2.22$, $p < .05$). The groups also differed on the Experiential scale (t

(64) = 2.14, $p < .05$), with therapists in the supervisor sample having lower scores ($M = 28.9$, $SD = 2.9$) than therapists for which no supervisor data were available ($M = 30.8$, $SD = 3.9$).

The correlations between therapist and supervisor scores on the TRSMP scales are reported in Table 12. The alpha coefficients, means, and standard deviations for the Supervisor versions of the scales are also tabled. For purposes of comparison, the corresponding statistics for the TRSMP scales based on the therapist-reports (Table 5) are repeated. The correlation coefficients in the first column of Table 12 represent convergent coefficients. The full multitrait-multimethod matrix is displayed in Appendix I.

Significant correlations ($p < .05$) were obtained for eight of the 23 scales: Structuring, Expertness, Activity Level, Behavioural, Psychodynamic, Social Structure, Paradoxical Interventions, and Family Therapy. The magnitude of the correlations for these scales is comparable, if not higher than, to those reported previously in the literature for therapist and observer reports. The convergent coefficients were low for the scales that measure constructs related to therapist relationship attitudes (i.e., Openness/ Warmth/ Understanding, Attractiveness, Experiential). The coefficients for the majority of the practice scales were also surprisingly low (i.e., Role Playing, Skill Training, Relabeling, Homework, Social Networks).

While therapist/supervisor convergence was observed for 8 of the TRSMP scales, an inspection of the full multitrait-

Table 12

Therapist/Supervisor Convergent Validity Coefficients with Alphas
Means, and Standard Deviations

TRSPM Scales	Supervisor/ Therapist	Supervisor			Therapist		
	r	Alpha	Means	S.D.	Alpha	Means	S.D.
Openness/Warmth /Understanding	.16	.86	50.54	5.50	.83	51.70	4.86
Direction	.15	.83	46.28	6.12	.85	43.98	6.85
Structure	.31*	.76	28.91	4.06	.72	27.18	4.34
Expertness	.47*	.80	19.85	3.23	.67	20.16	2.19
Attractiveness	.01	.82	47.94	5.43	.72	47.27	4.76
Provides Meaning	-.19	.72	29.08	3.56	.68	27.53	3.76
Focus on Feelings	-.19	.85	16.15	2.48	.78	17.15	2.35
Activity Level	.27*	.78	15.00	2.75	.60	15.20	1.92
Flexibility	.13	.59	13.51	2.61	.58	14.63	2.32
Goal Setting	.10	.78	33.77	4.09	.81	32.48	5.13
Emotional Distress	.20	.70	9.22	2.46	.72	8.61	2.11
Behavioural	.46*	.78	32.37	4.87	.73	30.23	5.08
Psychodynamic	.31*	.49	13.45	2.24	.66	13.15	2.97
Cognitive	-.07	.71	19.05	2.86	.61	17.86	2.75
Experiential	.01	.61	30.20	3.52	.63	29.98	3.63
Social Structure	.33*	.93	29.97	6.05	.93	27.50	6.67
Paradoxical Interventions	.39*	.87	10.85	3.16	.79	10.42	2.96
Role Playing	.14	.90	6.05	1.71	.85	5.36	1.64
Skill Training	.12	.89	29.85	5.37	.77	28.80	3.95
Relabeling	-.04	.79	8.08	1.14	.73	7.97	1.21
Homework	.20	.88	28.97	5.69	.78	27.50	5.09
Social Networks	.15	.90	25.11	3.53	.89	23.71	4.04
Family Therapy	.29*	.91	65.94	10.38	.83	63.75	8.33

* $p < .05$, $n = 35$.

multimethod matrix revealed that convergent coefficients were exceeded by divergent coefficients for both within and across method comparisons in the majority of cases. Therefore, if strict multitrait-multimethod criteria are applied, there is poor evidence of the construct validity of the scales. It remains to be determined whether or not the lack of divergence in therapist and supervisor scores reflects low construct validity, or alternatively, is a function of the supervisors' lack of knowledge about the characteristics of their therapists.

Despite the later results, Table 12 indicates that alpha coefficients, means, and standard deviations were remarkably similar across the two methods of report. The level of concordance between the two sets of alpha coefficients furnishes evidence that the internal consistencies of the TRSMP scales remain stable when an alternative method of assessment is employed (i.e., observer reports).

CFQ Process Correlates of the TRSMP Scales

Several hypotheses were made regarding the relationships between the TRSMP scores of therapists and their clients' feedback regarding therapy process (Table 3). Pearson correlation coefficients were computed for Client Feedback Questionnaire (CFQ) scores and TRSMP scores.

A total of 388 CFQ's were completed by clients who were included in the Family Service Assessment and Evaluation sample. Although the research design required that all clients be invited to complete CFQ forms following termination of therapy, many clients chose not to return the questionnaires. A major concern was that CFQ responders and non-responders might differ systematically on variables which might effect the results of the present analyses. Since data collection for the project was terminated before all intake cases were officially closed, not all clients included among the project intake cases would have had an opportunity to complete the survey. To estimate the number of clients who received CFQ forms, we counted the number of cases for which closing assessments (FSAI-Closure) had been filed by therapists ($n = 1412$). Non-responders were defined as cases belonging to the closure sample who had not returned a CFQ form. On the basis of the estimates, the CFQ response rate was calculated to be 27.5% ($388/1412$).

CFQ responders and non-responders, were compared on therapist assessments of intake risk level (FSAI Risk), positive termination of therapy (FSAI Positive Termination), and number of interviews with therapists. The results indicated that the CFQ responders completed significantly ($t(1410) = 3.22, p < .001$) more sessions with their therapists ($M = 4.18, SD = 3.7$) than non-responders ($M = 3.36, SD = 4.8$). The former group was also rated as lower risk ($M = 8.75, SD = 1.7$) in comparison to non-responders ($M = 9.31, SD = 1.8$) ($t(1410) = 4.81, p < .0001$).

Responders also had significantly higher ($t(1410) = 6.26, p < .0001$) positive termination scores ($M = 1.71, SD = .58$) than non-responders ($M = 1.44, SD = .69$). One implication of these findings is that lower risk cases with more favorable outcomes may have a tendency to view their therapy experiences more positively than higher risk clients with poorer outcomes.

A total of 324 CFQ's were completed by the clients of the therapists who comprised the present sample. There were no client reports available for 13 of the 66 therapists. The number of CFQ's available per therapist ranged from 1 to 17 with a mean of 6.11 ($s.d. = 4.06$). Therefore, some therapists were over-represented and others under-represented in the available CFQ sample. It was possible that variability in the number of clients per therapists might result in undetectable influences on the data analyses. For example, the artifactual effect of an extreme outlier associated with a single therapist would be multiplicative if the therapist had a large number of cases.

To safeguard against the potential problems, a sub-sample that equalized the number of CFQ cases per therapist was constructed. This was achieved by randomly selecting CFQ cases until each therapist had 6 CFQ cases. Therapists for which there were fewer than 6 completed CFQ's were eliminated from the sub-sample. Although the selection of 6 cases per therapist is somewhat arbitrary, this criterion appeared to maximize the number of therapists and clients that could be included. The

resulting sub-sample was composed of 28 therapists and 168 CFQ cases.

To ensure that the characteristics of these 28 selected therapists were not different from the remaining therapists who were excluded from the sub-sample, scores on the 23 TRSMP scales were compared for the two groups. The 28 therapists in the selected group had higher scores ($t(64) = 2.22, p < .05$) on the Cognitive Scale ($M = 18.71, SD = 2.85$) than the remaining 38 therapists ($M = 17.23, SD = 2.4$). The single difference (all other t 's (64) < 1.97) was not judged to be sufficient grounds for abandoning the use of the sub-sample. Tests were also conducted to rule out the possibility that clients in the CFQ sub-sample differed from clients who were excluded. The 168 selected CFQ cases were compared with the remaining 156 CFQ cases on FSAI Risk, FSAI Positive Termination, and CFQ Overall Outcome as reported by clients. There were no significant differences between the two groups on the these measures (FSAI Risk: $t(322) = 1.08$; FSAI Positive Termination: $t(272) = 0.6$; CFQ Overall Outcome: $t(291) = 1.29$).

The correlations between the therapist TRSMP scales and the CFQ process scales are presented in Table 13. Underscored coefficients indicate the hypothesized correlations summarized in Table 3. The Openness/Warmth/Understanding scale, was significantly related to clients' impressions that their therapists provided emotional support (Basic Support) and were understanding (CFQ Active Understanding). Openness/ Warmth/

Table 13

Correlation Coefficients: TRSMP Scales and CFQ Process Scales¹

	Basic Support	Under- standing	Explora- tion	Problem Solving	Assess- ment
Openness/Warmth	.13*	.22**	.16*	.18**	.14*
Understanding					
Direction	-.02	-.02	.10	.10	.09
Structuring	-.03	.01	.08	.10	.10
Expertness	.11	.16*	.16*	.10	.07
Attractiveness	-.03	.02	.09	.05	.08
Provides Meaning	-.04	.03	.13*	.17*	.09
Focus on Feelings	.01	.06	-.01	.01	-.01
Activity Level	-.03	-.03	.07	-.05	.06
Flexibility	-.01	-.01	.09	.01	.04
Goal Setting	-.01	.06	.04	.24**	.12*
Emotional Distress	-.04	-.11	-.01	-.13*	-.11
Behavioural	-.01	.03	.18*	.15*	.23**
Psychodynamic	.09	.16*	.09	.04	.15*
Cognitive	-.05	.01	.12	.16*	.06
Experiential	.03	.10	.02	.17*	-.01
Social Structure	.01	.04	.24**	.06	.08
Paradoxical	-.07	-.17*	-.06	.05	-.04
Interventions					
Role Playing	-.05	-.01	.06	-.02	.05
Skill Training	.04	.08	.17*	.11	.08
Relabeling	-.09	-.04	-.01	-.07	-.04
Homework	-.01	-.06	.07	.08	.07
Social Networks	-.03	.06	.14*	-.03	.04
Family Therapy	-.11	-.02	.10	.05	.02
Means	3.64	1.77	1.87	1.54	1.38
S.D.	.68	.50	.38	.67	.74

* $p < .05$ ** $p < .01$ ¹ n (clients) = 168; n (therapists) = 28).

Understanding was also significantly related to positive evaluations of clients regarding the exploration, problem-solving, and assessment skills of the therapists (Encourage Exploration and Explicit Problem Solving, Active Assessment). In short, Openness/Warmth/Understanding, as self-reported by therapists, related in the predicted direction to all of the therapist process measures that were supplied by clients.

Consistent with hypotheses, client ratings of therapist supportiveness and understanding were inversely related to the TRSMP Emotional Distress scale. However, the correlations were weak and failed to reach significant levels. The only process scale that was significantly related to therapist Emotional Distress was Explicit Problem Solving. Therapists who rated themselves high on Emotional Distress were rated low on problem solving by their clients. The Behavioural scale was related to Explicit Problem Solving, as hypothesized, and also positively correlated with Active Assessment. The prediction that Goal Setting would be related to the latter two CFQ scales was also supported by the data.

Contrary to expectations, therapist self-reported Attractiveness was not significantly correlated with the CFQ Basic Support and Active Understanding scales. In addition, the Direction and Structuring scales did not demonstrate the expected pattern of association with the CFQ Explicit Problem Solving and Active Assessment scales. It had also been hypothesized that the Focus on Feelings and Experiential scales would be positively

correlated with CFQ Encourages Exploration, but the data did not substantiate this hypothesis.

There were other unanticipated significant correlations that support the validity of the TRSMP scales. Therapists who scored high on the Expertness scale were given higher scores by clients on the Active Understanding, and Encourages Exploration scales. Therapists who reported that they applied paradoxical interventions were rated lower in understanding by their clients. Finally, therapists who endorsed items on the Social Structure scale were perceived as encouraging exploration by their clients.

Overall, the correlations between the TRSMP scales and the CFQ Process scales were not strong; only four of the coefficients reached the .2 level. Nevertheless, a number of predictions were supported by the data. It should also be noted that the low magnitude of association observed is consistent with previous reports in the psychotherapy process literature.

FSAI Technique Scales

The eighteen FSAI Technique scales are based on the therapist's plans to use various techniques in the course of pursuing therapeutic goals with individual clients. The techniques identified by the therapists in their pre-therapy narrative case plans proved to be difficult to categorize in terms of the therapist constructs operationalized by the TRSMP scales. Inter-rater agreement on assignment of the techniques to the eighteen scales was poor, and a majority of the 532 techniques enumerated by the therapists could not be assigned to any scales. Working independently, the two judges were in agreement on the assignment of 30.5% (162/362) of the techniques. This included 35 items which both judges were unable to assign to any of the eighteen categories. The number of unique items assigned to each scale, and the percentage of agreement by the two judges is tabulated in Table 14. Considering the number of techniques that had to be assigned to the eighteen scales, agreement is obviously higher than would be expected by chance. However, as an overall index of inter-rater reliability, the agreement rate of 30% is clearly low.

In an attempt to salvage the set of measures, the two judges reviewed the remaining 370 techniques on which they had failed to reach agreement. Joint decisions were then made on the assignment of each item. Even after this exercise was completed, the judges had not been able to assign 54.7% of the technique

Table 14

FSAI Technique Scales: Inter-Judge Agreement

TRSMP Scales	Number of Items Assigned ¹	% Item Agreement	Final Number of Items ²
Openness/Warmth	33	15.1	9
Understanding			
Direction	85	11.7	32
Structuring	55	10.9	17
Provides Meaning	22	0.0	8
Focus on Feelings	45	20.0	14
Goal Setting	11	18.1	6
Behavioural	21	57.1	16
Psychodynamic	8	37.5	4
Cognitive	33	30.3	20
Experiential	43	18.6	13
Social Structure	64	12.5	10
Paradoxical	3	100.0	3
Interventions			
Skill Training	58	25.9	1
Role Playing	3	33.3	19
Relabeling	4	25.0	2
Homework	10	20.0	9
Social Networks	67	25.4	26
Family Therapy	83	25.3	31
Unassignable	254	13.7	292

¹ Total number of unique items assigned by both judges.

² Total number of items comprising scale after final assignments by judges.

items (291/532) to any of the scales. The final number of technique items comprising each scale are displayed in the last column of Table 14.

The therapist scores for each of the eighteen FSAI Technique scales were calculated using a sub-sample of FSAI intake cases. There were 2013 FSAI Intake cases available for the therapists in the sample with a mean of 30.96 cases per therapists (SD = 26.87, range = 2 - 147). As with the CFQ data, a sub-sample which equalized the number of clients per therapists was selected in order to avoid under and over-representation of therapists. The sub-sample consisted of 53 therapists with 13 FSAI intake cases per therapist (total client n = 689). Thirteen therapists and 1324 clients were excluded from the sub-sample. However, a series of t-tests indicated that the 13 excluded therapists did not differ from the therapists in the sub-sample on any of the TRSMP scales (all t (64) < 1.06). In addition, the excluded clients did not differ from the sub-sample of clients on pre-service risk level (t (2011) = .67) or therapist-rated outcome of therapy (t (1103) = .28).

The means and standard deviations for the 18 FSAI Technique scales are displayed in Table 15 along with the percentage of therapists who obtained scores of 0 on the scales. Scores for the 18 scales were computed for each therapist based on the samples of 13 clients per therapist. Therefore, the mean FSAI Technique scores refer to the mean number of items mentioned for the 13 clients of each therapist. A score of 0 on any particular

Table 15

Means, Standard Deviations and Convergent Validity Coefficients
for FSAI Technique Scales

FSAI Technique Scales	Means	S.D.	Proportion of Zero Scores	Convergent Coefficients with TRSMP Scales ¹
Openness/Warmth/ Understanding Direction	.2323	.3678	.34	.09
	.0668	.1189	.64	.04
Structuring	.0305	.0730	.81	.22*
Provides Meaning	.0174	.0444	.83	-.06
Focus on Feelings	.1031	.1561	.57	-.15
Goal Setting	.0189	.0451	.83	.05
Behavioural	.0305	.0714	.77	.27*
Psychodynamic	.0087	.0359	.92	-.03
Cognitive	.1641	.2753	.47	.03
Experiential	.0581	.1357	.70	.02
Social Structure	.0160	.0462	.89	.05
Paradoxical Interventions	.0044	.0235	.96	.06
Skill Training	.3818	.5221	.28	.24*
Role Playing	.0160	.0486	.88	.15
Relabeling	.0145	.0479	.87	.06
Homework	.0407	.1041	.86	.16
Social Networks	.1075	.1541	.51	.46**
Family Therapy	.1147	.2206	.55	-.08

¹ FSAI Technique Scales were adjusted for the total number of techniques listed in the narrative case plans before coefficients were computed.

* $p < .05$, ** $p < .01$, $n = 53$ therapists.

scale would indicate that a therapist recorded none of the respective coded technique items for his or her sample of 13 clients. Table 15 shows that over 80% of the therapists did not specify any of the identified techniques for the majority of the scales. The low frequencies observed for these measures casts some doubt on the meaningfulness of the measures for the current purposes.

Before computing correlations between FSAI Techniques and the TRSMP scales, each technique scale was divided by the total number of techniques enumerated by the therapists in order to adjust for variations in the level of reporting detail in the narrative case plans. It was interesting that the number of techniques listed by the therapists was positively and significantly ($p < .01$) correlated with their scores on Openness/Warmth/Understanding ($r = .30$), Expertness ($r = .32$), Flexibility, ($r = .34$) and Skill Training ($r = .35$). The association between Flexibility and the technique index supports the notion that more flexible therapists draw from a large set of therapeutic procedures.

The convergent correlation coefficients presented in Table 15 for parallel FSAI Technique and TRSMP scales are unimpressive. Only 4 of the 18 coefficients were statistically significant: Structuring ($r = .22$), Behavioural $r = .27$), Skill Training ($r = .24$), and Social Networks ($r = .46$). While the correlation between the two methods of measuring Social Networks is high, inspection of the full multitrait-multimethod matrix

(see Appendix J) revealed that in each example, the divergent coefficients exceeded the convergent validity coefficients. The FSAI Techniques scales provide little evidence of the construct validity of the TRSMP scales. However, difficulties encountered in developing the scoring scheme for the techniques scales and the resulting distributions of scores, lead to the conclusion that the latter scales probably do not possess sufficient psychometric robustness for use in the validation of other measures.

Assessment, Service Planning and Service Delivery Correlates of the TRSMP Scales

The FSAI Intake protocol not only allows for narrative case plan materials, but also provides for the quantitative assessment of clients problems, the specification of problems that will be targeted for therapeutic action, the number of interviews planned, and the overall level or duration of therapy that is anticipated. The FSAI Closure specifies the actual number of therapeutic sessions that were attended by the members of the client group.

Analyses of the intake assessment and planning variables was based on the same sample of 689 cases used to calculate the FSAI technique scales. In terms of the actual number of interviews completed, a sub-sample was selected from the larger FSAI Closure sample. The 66 therapists had completed FSAI Closures for a

total of 1105 clients. The problem of variability in the number of clients per therapists was also apparent in this sample (range 1 - 96, $M = 18.72$, $SD = 16.67$). The strategy of randomly selecting cases in a manner that equalized the number of clients per therapist was also employed for this sample. The procedure yielded a sample of 13 clients per therapists (n clients = 455, n therapists = 35). The 650 clients excluded from the sample did not differ from the selected cases on FSAI Risk (t (1103) = .97) or FSAI Positive Termination (t (1103) = .81). With the exception of the Cognitive scale (t = (64) 2.09, $p < .05$), the excluded therapists (n = 31) did not differ from selected therapists on the TRSMP scales (all other t (64) < 1.86). Therapists included in the current sample had higher scores on the Cognitive measure ($M = 18.51$, $SD = 2.6$) than the excluded therapists ($M = 17.12$, $SD = 2.8$).

The correlation coefficients for the TRSMP scales and the various assessment, planning, and therapy delivery indices are displayed in Table 16. The correlations between the TRSMP scales and Number of Interviews Delivered represent partial coefficients with controls for number of interviews planned. Consistent with expectations, TRSMP scales having a directive component were positively related to the total number of problems identified (Total FSAI), number of problems targeted for service (Total Targets), number of interviews planned, and duration of therapy (Level of Service). For example, the Activity Level, Behavioural, and Homework scales were correlated with Total FSAI

Table 16

TRSMP Correlates of FSAI Assessment, Targets, and Service Plans

TRSMP Scales	Total FSAI	Total Targets	Level of Service Planned ¹	Number of Interviews Planned	Number of Interviews Delivered ²
Openness/Warmth Understanding	.08	.13**	.05	-.05	.08*
Direction	-.01	.00	.10*	.07	.06
Structuring	.06	.10*	.09*	.11**	.03
Expertness	.13**	.13**	.05	-.04	.11*
Attractiveness	.02	.06	.05	-.02	.04
Provides Meaning	.02	.01	.07	.01	.03
Focus on Feelings	.08*	.05	.02	-.05	.10*
Activity Level	.15**	.13**	.10*	.10*	.01
Flexibility	.07	-.05	-.04	-.13**	.11*
Goal Setting	.03	.14**	.07	.03	.01
Emotional Distress	-.04	-.14**	-.00	.03	-.04
Behavioural	.21**	.20**	.19**	.21**	.01
Psychodynamic	.10*	.10*	.09*	-.04	.01
Cognitive	.06	.07	.10*	-.01	.08
Experiential	-.03	.01	.06	-.03	.01
Social Structure	.07	.08	.03	.07	.08*
Paradoxical Interventions	.06	.03	.00	-.01	-.04
Role Playing	.10*	.16**	.06	.04	.09*
Skill Training	.09*	-.00	.03	-.01	.06
Relabeling	.01	.01	-.05	-.01	.03
Homework	.23**	.18**	.02	.02	.02
Social Networks	-.01	.03	-.00	.01	.10*
Family Therapy	-.01	.01	.05	-.01	.10*
Means	14.19	7.05	2.75	6.97	3.49
S.D.	8.38	4.73	.74	4.71	3.08

* $p < .01$, ** $p < .001$, n (clients) = 689, n (therapists) = 53.

¹ Level of Service was coded: 1 = No further service, 2 = short term, 3 = medium term, 4 = long term service.

² Partial r 's controlling for number of interviews planned.
 n (clients) = 455, n (therapists) = 35. All starred coefficients are significant at $p < .05$ for the FSAI Closure sample only.

and Total Target Scores. Therapists who scored high on Goal Setting designated more targets than therapists who were low on Goal Setting. While psychodynamic and experiential therapists might be expected to engage clients in long term therapy, the results in Table 16 do not reflect such a tendency.

Psychodynamic scale is significantly correlated with Level of Service Planned, but the coefficient is very low ($r = .09$).

Although there were several significant coefficients ($p < .05$), the partial correlations between the TRSMP scales and Number of Interviews Delivered are all below the .2 level. As 19 shows, number of interviews planned was related to some of the directive scales. However, once interviews planned had been statistically controlled, the directive scales contributed no new predictive information with respect to Number of Interviews Delivered.

The association between FSAI assessment scores and the TRSMP scales may be a function of client assignment procedures rather than actual links between the characteristics of the therapists and their assessment practices. For example, higher risk cases or clients with specific types of problems, may be assigned to therapists with particular characteristics. The existence of a selection bias of this type was explored by examining the relationship between TRSMP and FSAI scores after controlling for assessment information provided directly by clients.

Client self-report data based on the client version of the FSAI (FSAI - Client) were used for these analyses. Completed FSAI

- Client questionnaires were available for 180 clients. This sub-sample of clients was not found to differ from the larger samples of FSAI Intake and Closure cases with respect to FSAI Risk (t (2011) = .11) and Positive Termination (t (1103) = .20). There were no FSAI - Client reports for 21 of the 66 therapists. However, the 21 therapists who were not represented in the FSAI - Client subsample did not differ on any of the TRSMP scales from the 45 therapists who were included (all t values (64) < 1.73). Although the number of clients per therapists varied (M = 4.00, SD = 2.57, range = 1 - 10), equalization of the number of clients per therapists was not feasible for this small sub-sample because too many clients and therapists would be excluded.

Total FSAI - Client scores, which refer to the total number of problems checked by the client within seven problem areas, was correlated with some of the TRSMP scores. However, the TRSMP correlates of the FSAI - Client were different than the correlates of Total FSAI scores displayed in Table 16. This suggests that the correlations observed between assessment scores and therapist characteristics could not be explained by differences in client assignment procedures. Structuring (r = .13), Focus on Feeling (r = .13), Psychodynamic (r = .16) and Family Therapy (r = .13) were weakly but significantly (p < .05) related to higher presenting problem scores as reported by clients.

Table 17 reports the results of a hierarchical multiple regression analysis in which FSAI - Client and TRSMP scores are

Table 17

FSAI - Client and TRSMP Predictors of Total FSAI Scores:
Hierarchical Multiple Regression Results

Predictors ¹	B	β	r	Partial	R ²
				r	Increment
		.00	.00	.00	.00
Block 1					
FSAI - Client Total	.53	.29	.24	.35	.06
Block 2					
Behavioural	.92	.44	.40	.45	.16
Homework	.96	.49	.34	.45	.06
Family Therapy	-.72	-.57	.17	-.39	.04
Focus on Feelings	1.31	.33	.20	.32	.05
Social Structure	.33	.22	.20	.23	.03
Experiential*	-.48	-.16	.07	-.13	-.17
Constant	-13.61				
Total R ²	.426				
Adjusted R ²	.402				

¹ FSAI - Client measures were entered in the first block. All predictors were significant at .01 unless indicated by * ($p < .05$). Predictors are listed in the order of entry in the regression equation and the statistics reported refer to the results from the last step for the stepwise model. $n = 180$.

regressed on the Total FSAI scores. FSAI - Client scores were entered in the first block followed by the 23 TRSMP scales in the second block. Table 17 reveals that FSAI - Client scores accounted for the least amount of variance in the total number of problems therapists identified as measured by Total FSAI scores. The R^2 increment corresponding to the FSAI - Client block ($R^2 = .06$) was considerably smaller than the increment for the TRSMP block ($R^2 = .36$). The significant predictors (Behavioural, Homework, Family Therapy, Focus on Feelings, Social Structure, Experiential) were similar to those reported in Table 16 - higher FSAI scores tend to be associated with TRSMP scales that reflect directive models and practices. In the current regression model, Family Therapy was a strong predictor of Total FSAI scores (Partial $r = -.39$). The switch in signs from the zero-order (+) to partial coefficients (-) suggests that Family Therapy is a suppressor variable in relation to the Homework and Behavioural scales. Note that the partial coefficients are also higher than the respective zero-order correlations for all of the scales.

Although no hypotheses had been advanced, exploratory analyses were also conducted to determine whether or not the TRSMP scales would account for variation in the individual subscales of the FSAI. The FSAI - Client data were also used in these analyses. In this way it was possible to control for potential selection factors that involved assignments of clients with special problems to specific types of therapists. The seven FSAI - Intake subscales which are parallel to the subscales

derived from the FSAI - Client instrument (Marital Conflict, Problems with Children, Family Violence, Problems with Singles, Substance Abuse, Health Problems, and External Stressors) were used as dependent variables in a series of hierarchical multiple regression analyses. The parallel subscales based on client-reports were entered in the first block for each model, followed by the TRSMP scales in the second block. The results of these analyses appear in Table 18.

The results of the separate regression analyses departed from those obtained for the Total FSAI scores in that the client self-report variables contributed substantially more than the TRSMP scales to the prediction of therapist assessments within particular problem domains. Table 18 shows that the highest partial coefficients and the largest increments in R^2 were associated with the FSAI - Client scores. In terms of the significant TRSMP predictors, to a large extent the results were comparable to the results for the Total FSAI. For example, one or more of the directive scales (e.g. Behavioural, Skill Training, Homework) were included in the models for several subscales. There were a number of indications that suppressor effects were operating in the multiple regression models. The latter findings suggest significant complexity in the relationships among the various TRSMP scales.

An interesting finding was that the Social Structure scale was the only significant therapist predictor of Family Violence scores. The latter finding is consistent with concerns for the

FSAI - Client and TRSMP Predictors of FSAI Sub-Scale Scores: Hierarchical Multiple Regression Results

1 FSAI - client scores were entered in the first block. All predictors were significant at .01 unless indicated by * ($p < .05$).

rights of women which are reflected in the Social Structure scale. With this exception, the analyses of the FSAI subscales produced no other findings which bear on the construct validity of the scales.

CFQ Outcome Correlates of the TRSMP Scales

It had been predicted that the therapist scales Openness/Warmth/Understanding, Direction, Expertness, Attractiveness, Provides Meaning, Focus on Feelings, and Emotional Distress would be related to therapy outcomes. The correlations between the 23 TRSMP scales and client reports of outcome using the CFQ (Overall Outcome, Cognitive Gain, Behaviour Change, Client Satisfaction, and Positive Reason for Service Termination) are presented in Table 19. The sample of 168 CFQ cases in which the number of clients per therapists was equalized was used for these analyses.

Openness/ Warmth/ Understanding, Provides Meaning and Direction were correlated with client judgments of positive outcome (CFQ Overall Outcome). These scales were also significantly related to some of the outcome components which are combined to form the Overall Outcome scale. While Expertness and Emotional Distress were not significantly correlated with the composite measure of outcome, the latter scales were linked to client reports of Cognitive Gain. In addition, Attractiveness was unrelated to Overall Outcome but was related to positive behaviour change (CFQ Behaviour Change). Contrary to predictions,

Table 19

Correlation Coefficients: TRSMP Scales and CFQ Outcome Scales¹

	Overall ² Outcome	Cognitive Gain	Behaviour Gain	Satis- faction	Positive ² Closure
Openness/Warmth	.20**	.25**	.17*	.11	.07
Understanding					
Direction	.14*	.13*	.10	.11	.06
Structuring	-.01	.08	-.08	.06	-.03
Expertness	.11	.17*	.06	.05	.04
Attractiveness	.09	.05	.15*	.03	-.01
Provides Meaning	.17*	.20**	.07	.08	.14*
Focus on Feelings	.08	.11	.07	.04	.02
Activity Level	.06	-.04	.08	-.02	.03
Flexibility	.11	.14*	.02	.08	.06
Goal Setting	.04	.15*	-.01	.06	.02
Emotional Distress	-.08	-.14*	.01	-.02	-.09
Behavioural	.08	.08	.03	.07	.07
Psychodynamic	.09	.13*	.01	.11	.02
Cognitive	.09	.18*	.02	.03	.07
Experiential	.05	.17*	.04	.04	-.01
Social Structure	.14*	.07	.16*	.05	.14*
Paradoxical	-.05	-.08	-.02	-.07	-.04
Interventions					
Role Playing	.08	.09	.04	.05	.06
Skill Training	.11	.15*	.04	.05	.06
Relabeling	.16*	.04	.11	.01	.15*
Homework	.05	.07	-.02	.05	.03
Social Networks	.09	.12	.07	.03	.09
Family Therapy	.06	.08	.03	.01	.05
Means	3.17	1.59	.83	2.79	1.49
S.D.	1.02	.65	.36	.65	.60

* $p < .05$ ** $p < .01$ ¹ n (clients) = 168; n (therapists) = 28.² n = 162.

Focus on Feelings was not related to any of the CFQ outcome indices.

A multiple regression analysis was conducted to explore whether or not the TRSMP scales would make independent contributions to Overall Outcome. As indicated in Table 19, there were five significant zero-order correlations between CFQ Overall Outcome and the TRSMP measures. However, Openness/ Warmth/ Understanding was the only scale that was included in the multiple regression equation ($R^2 = .042$; $p < .01$). It appears that the associations between client-reported outcome and the Direction, Provides Meaning, Social Structure, and Relabeling scales may be explained by the variance these scales share with Openness / Warmth / Understanding. Unfortunately, the CFQ sample is too small to permit the application of cross-validation procedures. It should be kept in mind that the magnitude of the correlations between each of the TRSMP scales and CFQ outcome was low, and that a large number of variables were entered in the regression analysis. Therefore, the current test may not have been sufficiently sensitive to detect independent contributions of the scales.

A series of two-way analyses of variance were also conducted to explore potential moderating effects on the relationship between CFQ outcome and the TRSMP scales. For these analyses, the Openness/ Warmth/ Understanding, Direction, Structuring, Expertness, Attractiveness, Provides Meaning, Focus on Feelings and Emotional Distress scales were dichotomized to

form factors. FSAI Risk was included as the second factor in eight separate ANOVAs. Risk was dichotomized using a 50% cut-off point based on the distribution of scores for the larger sample of 2620 FSAI intake cases.

A one-way ANOVA indicated that low risk clients reported better outcomes than high risk clients ($F(1,160) = 5.82, p < .01$). No significant interactions between the therapist characteristics and the TRSMP scales were observed when the two-way analyses were performed. However, closer inspection of Table 20 showing the group means for CFQ Overall Outcome, reveals some non-significant trends that follow earlier predictions. For example, high risk clients served by therapists who scored high on the TRSMP Expertness scale had higher mean outcome scores ($M = 3.19$) than clients with therapists who scored low on Expertness ($M = 2.78$). A difference between scores of clients with high Expertness therapists ($M = 3.35$) and clients with low Expertness therapists ($M = 3.36$) was not evident in the low risk client group. A more pronounced positive effect among high risk clients was also suggested when the Direction scale was examined.

As the literature suggests, some therapist characteristics may influence outcome only when the Rogerian relationship conditions are present. For this reason, the potential moderating influence of Openness/Warmth/Understanding was tested in another series of two-way analyses of variance. The latter scale was included as a second factor in combination with each of Direction, Structuring, Expertness, Attractiveness, Provides

Table 20

CFQ Overall Outcome Means by Selected TRSMP Scales and FSAI Risk Level

FSAI Risk Level ¹	TRSMP Scales		<u>t</u> ¹	p<
	Low	High		
Openness/Warmth/Understanding				
High Risk	2.94 (n=37)	3.04 (43)	.39	ns
Low Risk	3.21 (42)	3.50 (40)	1.59	ns
Direction				
High Risk	2.74 (39)	3.24 (41)	2.01	.05
Low Risk	3.28 (53)	3.48 (29)	1.05	ns
Structuring				
High Risk	3.13 (38)	2.88 (42)	.98	ns
Low Risk	3.38 (36)	3.32 (46)	.34	ns
Expertness				
High Risk	2.78 (37)	3.18 (43)	1.59	ns
Low Risk	3.34 (43)	3.35 (39)	.06	ns
Attractiveness				
High Risk	2.83 (37)	3.13 (43)	1.17	ns
Low Risk	3.23 (43)	3.48 (39)	1.41	ns
Provides Meaning				
High Risk	2.88 (36)	3.09 (44)	.79	ns
Low Risk	3.27 (43)	3.43 (39)	.86	ns
Focus on Feelings				
High Risk	2.95 (47)	3.06 (33)	.40	ns
Low Risk	3.26 (56)	3.53 (26)	1.40	ns
Emotional Distress				
High Risk	3.18 (38)	2.83 (42)	1.39	ns
Low Risk	3.37 (37)	3.33 (45)	.25	ns

¹ Low Risk $df = 80$, High Risk $df = 78$.

Meaning, Focus on Feelings, and Emotional Distress. The cell means for this series of ANOVA's are presented in Table 21. There were no significant interaction effects, although an interaction involving Openness/ Warmth/ Understanding and the Emotional Distress scale approached significance ($F(1,158) = 2.99, p < .09$). Clients with therapists who reported high levels of Openness/ Warmth/ Understanding and low levels of Emotional Distress reported the best outcomes. There appeared to be no difference in the outcomes for the remaining groups. This, suggests that the positive effects of therapist emotional well-being may only obtain for therapists who also demonstrate good relationship skills.

FSAI Positive Termination

The TRSMP scales were also examined in relation to client outcome as judged by the therapists. The data were derived from the sample of 455 cases for which the number of clients per therapist has been randomly equalized. FSAI Positive Termination, a three level outcome ranking based on information provided by the therapist in the FSAI - Closure, is used in these analyses. There is considerable overlap between FSAI Positive Termination and CFQ Overall Outcome ($r = .39, p < .001, n = 291$).

FSAI Positive Termination was correlated with the Openness/ Warmth/ Understanding ($r = .14$), Expertness ($r = .09$), Activity Level ($r = .09$), Cognitive ($r = .09$), Experiential ($r = .08$)

Table 21

CFQ Overall Outcome Means by Selected TRSMP Scales and Openness/
Warmth/Understanding

Openness/Warmth/ Understanding (OWU) ¹	TRSMP Scales			
	Low	High	<u>t</u> ¹	p<
<hr/>				
Direction				
High OWU	3.03 (n=30)	3.39 (53)	1.71	.09
Low OWU	3.06 (62)	3.17 (17)	1.05	ns
Structuring				
High OWU	3.37 (29)	3.20 (54)	.81	ns
Low OWU	3.17 (45)	2.97 (34)	.86	ns
Expertness				
High OWU	3.11 (36)	3.38 (47)	1.31	ns
Low OWU	3.06 (44)	3.11 (35)	.06	ns
Attractiveness				
High OWU	3.16 (12)	3.28 (71)	.34	ns
Low OWU	3.02 (68)	3.45 (11)	1.23	ns
Provides Meaning				
High OWU	3.21 (23)	3.28 (60)	.29	ns
Low OWU	3.05 (56)	3.17 (23)	.45	ns
Focus on Feelings				
High OWU	3.25 (24)	3.27 (59)	.09	ns
Low OWU	3.08 (79)	- (0)	-	-
Emotional Distress				
High OWU	3.44 (47)	3.02 (36)	2.08	.05
Low OWU	3.00 (28)	3.13 (51)	.55	ns

¹ Low OWU $df = 81$, High OWU $df = 77$.

scales. Although statistically significant ($p < .05$), the coefficients are too meager to furnish support for the construct validity of the scales. The results of a multiple regression analysis in which the TRSMP scales were regressed on FSAI Positive Termination were also unencouraging.

For this regression analysis the generous sample size ($n = 455$) made it possible to use cross-validation techniques. The closure cases were randomly split into two samples of therapists. A prediction equation was formed on the first sub-sample (client $n = 234$, therapist $n = 18$) then tested on the remaining half of the cases (client $n = 221$, therapist $n = 17$) according to the method recommended by Pedhazur (1982). Only Openness/ Warmth /Understanding was included in the regression model for the first sample ($R^2 = .06$). The regression equation was applied to the data from the second sample and predicted scores for FSAI Positive Termination were calculated. The regression model failed to cross-validate since there was an absence of correlation between predicted and actual scores ($r = .03$).

The series of analyses of variance conducted with the CFQ outcome data were repeated for the FSAI Positive Termination measure. Eight separate ANOVA's were performed using Openness/ Warmth/ Understanding, Direction, Structuring, Expertness, Attractiveness, Provides Meaning, and Focus on Feelings. In each test FSAI Risk was included as a second factor. Since the size of the FSAI - Closure sample allowed for the testing of more complex models, Number of Interviews Delivered was included as a

third factor. The intention was to explore the hypothesis that the TRSMP variables would interact with degree of client exposure to the therapists. Number of Interviews was dichotomized such that clients who received more than two interviews were classified in the "high" group.

There were significant main effects for both FSAI Risk ($F(1,150) > 19.83, p < .05$) and Number of Interviews ($F(1,150) > 29.88, p < .05$). Low risk clients and those who completed more than two interviews had more positive outcomes as judged by their therapists. There were also significant interactions between risk and number of interviews in each of the ANOVA ($F(1,448) > 3.63, p < .05$). High risk cases exposed to more than two interviews received better outcome ratings than high risk cases who had fewer interviews. However, the effect of number of interviews was not present in the low risk group.

The only significant interaction observed for the TRSMP factors involved Number of Interviews and Expertness ($F(1,448) > 3.63, p < .05$). As the cell means in Table 22 show, high scores on the Expertness scale were associated with more positive outcomes among clients receiving three or more interviews but not among clients exposed to fewer than three interviews. Other trends are also evident in Table 22. Positive effects of Openness/ Warmth/ Understanding appeared to be present for high risk cases and cases exposed to higher levels of service. There was also an interesting pattern of outcome ratings associated with the Structuring scale. High Structuring scores were linked

Table 22

FSAI Positive Termination Means by Selected TRSMP Scales, FSAI Risk, and Number of Interviews Delivered

FSAI Risk Level ¹	TRSMP Scales		t ¹	p<
Service Delivered ²	Low	High		
Openness/Warmth/Understanding				
High Risk	1.32 (n=159)	1.56 (125)	2.85	.01
Low Risk	1.67 (87)	1.80 (81)	1.5	ns
High Service	1.62 (115)	1.81 (117)	2.45	.05
Low Service	1.28 (132)	1.41 (91)	1.41	ns
Direction				
High Risk	1.41 (180)	1.45 (104)	.46	ns
Low Risk	1.74 (104)	1.73 (64)	.07	ns
High Service	1.71 (136)	1.72 (96)	.20	ns
Low Service	1.34 (150)	1.31 (73)	.31	ns
Structuring				
High Risk	1.48 (147)	1.35 (137)	.98	ns
Low Risk	1.76 (73)	1.71 (95)	.61	ns
High Service	1.72 (108)	1.71 (124)	.06	ns
Low Service	1.43 (113)	1.23 (110)	2.07	ns
Expertness				
High Risk	1.39 (143)	1.45 (141)	.65	ns
Low Risk	1.64 (86)	1.81 (92)	2.06	.05
High Service	1.60 (108)	1.82 (124)	2.92	.01
Low Service	1.34 (113)	1.32 (110)	.19	ns
Attractiveness				
High Risk	1.38 (154)	1.47 (130)	1.11	ns
Low Risk	1.73 (78)	1.74 (90)	.16	ns
High Service	1.70 (112)	1.73 (120)	.36	ns
Low Service	1.28 (122)	1.39 (101)	1.13	ns

Table 22 Continued

FSAI Risk Level	TRSMP Scales		t	p<
Service Delivered	Low	High		
Provides Meaning				
High Risk	1.43 (185)	1.40 (99)	.38	ns
Low Risk	1.72 (86)	1.75 (82)	.42	ns
High Service	1.67 (129)	1.77 (103)	1.33	ns
Low Service	1.37 (144)	1.26 (79)	1.09	ns
Focus on Feelings				
High Risk	1.38 (164)	1.48 (120)	1.16	ns
Low Risk	1.71 (94)	1.77 (74)	.69	ns
High Service	1.68 (122)	1.75 (110)	.86	ns
Low Service	1.31 (138)	1.36 (85)	.46	ns
Emotional Distress				
High Risk	1.40 (123)	1.44 (161)	.40	ns
Low Risk	1.77 (97)	1.69 (71)	.99	ns
High Service	1.73 (110)	1.70 (122)	.41	ns
Low Service	1.38 (111)	1.28 (112)	1.06	ns

1 Low Risk df = 166, High Risk df = 245.

2 Low Service is defined as 1 - 2 interviews and High Service refers to 3 or more interviews. Low Service df = 221, High Service df = 230.

to poorer outcomes among clients who received fewer than three interviews, but not among clients who completed three or more interviews. It also appears that the positive effects of Expertness were only present among clients classified as low risk.

The Openness/ Warmth/ Understanding scale was also investigated as a potential moderator variable. The seven ANOVA's used to test this hypothesis in the CFQ sample were performed with FSAI Positive Termination as the criterion. Again no significant interactions emerged from this series of analyses (all $F(1,448) < 1.83$). Inspection of the relevant cell means presented in Table 23 failed to identify any non-significant trends involving the moderating influence of Openness/ Warmth/ Understanding.

Supervisor TRSMP Scales and Outcome

The TRSMP scales based on supervisor reports were also examined in relation to FSAI Positive Termination and the CFQ Outcome measures. These analyses are relevant to assessing the predictive validity of the supervisor versions of the TRSMP scales, and provide further information for interpreting the results of the therapist/supervisor multitrait-multimethod analysis reported earlier. FSAI Closure data were available on the clients of 22 therapists who had been rated by their supervisors. The client cases ($n = 286$) were drawn from the

Table 23

FSAI Positive Termination Means by Selected TRSMP Scales and Openness/ Warmth/ Understanding

Openness/Warmth/ Understanding (OWU) ¹	TRSMP Scales			
	Low	High	t ¹	p<
Direction				
High OWU	1.67 (n=91)	1.61 (117)	.61	ns
Low OWU	1.40 (195)	1.40 (52)	.44	ns
Structuring				
High OWU	1.73 (78)	1.58 (130)	1.59	ns
Low OWU	1.48 (143)	1.37 (104)	1.28	ns
Expertness				
High OWU	1.57 (78)	1.67 (130)	1.08	ns
Low OWU	1.41 (143)	1.48 (104)	.76	ns
Attractiveness				
High OWU	1.61 (39)	1.64 (169)	.26	ns
Low OWU	1.46 (195)	1.36 (52)	.89	ns
Provides Meaning				
High OWU	1.70 (91)	1.58 (117)	1.26	ns
Low OWU	1.42 (182)	1.49 (65)	.69	ns
Focus on Feelings				
High OWU	1.65 (52)	1.63 (156)	.19	ns
Low OWU	1.45 (208)	1.38 (39)	.55	ns
Emotional Distress				
High OWU	1.69 (117)	1.57 (91)	1.34	ns
Low OWU	1.41 (104)	1.46 (143)	.54	ns

¹ Low OWU $df = 245$, High OWU $df = 206$.

subsample employed earlier in order that the number of clients would be equalized across therapists. From the pool of 324 CFQ cases, a sub-sample of 6 cases was randomly selected for each therapist who had complete TRSMP supervisor data. This resulted in a sub-sample of 17 therapists with a total of 102 CFQ cases. Therapists who were excluded from the sub-sample did not differ from selected therapists on any of the TRSMP scales (all $t(64) < 1.92$) and excluded CFQ cases did not differ from selected CFQ cases on FSAI Risk ($t(322) = .91$), FSAI Positive Termination ($t(272) = .05$), or CFQ Overall Outcome ($t(291) = 1.19$).

FSAI and CFQ outcome correlates of the Supervisor TRSMP scales appear in Table 24. There are a number of differences between these validity coefficients and the coefficients that were observed for TRSMP scores based on the therapist self-report data. For example, Openness/ Warmth/ Understanding and Expertness were not related to therapist judgements of outcome on the various CFQ indices. In addition, the TRSMP scales that were reflective of a directive focus (Direction, Structuring, Behavioural, Skill Training) correlated with FSAI Positive Termination in the supervisor sample. Although there were a number of significant correlations between the TRSMP scales and CFQ Cognitive Gain, there were no predictors of this criterion using the scoring based on supervisor data. It should also be noted that there were a number of significant negative correlations between the CFQ outcome measures and the supervisor TRSMP scales (e.g. Goal Setting, Role Playing, Skill Training,

Table 24

Correlation Coefficients: Outcome Measures with Supervisor TRSMP Scores

	FSAI Positive Termination ¹	CFQ Overall Outcome ²	CFQ Cognitive Gain	CFQ Behaviour Gain	CFQ Satis- faction	CFQ Positive Closure
Openness/Warmth/Understanding	.04*	.04	.05	.14	.03	-.03*
Direction	.11*	-.14	-.02	.02	-.12	-.16*
Structuring	.11*	-.11	-.08	.05	-.04	-.15
Expertness	.09	-.07	.04	.09	-.08	-.14
Attractiveness	.05	-.06	-.00	.12	-.02	-.15
Provides Meaning	.06	.00	-.01	.08	-.04	-.05
Focus on Feeling	.04	.10	.11	.07	.05	.00
Activity Level	.07	-.01	.08	.12	-.06	-.13*
Flexibility	.09	-.09	.01	.06	-.06	-.21*
Goal Setting	.09	-.17*	-.10	-.00	-.15	-.13
Emotional Distress	-.06**	.08	.04	-.11	.03	.13
Behavioural	.14**	-.09	.01	.02	-.05	-.20*
Psychodynamic	-.03	.15	.09	-.04	.10	.19*
Cognitive	.12*	-.10	-.00	-.01	-.06	-.11
Experiential	.10*	-.04	-.02	.04	-.00	-.11
Social Structure	.10*	-.07	-.00	.06	-.15	-.16*
Paradoxical Interventions	.04	-.09**	-.03	.04	-.00	-.19*
Role Playing	.03	-.22**	-.12	-.05	-.15	-.16*
Skill Training	.14*	-.19*	-.01	-.05	-.10	-.19**
Relabeling	.11*	-.15	-.06	.01	-.08	-.24**
Homework	.07	-.05	-.01	.01	-.02	-.10
Social Networks	.09	-.02	.02	.10	-.14	-.13
Family Therapy	.13*	-.16*	-.07	.00	-.15	-.22**

* $p < .05$; ** $p < .01$, $n = 102$.¹ n (clients) = 286, n therapists = 22.² n (clients) = 102, n therapists = 17.

etc.). This trend, which was particularly evident for CFQ Positive Closure, was not identified in the previous analyses.

Using the same sub-sample of CFQ cases ($n = 102$), the correlations between supervisor TRSMP scores and client-reported process were also calculated. Here again, as Table 25 indicates, the results were somewhat different than the pattern reported for the therapist-based scoring method. Most notably, the links between CFQ process scales and Openness/ Warmth/ Understanding were less evident, and a number of the directive scales were positively associated with client ratings of therapist supportiveness (Basic Support). Only one of the hypotheses regarding the TRSMP and CFQ process scales (Table 3) was supported by the data provided by supervisors.

Mean Client Outcomes for Individual Therapists

Up to this point, individual cases have been employed as the units of analysis when the relationship between client variables and the TRSMP scales were explored. An alternative approach is to use the therapist as the unit of analysis, whereby client outcome variables are treated as characteristics of therapists. For example, the average outcome rating for an individual therapist's clients might be regarded as an index of the therapist's overall success. By averaging client ratings, the effects of extreme scores associated with specific clients may be diminished. Therefore, the use of the therapist as a unit of

Table 25

Correlation Coefficients: Supervisor TRSMP Scores and CFQ Process Scales

	Basic Support	Under- standing	Explora- tion	Problem Solving	Assess- ment
Openness/Warmth Understanding	.21*	.09	.06	-.07	.05
Direction	.15	.01	.06	-.00	.08
Structuring	.15	.10	.08	.01	.09
Expertness	.17*	.10	.09	-.01	.19*
Attractiveness	.14	.12	.07	-.08	.11
Provides Meaning	.14	.03	-.00	-.01	-.07
Focus on Feelings	.23**	.10	.14	-.01	.04
Activity Level	.16*	.21*	.09	.01	.10
Flexibility	.22**	.07	.13	-.00	.15
Goal Setting	.04	-.08	.01	.05	.11
Emotional Distress	-.12	-.00	-.04	.17	-.12
Behavioural	.21*	.07	.08	.05	.09
Psychodynamic	-.06	-.01	-.02	.04	-.11
Cognitive	.23**	-.01	.09	.05	.07
Experiential	.22**	-.00	.10	-.02	.13
Social Structure	.13	.02	.02	.02	-.00
Paradoxical Interventions	.14	.08	.02	-.01	-.07
Role Playing	.08	-.00	.09	-.00	.06
Skill Training	.20*	.00	.15	.07	.27**
Relabeling	.06	-.00	-.02	-.12	-.01
Homework	.26**	.14	.15	.10	.03
Social Networks	.17	.07	.08	.04	-.03
Family Therapy	.14	.04	.00	.08	-.00

* $p < .05$; ** $p < .01$, $n = 102$.

analysis may produce more stable estimates of criterion-related validity.

To pursue this line of investigation, mean CFQ Process and Outcome scores were calculated for the six clients of each of the 28 therapists that comprised the CFQ sub-sample. Mean therapist scores ($n = 35$) were computed for FSAI Positive Termination based on the data for the 13 clients of each therapist. The correlations between the various mean outcome criteria and the TRSMP scales are displayed in Table 26. This method of analysis produced dramatic results, especially for the CFQ Outcome measures. When the coefficients in Table 26 are compared with the corresponding coefficients in Table 19, the magnitude of the correlations is substantially augmented for the CFQ outcome scales based on average therapist scores. For example, the correlation between CFQ Cognitive Gain and Openness/ Warmth/ Understanding, which was initially .25 ($p < .01$, $n = 168$ clients), increased to .60 when therapist scores were used as the units of analysis. The trend was evident for all of the coefficients that were statistically significant in the first round of analyses.

Although the strength of the associations between the TRSMP scales and average therapist FSAI Positive Termination ratings is less impressive than the findings for the CFQ data, the pattern of results follows the same trend. While the original validity estimate for the TRSMP Openness/ Warmth/ Understanding scale was .14, the estimate increased to .46 in the therapist-

Table 26

Correlation Coefficients: TRSMP Scales and Mean Therapist Outcome Scores¹

TRSMP Scales	FSAI ¹ Positive Termination Outcome	CFQ ² Overall Outcome	CFQ Cognitive Gain	CFQ Behaviour Gain	CFQ Satis- faction	CFQ Positive Closure
Openness/Warmth Understanding	.46**	.49**	.60**	.45**	.28	.17
Direction	.01	.31*	.31*	.27	.28	.14
Structuring	.07	-.01	.20	-.22	.15	-.06
Expertness	.28*	.27	.42*	.15	.12	.10
Attractiveness	.11	.23	.11**	.40*	.07	.01
Provides Meaning	-.09	.40*	.48**	.19	.22	.33*
Focus on Feelings	.21	.21	.26	.20	.09	.05
Activity Level	.28*	.15	-.11	.21	-.06	.07
Flexibility	.15	.29	.35*	.06	.20	.14
Goal Setting	.01	.08	.36*	-.03	.16	.04
Emotional Distress	-.21	-.21	-.33*	.03	-.06	-.24
Behavioural	.20	.16	.19	.08	.18	.15
Psychodynamic	.18	.22	.32*	.01	.29	.04
Cognitive	.29*	.20	.44**	.04	.09	.16
Experiential	.27	.13	.41*	.10	.11	-.03
Social Structure	.01	.31	.16	.43*	.12	.31*
Paradoxical Interventions	.01	-.12	-.18	-.04	-.18	-.09
Role Playing	-.18	.20	.21	.11	.14	.13
Skill Training	.13	.26	.38*	.10	.11	.13
Relabeling	.14	.36*	.09	.31	.03	.35*
Homework	.08	.10	.17	-.07	.13	.05
Social Networks	-.14	.22	.29	.20	.08	.22
Family Therapy	.20	.14	.20	.07	.02	.11

* $p < .05$ ** $p < .01$ 1 n (therapists) = 53.2 n (therapists) = 28.

based sample. The general pattern was also confirmed when mean therapist scores were computed for the assessment, targets, service plans, and service delivery variables. Correlations observed between these variables and the TRSMP predictors increased from initial values in the .1 to .2 range to values in the .2 to .3 range.

Finally, mean therapist scores were computed for the CFQ process measures. Table 27 presents the coefficients based on the sample of 28 therapists. Again, dramatic increases from the initial validity coefficients (Table 13) were observed. Note for example, the correlation of .56 between CFQ Active Assessment and the Behavioural scale was initially reported as .23 for the CFQ client sample. Thus, the TRSMP scales demonstrate very promising evidence of criterion-related validity when therapists are treated as the units of analysis.

Table 27

Correlation Coefficients: TRSMP Scales and Mean Therapist CFQ
Process Scales¹

	Basic Support	Under- standing	Explora- tion	Problem Solving	Assess- ment
Openness/Warmth Understanding Direction	<u>.22</u>	<u>.44</u> **	.36*	.38*	.33*
Structuring	-.10	.01	.17	<u>.10</u>	<u>.10</u>
Expertness	.36*	.32*	.38*	.20	.17
Attractiveness	-.08	<u>.04</u>	.19	.10	.19
Provides Meaning	-.05	.06	.29	.34*	.21
Focus on Feelings	.01	.11	-.02	.01	-.01
Activity Level	-.10	-.06	.16	-.11	.14
Flexibility	.06	-.01	.19	.01	.09
Goal Setting	-.06	.11	.10	<u>.49</u> **	<u>.30</u> *
Emotional Distress	-.13	-.22	-.04	-.26	-.26
Behavioural	-.01	.07	.41*	<u>.31</u>	.56**
Psychodynamic	.21	.31	.20	.07	.36*
Cognitive	-.06	.01	.27	.32*	.14
Experiential	.04	.19	<u>.04</u>	.35*	-.01
Social Structure	.03	.07	.54**	.13	.18
Paradoxical Interventions	-.14	-.35*	-.13	.09	-.10
Role Playing	-.15	-.03	.13	-.02	.12
Skill Training	.21	.16	.39*	.22	.19
Relabeling	-.32	-.09	-.04	-.14	-.09
Homework	.03	-.11	.16	.17	.18
Social Networks	-.11	.12	.31*	-.06	.11
Family Therapy	-.24	-.04	.23	.10	.04

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

¹ n (therapists) = 28).

DISCUSSION

The psychometric properties of a comprehensive set of scales designed to measure therapy relevant characteristics of therapists and counsellors have been explored. The TRSMP scales displayed adequate reliability and evidence of validity was presented for a number of scales. The major sources of support for the construct validity of the scales came from the pattern of inter-correlations among the 23 scales, and from criterion-related validity estimates which revealed links between the therapist scales and various indicators of therapy process, assessment practices, treatment planning and delivery, and therapeutic outcome. Unfortunately, attempts to demonstrate convergent and divergent validity were less successful when the TRSMP scales were evaluated against alternative methods of measuring the constructs.

Psychometric Properties of the TRSMP

Style Scales

The majority of the TRSMP style scales were correlated with other style, model, and practice scales in the predicted directions, and also predicted other therapist and client criteria. In particular, Openness/ Warmth/ Understanding was consistently related to both client and therapist ratings of

positive therapeutic outcome. The highest validity coefficients in this study were associated with Openness/ Warmth/ Understanding scale. Given the centrality of therapist relationship skills in the empirical and theoretical literature, this finding offers encouraging support for the measurement approach utilized here.

Although the constructs of Direction and Structuring were accorded considerable theoretical importance in this study, there was little support for the distinction between the two constructs. Apart from the correlation observed between Direction, Structuring, and the more specific indicators of a directive therapeutic style (e.g., Activity Level, Goal Setting, Behavioural, Skill Training, Homework), the two scales did not perform well when other therapist and client criteria were investigated. In fact the more specific indicators of directiveness were correlated with appropriate criterion (e.g., client measures of process, assessment practices, treatment plans) to a greater extent than Direction and Structuring. For example, the correlations between criterion variables and the Behavioural scale suggest that the latter measure represents the construct of directiveness better than the Direction scale.

One possibility is that some of the Direction items were too general and may have been endorsed by both directive and non-directive therapists (e.g., offering or providing help, identifying post-therapy problems and responses). The fact that the Direction and Experiential scales loaded on the same factor

when the 23 scales were factor analyzed is a good illustration of this point. While further item revisions to the Direction scale may be necessary to adequately operationalize this important construct. However, the utility of the Structuring construct to reflect a more authoritative approach to therapy remains a question.

The Expertness scale showed considerable promise as a self-report measure of social influence. It was related to positive evaluations of process and outcome from clients and was strongly correlated with its parallel supervisor rating. However, there was a lack of consistency in the way Attractiveness was related to the various criteria. It is possible that the use of client perceptions may be more appropriate for tapping the Attractiveness component of therapist social influence.

There was some evidence of the validity of Provides Meaning. This scale correlated with other TRSMP scales in a predictable fashion and was also appropriately related to CFQ outcome (Cognitive Gain). The Flexibility scale also appeared to be measuring the intended construct since it was related to therapists' admissions that they preferred eclectic practices. Consistent with the notion that flexible therapists do not rely solely on any particular mode of therapy, Flexibility emerged as a relatively separate factor in the factor analysis of the TRSMP scales. There was also good evidence of the validity of the Goal Setting scale since it correlated with relevant process measures and treatment planning variables.

On the other hand there was a lack of support for the validity of Focus on Feelings. While this scale was related to some of the TRSMP scales in meaningful ways, it was unrelated to its parallel scale from the client process set (i.e., Encourages Exploration). The Activity Level scale was predictably related to a number of the more directive scales in the battery. However, there was a lack of alternative criteria for assessing the construct validity of this scale.

While the Emotional Distress scale was not significantly correlated with the majority of criteria, in almost every instance coefficients for this scale carried the expected negative sign. This measure may not be highly related to outcome, however, it appeared to be operationalizing the construct under investigation.

Model Scales

It proved to be more difficult to provide information for validating the TRSMP model scales than it was for the style scales. Although there was some support for the validity of the model scales in the inter-correlation matrix, there were insufficient alternative criteria that could be used to establish construct validity. An exception was the Behavioural scale, which exhibited meaningful correlations to client process ratings and the various measures of assessment and treatment planning. To a less extent, the Cognitive scale was appropriately linked to the CFQ process and outcome ratings. However, in view of the

popularity of cognitive methods, more information is needed to evaluate the usefulness of the current measure. The Social Structure scale appears to possess some promise. Although few hypotheses were advanced with respect to this scale, there were correlations between Social Structure and other variables that logically fit with the definition of this construct (e.g., positive correlations with assessment of family violence, directive scales).

There was less evidence regarding the validity of the Psychodynamic and Experiential scales. For the most part, these scales were found to correlate as expected with alternative TRSMP scales. For example, the Psychodynamic and Experiential scales were relatively independent of the scales characterized by more directive therapeutic methods. However, there was a lack of alternative criteria against which the two scales could be evaluated. As mentioned earlier, previous researchers have reported difficulty in designing valid measures of the experiential models of psychotherapy (Heron, Ginot and Sitkowski, 1987; Wogan and Norcross, 1985).

Technique Scales

Fortunately, the technique scales are composed of items which appear to possess high face validity (e.g., use of paradoxical techniques, role playing exercises, assigning homework). For this reason, the problem of a lack of alternative criterion measures for the validation process was not as salient for the technique scales. Generally, the

hypothesized links between these scales and other TRSMP measures were supported by the data. Exceptions were the Relabeling and Family Therapy scales, which were not as highly correlated with other scales as predicted.

There was additional support for the validity of some of the scales using other criterion variables. Both Paradoxical Interventions and Family Therapy showed a degree of convergence with parallel scales based on the supervisor data. The Social Networks scale was the only scale in the entire battery that exhibited reasonable convergence with its parallel version based on therapists specifications of techniques planned.

The psychometric status of the Family Therapy technique scale remains unclear. Although it possessed high internal consistency, there is the possibility that a single scale aimed at measuring Family Therapy techniques may blur important distinctions between various interpretations within family systems theory. This scale may be adequate for measuring interest in family issues and affiliation with systems theory in heterogeneous samples of therapists. In samples of family therapists the use of multiple dimensions to measure family therapy techniques would likely be more appropriate. Factor analysis of the items assigned to the Family Systems scale failed to provide a solution that would result in a sub-division of the items into meaningful subscales. What is required may be a broader sampling of family systems technique indicators in order to do justice to the measurement of this construct.

Other Psychometric Issues

Multitrait-Multimethod Analyses

The best support for the construct validity of this large battery of measures would have been derived from multitrait-multimethod evidence of convergent and divergent validity. This is particularly the case since pertinent constructs for establishing criterion-related validity for some of the scales were either unknown or not assessed in the current study. In some cases, signs of predictive validity emerged from exploratory analyses in which unpredicted significant correlations could be understood in light of the definitions of the constructs. However, for some of the scales (e.g., Direction, Structuring, Provides Meaning, Activity Level, Cognitive, Psychodynamic, Experiential, Relabeling), construct validity estimates based on corresponding measures of the same constructs would have greatly contributed to this validation effort. While parallel versions of the TRSMP were available (i.e., Supervisor TRSMP scores and FSAI Technique Scales), there appeared to be methodological flaws in these measurements which restrict the degree of confidence that can be placed in the results.

The supervisor-based scoring of the TRSMP produced some respectable evidence of convergent validity with coefficients ranging from .27 to .46. However, there was virtually no consistent evidence of divergent validity in the correlation matrices. One interpretation of these findings is that the

scales lack construct validity. The alternative explanation is that validity estimates may have been deflated because of some degree of invalidity present in the supervisor-based scales. There were limited opportunities to explore the latter hypothesis in the present investigation. However, the correlations between the supervisor measures and the client-reports of process and outcome did suggest that the measures may not be performing as intended.

Despite previous findings that show a link between observer reports of therapist relationship attitudes and therapeutic outcomes (e.g. see Patterson, 1984; Howard and Orlinsky, 1986), this well-established pattern was not manifested when supervisor reports of therapists' Openness/ Warmth/ Understanding were examined in relation to the client outcome measures. Moreover, both significant and non-significant coefficients representing correlations between the five CFQ outcome indices and the 23 TRSMP scales were almost always negative. One possibility is that therapists who were known by their supervisors to have poor therapeutic success rates may have been rated consistently lower on the majority of the items in the battery. If it exists, this rating bias might reflect the belief that unsuccessful therapists are passive and are unable to commit themselves to specific therapeutic styles or techniques. The results of the comparisons between CFQ process and the supervisor ratings were also somewhat puzzling. It will be recalled that few of the hypotheses concerning the TRSMP and CFQ process scales were

confirmed using the supervisor scores. There were also a number of negative coefficients, and the unique pattern of significant relationships observed between the two sets of measures was not interpretable.

The greatest obstacle to achieving valid supervisor ratings involved the lack of control over variability in the knowledge that supervisors possessed. Variability in the supervisors' familiarity with their therapists' behaviour likely existed within and across supervisors. Since the study was conducted in eleven different agencies, differences in supervision styles relating to the frequency and intensity of supervision sessions were likely to occur. While high correlations between self-ratings and the ratings of co-therapy partners were reported by Rice and his associates (Rice, Gurman and Razin, 1974), it is unlikely that the supervisors in the present sample had the high quality of exposure to the in-therapy behaviour of their therapists that would apply for co-therapists. In validating self-report measures of this kind in the future, the use of observational techniques (e.g., audio or video) might be employed to augment the supervisor's knowledge of their therapists' working styles.

In order to establish the validity of the self-report scales under investigation, there must be an indication that the techniques therapists employ in treating individual clients correspond to their pre-service self-descriptions of therapeutic behaviour. The results of the FSAI Technique analyses were

characteristics may be most influential for clients who are at high of risk of obtaining poor outcomes. Additional hypotheses could have been examined regarding the interaction between various therapist variables and interactions between therapist variables and alternative client variables. However, the number of tests was limited so as to avoid the generation of chance findings.

One implication of the trends that were observed is that the relationship between therapist variables and outcome may be very complex. This argument may have more salience now that eclecticism has emerged as the first preference of many therapists and counsellors. As surveys of mental health professionals have revealed, numerous combinations of psychotherapy models are currently employed by therapists. The most recent study of this phenomena found that 22% of 277 therapists combined all four models of Dynamic, Cognitive/Behavioural, Humanistic, and Systems therapy (Jensen, Bergen and Greaves, 1990). Aside from combinations of the major psychotherapy models, there is also a large range of possible combinations of the therapeutic styles and practices measured here. The extent to which therapeutic success is a function of different eclectic combinations remains an important research question.

Another finding which draws attention to the complexity of therapists effects concerns the identification of suppressor effects in the analyses of therapist characteristics and

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disappointing, especially given the degree of effort required to code the large number of narrative technique entries from the FSAI protocols. However, the lack of correlation between this set of measures and the TRSMP scales was not surprising. Difficulty in reaching consensus between the two raters was not the only problem encountered. Even after the raters resorted to jointly assigning questionable items, over half of the items could not be assigned to any of the 18 technique categories. The design of the FSAI - Intake did not provide sufficient structure to elicit the type of detail about therapeutic techniques that would provide data to facilitate the development of a reliable coding scheme. In view of these difficulties, the outcome of analyses involving the FSAI Technique scales was probably more a function of the quality of the latter scales rather than the psychometric properties of the TRSMP scales.

In summary, it is clear that future efforts at validating large batteries of therapist characteristics measures would be greatly enhanced by the development of valid parallel scales which rely on alternative measurement sources.

Client and Therapist Validation Criteria

The predictive criterion validity estimates that were derived from the analyses of client ratings of therapeutic process and outcome were impressive in view of the reservations that have been raised with respect to self-reported measures of therapist characteristics (e.g., Fiske, 1977). It was important that connections between client and therapist-based measures be

identified in order to establish the suitability of the TRSMP instrument for exploring hypotheses about therapist characteristics and therapeutic outcomes. The findings suggest that the measurement techniques used to investigate therapist characteristics in the present study pass this critical test. If links between the TRSMP scales and therapeutic outcome had been limited to correlations with therapist judgments of outcome, there would be reasonable grounds for criticism of this measuring approach. As Howard and Orlinsky's (1986) observations suggest, the criticism would be especially applicable to comparisons between therapist self-assessed relationship skills and therapist-rated outcome. Therefore, the present study furnishes optimistic data relevant to the predictive validity of therapist self-reported behaviour.

The results obtained can be viewed as particularly favorable when it is recalled that the CFQ sample was comprised of lower risk clients who were assessed by the therapists as having more positive benefits from therapy than the clients who were not included in the CFQ sample. The latter implies that a restriction in range for both process and outcome measures may have occurred for the CFQ sample. The overall influence of a restriction in range of this nature would normally be to lower the magnitude of the validity coefficients. It is possible that the predictive validity estimates reported for this study would increase in a sample involving more representative clients.

The low level of correlation between therapist self-reported characteristics and other criterion measures based on therapist sources was a surprising finding. For example, the correlation between Openness/ Warmth/ Understanding and therapist judgements of positive termination was below 0.2. It might be expected that such coefficients would be of higher magnitude due to method variance alone. It may be that the criterion used in the present study, positive termination of therapy, may not be broad enough to capture the relationship between the TRSMP and outcome as assessed by the therapist. For example, therapist characteristics may have a greater influence on ratings of behavioural change.

Complexity of Therapist Characteristics

It was argued earlier that the relationship between particular therapist variables and therapeutic success may be moderated by other therapist variables or by other client variables. The various tests that were performed did not uncover any major interaction effects that would support this type of hypothesis.

Nevertheless, there were some non-significant trends indicating that this line of investigation should be continued in future examinations of the impact of therapist characteristics on outcome. In support of the findings of risk by treatment interactions reported in other human service settings (Andrews, Kiessling, Robinson and Mickus, 1986; Andrews, Robinson and Bonta, 1986) the observed trends suggest that therapist

characteristics may be most influential for clients who are at high of risk of obtaining poor outcomes. Additional hypotheses could have been examined regarding the interaction between various therapist variables and interactions between therapist variables and alternative client variables. However, the number of tests was limited so as to avoid the generation of chance findings.

One implication of the trends that were observed is that the relationship between therapist variables and outcome may be very complex. This argument may have more salience now that eclecticism has emerged as the first preference of many therapists and counsellors. As surveys of mental health professionals have revealed, numerous combinations of psychotherapy models are currently employed by therapists. The most recent study of this phenomena found that 22% of 277 therapists combined all four models of Dynamic, Cognitive/Behavioural, Humanistic, and Systems therapy (Jensen, Bergen and Greaves, 1990). Aside from combinations of the major psychotherapy models, there is also a large range of possible combinations of the therapeutic styles and practices measured here. The extent to which therapeutic success is a function of different eclectic combinations remains an important research question.

Another finding which draws attention to the complexity of therapists effects concerns the identification of suppressor effects in the analyses of therapist characteristics and

assessment practices. One explanation of such effects is that models which were previously viewed as disparate are now being combined by some therapists. It is possible that the complex effects being observed are a function of combinations of styles and models which have differential impacts on outcome. The present findings underscore the importance of carefully attending to the potential joint effects of therapist variables.

Units of Analysis

An important finding involved the dramatic increases observed in predictive validity estimates when therapists were treated as the units of analysis. The most reasonable explanation for this phenomena is that by averaging client scores across therapists, a more stable estimate of the overall effect of therapist factors is achieved. The aggregation of scores may reduce the potential distortion effects caused by "outlier" cases. An example of this type of outlier concerns the client of a highly successful therapists who, for whatever reasons, experiences a particularly inferior therapeutic outcome. Assuming that the therapist's success is related to a measurable therapist characteristic, the obvious effect the client outlier would have on a sample would be to reduce the correlation observed between the therapist characteristic and client outcome.

The fact that variations in the average outcomes of therapists can be empirically linked to characteristics of the therapists, suggests considerable stability in the behaviour of

individual therapists over time and across clients. This suggestion is at variance with the dominant mood in the psychotherapy research literature. Study of the dynamic interplay between the therapist and client has been emphasized in recent writings (e.g., Butler and Strupp, 1986). However, findings reported here regarding the magnitude of the correlation between therapist variables measured prior to the delivery of therapy and client self-reported outcomes, suggest that research on the individual differences of therapists should not be abandoned.

Increases in validity estimates associated with the shift from clients to therapists as the units of analysis may also have implications for the interpretation of findings from previous studies of therapist characteristics. Since therapist behaviour has been typically examined in the context of individual therapy sessions, data are normally analyzed at the client level. One consequence of relying on this "process" method of gathering and interpreting data, is that the actual magnitude of the relationship between therapist factors and client outcome may be underestimated. Although the hypothesis requires testing with new data, therapist characteristics may be more important than previous researchers have implied.

Following the earlier work of Rice, Gurman and Razin (1974), therapists were asked to describe their therapeutic behaviour in terms of the general "picture" an observer would have of their work over time and with a variety of cases. For this reason,

averaging client measures across therapists may be the most appropriate method of examining the TRSMP scales. Unfortunately, the use of therapists as the units of analysis involves some weaknesses in terms of the types of statistical analyses that are feasible. For example, interactions between various therapist characteristics could only be studied in very large samples of therapists. In addition, there is less flexibility concerning the ability to use client variables as moderators or statistical controls.

Generalizability of the Findings

A weakness of this study concerns the possibility that the therapists who comprise the sample may not be representative of other mental health professionals. Since all of the therapists were employed by family service agencies, they will obviously exhibit a special interest in family therapy issues. In addition, these therapists have unique training and experience profiles. It will be recalled that over half of the sample possessed M.S.W. degrees, and only two therapists had received doctoral degrees. In comparison to psychotherapists who have been trained as clinical psychologists, the therapists in this sample are likely to differ on a number of therapeutic models and styles of delivery. For example, it is known that the majority of the therapists did not align themselves with the traditional models of psychotherapy (e.g., Psychodynamic, Behavioural). It has also been reported that the current sample was composed of a high proportion of women.

The obvious effect of any unique characteristics of these therapists is that their scores on some of TRSMP scales would be higher or lower than scores that would characterize a more representative sample of therapists and counsellors. The general pattern of findings has been reasonably consistent with a priori predictions. However, the possibility exists that the observed relationships among the various TRSMP scales and correlations with the validation measures may have been a function of the unique characteristics of the sample.

Another threat to the generalizability of the results concerns the representativeness of the client sample. Clients who approach family service agencies for help may have different demographic characteristics, complaints, and severity of problems than clients who seek help from other clinical settings. Again, the influence that such differences may have on the results of this study cannot be assessed.

Every effort was taken to obtain complete data on all of the clients and therapists who were involved with the family service agencies. However, it was impossible to secure FSAI - Closure data on all 2620 cases for which FSAI Intake assessments had been completed. Some cases were remained open after the data collection phase of the project was completed. Although the number of cases could not be established, it was known that some therapists were more likely than others to submit completed FSAI - Closure documents to the researchers. As elaborated earlier, there was also a high non-response rate associated with the CFQ

sample. Finally, not all therapists were willing to provide information on their therapeutic behaviour. Roughly 36% of the therapists who were employed at the agencies at the time the data were collected failed to complete the self-report inventory. Unfortunately it is not possible to determine the extent to which missing cases contributed to bias in the samples which may have influenced the results.

Questions about the generalizability of the findings reported here can only be answered with fresh data collected from more representative samples of therapists. However, the selection of the constructs that have been measured was based on rational rather than empirical criteria. This has ensured that the particular combination of therapist characteristics measured by the TRSMP scales was not dependent on biases related to the current sampling of therapists. The constructs underlying the scales have been drawn from a broad survey of the theoretical and research literature in psychotherapy. As such, the applicability of the scales will not be limited to specific clinical settings.

CONCLUSION

The present study furnishes support for the use of pre-service therapist self-report methods for assessing therapist characteristics. The results challenge the notion that knowledge about the influence of therapist factors is only obtainable through therapy process studies that rely on external observers as sources of "objective" measurement. However, the data suggest that therapists may be able to provide reliable and valid information about the usual behaviour they exhibit in therapeutic settings. Given the need for convenient measures of therapist factors for a variety of applications in psychotherapy research, the present findings are very encouraging.

Evidence of the validity of the 23 self-report measures was derived from the pattern of inter-correlation observed among the scales. However the scales were also shown to be linked to client and therapist assessments of therapeutic outcome, and the assessment and treatment planning practices of the therapists. Although the measures require further validation efforts, the utility of this battery of scales for use in research on the relationship between therapist factors and client outcome appears very promising. This investigation has also demonstrated that by focusing exclusively on clients as the units of analysis, previous research efforts may have underestimated the importance of therapist variables.

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Appendix A
Preferred Practices Inventory

WORKER REPORT ON PREFERRED PRACTICES

Agency: 1 Catholic Family Service of Ottawa
 (Circle) 2 Family Counselling Centre, Cornwall
 3 Family Counselling Service, Kingston
 4 Family Service Centre of Ottawa-Carleton

Worker Name or Number _____

Date:
 D M Y

Instructions

Therapists vary their behaviour to suit different clients, different stages with the same client, and various other conditions that are present in particular counselling contexts. Thus, no one picture of the therapist's behaviour does complete justice. Yet, beneath these variations, therapists have some sense of their style in general --- that picture which a panel of observing therapists would get from watching you work, over time, with a variety of cases. Please try to give us that sketch by responding rapidly and intuitively to each of the items on the following pages. Each item is rated on a scale of 1 to 5 with a sixth response category for "cannot say". Simply circle the response number which is most descriptive of your behaviour for each of the items.

DEFINITELY NOT, NEVER, NOT AT ALL DESCRIPTIVE OF WORKER

1 Not Much, Not Very, Rarely, Occasionally

1 1 Moderately Descriptive of Worker

1 1 1 Quite a Lot, Frequently, Often

1 1 1 1 DEFINITELY YES, ALWAYS, VERY DESCRIPTIVE OF WORKER

1 1 1 1 1 Cannot Say

1 1 1 1 1 1

1 2 3 4 5 6

Your name which appears on the face sheets of this questionnaire package will be deleted once your responses have been coded by the research team. Just as in the case of clients, your individual responses will never be reported upon except as part of group data.

Thank You for Your Co-operation.

WORKER REPORT ON PREFERRED PRACTICES

Agency: 1 Catholic Family Service of Ottawa
 (Circle) 2 Family Counselling Centre, Cornwall
 3 Family Counselling Service, Kingston
 4 Family Service Centre of Ottawa-Carleton

Worker Name or Number _____

Date:
 D M Y

Instructions

Therapists vary their behaviour to suit different clients, different stages with the same client, and various other conditions that are present in particular counselling contexts. Thus, no one picture of the therapist's behaviour does complete justice. Yet, beneath these variations, supervisors have some sense of each worker's style in general --- that picture which a panel of observing therapists would get from watching the worker work, over time, with a variety of cases. Please try to give us that sketch by responding rapidly and intuitively to each of the items on the following pages for each worker you supervise. Each item is rated on a scale of 1 to 5 with a sixth response category for "cannot say". Simply circle the response number which is most descriptive of the worker's behaviour for each of the items.

DEFINITELY NOT, NEVER, NOT AT ALL DESCRIPTIVE OF WORKER

1 Not Much, Not Very, Rarely, Occasionally

1 1 Moderately Descriptive of Worker

1 1 1 Quite a Lot, Frequently, Often

1 1 1 1 DEFINITELY YES, ALWAYS, VERY DESCRIPTIVE OF WORKER

1 1 1 1 1 Cannot Say

1 1 1 1 1 1

1 2 3 4 5 6

The worker name which appears on the face sheet of this questionnaire package will be deleted once the responses have been coded by the research team. Just as in the case of clients, individual responses will never be reported upon except as part of group data.

Thank You for Your Co-operation.

2

DEFINITELY NOT, NEVER, NOT AT ALL DESCRIPTIVE OF WORKER

1 Not Much, Not Very, Rarely, Occasionally

1 1 Moderately Descriptive of Worker

1 1 1 Quite a Lot, Frequently, Often

1 1 1 1 DEFINITELY YES, ALWAYS, VERY DESCRIPTIVE OF WORKER

1 1 1 1 1 Cannot Say

1 1 1 1 1 1

1.	1	2	3	4	5	6	1. Talkative
2.	1	2	3	4	5	6	2. Passive
3.	1	2	3	4	5	6	3. Explanatory
4.	1	2	3	4	5	6	4. Businesslike, "in charge"
5.	1	2	3	4	5	6	5. Supportive, reassuring
6.	1	2	3	4	5	6	6. Emphasizes "here-and-now" interaction
7.	1	2	3	4	5	6	7. Consistent during session
8.	1	2	3	4	5	6	8. Guiding, directing obliquely
9.	1	2	3	4	5	6	9. Provocative, challenging
10.	1	2	3	4	5	6	10. Guided by theory
11.	1	2	3	4	5	6	11. Patient, willing to wait
12.	1	2	3	4	5	6	12. Interpretive, inferential
13.	1	2	3	4	5	6	13. Persistent, unyielding
14.	1	2	3	4	5	6	14. Interested in client's history
15.	1	2	3	4	5	6	15. Casual, informal
16.	1	2	3	4	5	6	16. Critical, disapproving
17.	1	2	3	4	5	6	17. Objective, impartial
18.	1	2	3	4	5	6	18. Spontaneous, intuitive, improvising
19.	1	2	3	4	5	6	19. Working toward definite goals
20.	1	2	3	4	5	6	20. Focusing upon relationship(s)
21.	1	2	3	4	5	6	21. Encouraging conformity
22.	1	2	3	4	5	6	22. Cautious, premeditated interventions
23.	1	2	3	4	5	6	23. Open, warm, understanding
24.	1	2	3	4	5	6	24. Active, directive, structured interaction
25.	1	2	3	4	5	6	25. Firm but fair
26.	1	2	3	4	5	6	26. Encourage discussion of concrete behaviour
27.	1	2	3	4	5	6	27. Encourage discussion of feelings
28.	1	2	3	4	5	6	28. Encourage discussion of relationships with others
29.	1	2	3	4	5	6	29. Encourage discussion of values and beliefs
30.	1	2	3	4	5	6	30. Integrates the behaviour and affect realms of family experience (linking the behaviour of one person with the affect they generate in another person)
31.	1	2	3	4	5	6	31. Being non-blaming
32.	1	2	3	4	5	6	32. Alleviating tension with humour
33.	1	2	3	4	5	6	33. Demonstrating interpersonal warmth
34.	1	2	3	4	5	6	34. Being directive (giving instructions, prompting verbal participation, giving corrective feedback or support)
35.	1	2	3	4	5	6	35. Being self-confident (portraying mastery of self and of helping procedures)
36.	1	2	3	4	5	6	36. Being clear and specific (not vague)
37.	1	2	3	4	5	6	37. Using oneself as source of information and as model through self-disclosure
38.	1	2	3	4	5	6	38. Calm, pleasant voice tone
39.	1	2	3	4	5	6	39. Offering or providing help
40.	1	2	3	4	5	6	40. Joking
41.	1	2	3	4	5	6	41. Providing positive feedback
42.	1	2	3	4	5	6	42. Fair
43.	1	2	3	4	5	6	43. Describing only what client did wrong (no initial praise for what had been done correctly)
44.	1	2	3	4	5	6	44. Angry
45.	1	2	3	4	5	6	45. Providing negative feedback

DEFINITELY NOT, NEVER, NOT AT ALL DESCRIPTIVE OF WORKER
 1 Not Much, Not Very, Rarely, Occasionally
 1 1 Moderately Descriptive of Worker
 1 1 1 Quite a Lot, Frequently, Often
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 1 1 1 1 1 Cannot Say
 1 1 1 1 1 1

46.	1	2	3	4	5	6	46. Profanity
47.	1	2	3	4	5	6	47. Lack of Understanding
48.	1	2	3	4	5	6	48. Explanation of how or what to do
49.	1	2	3	4	5	6	49. Explanation of why (giving reasons)
50.	1	2	3	4	5	6	50. Concern
51.	1	2	3	4	5	6	51. Enthusiasm
52.	1	2	3	4	5	6	52. Politeness
53.	1	2	3	4	5	6	53. Unfriendly
54.	1	2	3	4	5	6	54. Unpleasant
55.	1	2	3	4	5	6	55. Bossy-demanding
56.	1	2	3	4	5	6	56. Bad attitude
57.	1	2	3	4	5	6	57. Unpleasant physical contact
58.	1	2	3	4	5	6	58. Getting right to the point
59.	1	2	3	4	5	6	59. Sailing
60.	1	2	3	4	5	6	60. Makes mean, insulting remarks
61.	1	2	3	4	5	6	61. Gives client little opportunity to speak
62.	1	2	3	4	5	6	62. Shouting
63.	1	2	3	4	5	6	63. Accusing, blaming statements
64.	1	2	3	4	5	6	64. Give lots of examples
65.	1	2	3	4	5	6	65. Blue, sad, solemn
66.	1	2	3	4	5	6	66. Uneasy, troubled, preoccupied
67.	1	2	3	4	5	6	67. Genial, witty, playful
68.	1	2	3	4	5	6	68. Interested, eager, enthusiastic
69.	1	2	3	4	5	6	69. Dogmatic, stern, opinionated
70.	1	2	3	4	5	6	70. Angry, irritated, annoyed
71.	1	2	3	4	5	6	71. Afraid, fearful, scared
72.	1	2	3	4	5	6	72. Tense, worried, anxious
73.	1	2	3	4	5	6	73. Curious, attentive, engrossed
74.	1	2	3	4	5	6	74. Analyzing, contemplating, reasoning
75.	1	2	3	4	5	6	75. Confident, assured, secure
76.	1	2	3	4	5	6	76. Wise, intelligent, skilled
77.	1	2	3	4	5	6	77. Happy, smiling, joyful
78.	1	2	3	4	5	6	78. Relaxed, serene, contented
79.	1	2	3	4	5	6	79. Kind, loving, caring
80.	1	2	3	4	5	6	80. Patient, tolerant
81.	1	2	3	4	5	6	81. Interested in talking about feelings
82.	1	2	3	4	5	6	82. Spontaneous, unpredictable
83.	1	2	3	4	5	6	83. Sarcastic, cynical, sneering
84.	1	2	3	4	5	6	84. Dominating, pushy, aggressive
85.	1	2	3	4	5	6	85. Forceful, bold, robust
86.	1	2	3	4	5	6	86. Shy, insecure, meek
87.	1	2	3	4	5	6	87. Attentive: eye contact, open posture
88.	1	2	3	4	5	6	88. Genuine: congruent, authentic
89.	1	2	3	4	5	6	89. Unconditional warmth, liking, respect
90.	1	2	3	4	5	6	90. Immediacy: "here-and-now"
91.	1	2	3	4	5	6	91. Confrontation: "telling it like it is"
92.	1	2	3	4	5	6	92. Concreteness: being specific
93.	1	2	3	4	5	6	93. Offer direct suggestions/give advice
94.	1	2	3	4	5	6	94. Withheld direct suggestions/advice
95.	1	2	3	4	5	6	95. Clarify role as worker in relation to agency

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96.	1	2	3	4	5	6	96. Clarify client's role in relation to worker
97.	1	2	3	4	5	6	97. Clarify client's rights and obligations in relation to agency
98.	1	2	3	4	5	5	98. Clarify client's rights and obligations in relation to other agencies
99.	1	2	3	4	5	6	99. Offer interpretation of general problem
100.	1	2	3	4	5	6	100. Offer interpretation of an immediate event
101.	1	2	3	4	5	6	101. Re-label a problem/person in more positive terms
102.	1	2	3	4	5	6	102. Re-label a problem/person in more negative terms
103.	1	2	3	4	5	6	103. Re-label a feeling in more positive terms
104.	1	2	3	4	5	6	104. Re-label a feeling in more negative terms
105.	1	2	3	4	5	6	105. Re-label in paradoxical manner
106.	1	2	3	4	5	6	106. Encourage ventilation, expression of feelings
107.	1	2	3	4	5	5	107. Discourage ventilation
108.	1	2	3	4	5	6	108. Paraphrase content
109.	1	2	3	4	5	5	109. Reflect feelings
110.	1	2	3	4	5	6	110. Express understanding of client's behaviour
111.	1	2	3	4	5	6	111. Express understanding of client's feelings
112.	1	2	3	4	5	6	112. Report a personal experience as an example
113.	1	2	3	4	5	6	113. Express personal opinion on a value issue
114.	1	2	3	4	5	6	114. Provided opportunity to practice new skill
115.	1	2	3	4	5	6	115. Set up a role playing exercise
116.	1	2	3	4	5	6	116. Set up a role playing exercise involving role reversals
117.	1	2	3	4	5	6	117. Assign homework involving reciprocal tasks
118.	1	2	3	4	5	6	118. Assign homework involving sex therapy exercises
119.	1	2	3	4	5	6	119. Assign homework involving paradoxical tasks
120.	1	2	3	4	5	5	120. Assign homework involving systematic record keeping
121.	1	2	3	4	5	5	121. Assign homework (other _____)
122.	1	2	3	4	5	6	122. Assign homework (other _____)
123.	1	2	3	4	5	6	123. Assign homework (other _____)
124.	1	2	3	4	5	6	124. Check for completion of homework
125.	1	2	3	4	5	6	125. Suggest/assign readings or audio-visual materials
126.	1	2	3	4	5	6	126. Praise conformity with contract
127.	1	2	3	4	5	6	127. Praise openness
128.	1	2	3	4	5	5	128. Willing to confront if contract not followed
129.	1	2	3	4	5	6	129. Reference to legality of client's conduct (when relevant)
130.	1	2	3	4	5	6	130. Reference to legality of significant other's conduct
131.	1	2	3	4	5	5	131. Ask for clarification
132.	1	2	3	4	5	6	132. Request paradoxical action
133.	1	2	3	4	5	6	133. Offer paradoxical interpretation
134.	1	2	3	4	5	6	134. Dealing with resistance
135.	1	2	3	4	5	6	135. Encourage reciprocal negotiations
136.	1	2	3	4	5	6	136. Use silence to increase anxiety
137.	1	2	3	4	5	6	137. Negotiating contract
138.	1	2	3	4	5	6	138. Re-negotiating contract
139.	1	2	3	4	5	6	139. Encouraging interaction among family members
140.	1	2	3	4	5	6	140. Involving extended family

5

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141.	1	2	3	4	5	6	141. Involving family of origin
142.	1	2	3	4	5	6	142. Promoting interaction between family and worker
143.	1	2	3	4	5	6	143. Deliberate blaming of an individual
144.	1	1	1	1	1	6	144. Inadvertent blaming of an individual
145.	1	2	3	4	5	6	145. Deliberate non-blaming
146.	1	2	3	4	5	6	146. Involving clients' friends
147.	1	2	3	4	5	6	147. Probing and questioning to clarify nature of problems
148.	1	2	3	4	5	6	148. Reaching consensus with client re problems
149.	1	2	3	4	5	6	149. Specify number of sessions to achieve goals
150.	1	2	3	4	5	6	150. Reviewing/evaluating alternative courses of action
151.	1	2	3	4	5	6	151. Selecting the most appropriate course of action
152.	1	2	3	4	5	6	152. Planning for implementation
153.	1	2	3	4	5	6	153. Monitoring progress/success of plan
154.	1	2	3	4	5	6	154. Revising plans on basis of results of progress checks
155.	1	2	3	4	5	6	155. Long-term follow-up goals set at closure
156.	1	2	3	4	5	6	156. Identifying possible post-therapy problems and appropriate responses
157.	1	2	3	4	5	6	157. Linking client with other services in community
158.	1	2	3	4	5	6	158. Deliberately communicated confusion/uncertainty
159.	1	2	3	4	5	6	159. Inadvertently communicated confusion/uncertainty
160.	1	2	3	4	5	6	160. Deliberately communicated frustration with client
161.	1	2	3	4	5	6	161. Inadvertently communicated frustration
162.	1	2	3	4	5	6	162. Promoting positive expectancies by making reference to other cases
163.	1	2	3	4	5	6	163. Management/control of emotions
a.	1	2	3	4	5	6	a. anger
b.	1	2	3	4	5	6	b. anxiety
c.	1	2	3	4	5	6	c. depression
d.	1	2	3	4	5	6	d. low self-esteem
e.	1	2	3	4	5	6	e. guilt
f.	1	2	3	4	5	6	f. expression of affection/intimacy
g.	1	2	3	4	5	6	g. fear of commitment
h.	1	2	3	4	5	6	h. powerlessness
i.	1	2	3	4	5	6	i. loneliness
j.	1	2	3	4	5	6	j. grief
k.	1	2	3	4	5	6	k. other
164.	1	2	3	4	5	6	164. Physical relaxation techniques
165.	1	2	3	4	5	6	165. Mental relaxation techniques
166.	1	2	3	4	5	6	166. Behavioural contracting
167.	1	2	3	4	5	6	167. Contingency management
168.	1	2	3	4	5	6	168. Understanding behavioural consequences
169.	1	2	3	4	5	6	169. Problem solving skills
170.	1	2	3	4	5	6	170. Decision-making skills
171.	1	2	3	4	5	6	171. Self-management/self-control skills
172.	1	2	3	4	5	6	172. Pinpointing behavioural targets
173.	1	2	3	4	5	6	173. Monitoring/graphing techniques
174.	1	2	3	4	5	6	174. Time-out procedures
175.	1	2	3	4	5	6	175. Token-economy procedures
176.	1	2	3	4	5	6	176. Assertion skills
177.	1	2	3	4	5	6	177. Listening skills
178.	1	2	3	4	5	6	178. Negotiation skills

5

DEFINITELY NOT, NEVER, NOT AT ALL DESCRIPTIVE OF WORKER

1 Not Much, Not Very, Rarely, Occasionally
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179.	1	2	3	4	5	6	179. Distinction between rules and requests
180.	1	2	3	4	5	6	180. Parenting skills: control
181.	1	2	3	4	5	6	181. Parenting skills: communication
182.	1	2	3	4	5	6	182. Parenting skills: demonstrating affection
183.	1	2	3	4	5	6	183. Parenting skills: other
184.	1	2	3	4	5	6	184. Legal rights
185.	1	2	3	4	5	6	185. Civil rights
186.	1	2	3	4	5	6	186. The rights of women
187.	1	2	3	4	5	6	187. The rights of children
188.	1	2	3	4	5	6	188. The rights of men
189.	1	2	3	4	5	6	189. Linking personal/familial problems to immediate socio-economic structure
190.	1	2	3	4	5	6	190. Linking personal/familial problems to broader political-economic structure
191.	1	2	3	4	5	6	191. Linking personal/familial problems to a sexist society
192.	1	2	3	4	5	6	192. Linking personal/familial problems to individual psychodynamics
193.	1	2	3	4	5	6	193. Linking personal/familial problems to personal attitudes, values, beliefs
194.	1	2	3	4	5	6	194. Linking personal/familial problems to personal habits
195.	1	2	3	4	5	6	195. Linking personal/familial problems to personal skill deficits
196.	1	2	3	4	5	6	196. Linking personal/familial problems to faulty communication
197.	1	2	3	4	5	6	197. Linking personal/familial problems to family of origin
198.	1	2	3	4	5	6	198. Linking personal/familial problems to interpersonal distribution of power
199.	1	2	3	4	5	6	199. Importance of social support
200.	1	2	3	4	5	6	200. Building social network
201.	1	2	3	4	5	6	201. Mobilizing social network
202.	1	2	3	4	5	6	202. Knowledge of community resources
203.	1	2	3	4	5	6	203. Linking with community resources
204.	1	2	3	4	5	6	204. General issues in separation/divorce
205.	1	2	3	4	5	6	205. General issues in custody
206.	1	2	3	4	5	6	206. General issues in child development
207.	1	2	3	4	5	6	207. General issues in home management
208.	1	2	3	4	5	6	208. General issues in budgeting/finances
209.	1	2	3	4	5	6	209. Values clarification
210.	1	2	3	4	5	6	210. Cognitive control methods
211.	1	2	3	4	5	6	211. Sexual techniques
212.	1	2	3	4	5	6	212. Sexual attitudes
213.	1	2	3	4	5	6	213. Sexual orientation issues
214.	1	2	3	4	5	6	214. Involved more as a "person" than as a "worker"
215.	1	2	3	4	5	6	215. Careful not to impose personal view
216.	1	2	3	4	5	6	216. Clients, not worker, must define <u>their</u> problem
217.	1	2	3	4	5	6	217. Avoid explicit formulation of goals
218.	1	2	3	4	5	6	218. Process of constant clarification of what clients want from therapy

DEFINITELY NOT, NEVER, NOT AT ALL DESCRIPTIVE OF WORKER

1 NOT MUCH, NOT VERY, RARELY, OCCASIONALLY

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219.	1	2	3	4	5	6	219. Try to uncover personal "contracts" in family relationships
220.	1	2	3	4	5	6	220. Working to help couples/families arrive at one mutually-agreed upon contract
221.	1	2	3	4	5	6	221. Working on "interactional scripts", on the "rules of the game"
222.	1	2	3	4	5	6	222. Teaching family members how to negotiate with each other
223.	1	2	3	4	5	6	223. Providing firm leadership, authoritative guidance
224.	1	2	3	4	5	6	224. Encouraging counter-transference
225.	1	2	3	4	5	6	225. Avoiding counter-transference
226.	1	2	3	4	5	6	226. Willing and ready to be eclectic
227.	1	2	3	4	5	6	227. Identifying and dealing with resistance
228.	1	2	3	4	5	6	228. Might recommend "advertising" rather than "concealing" some problem
229.	1	2	3	4	5	6	229. Encourage bringing in of family of origin
230.	1	2	3	4	5	6	230. Challenging
231.	1	2	3	4	5	6	231. Uses paradoxical techniques
232.	1	2	3	4	5	6	232. Focus on "relational ethics", a balance of equitable fairness between people
233.	1	2	3	4	5	6	233. An advocate for <u>all</u> family members
234.	1	2	3	4	5	6	234. Willing to request that client <u>does not change</u> as yet
235.	1	2	3	4	5	6	235. Willing to make further therapy contingent upon client's compliance with therapist's instructions
236.	1	2	3	4	5	6	236. Adopting the family's language, symbols, and manner of communication
237.	1	2	3	4	5	6	237. Avoiding an individual psychodynamic interpretation or focus
238.	1	2	3	4	5	6	238. Not emphasizing role of prior experience
239.	1	2	3	4	5	6	239. Promoting positive expectancies regarding outcome of therapy
240.	1	2	3	4	5	6	240. Giving credit to clients for gains
241.	1	2	3	4	5	6	241. Sometimes join with one person who is in conflict with other family members
242.	1	2	3	4	5	6	242. More likely to "relabel" than to "interpret"
243.	1	2	3	4	5	6	243. Avoids power struggles
244.	1	2	3	4	5	6	244. Deliberately going along with resistance
245.	1	2	3	4	5	6	245. Takes responsibility for the setting of treatment goals
246.	1	2	3	4	5	6	246. Goals are objective: observable, can be counted, measured
247.	1	2	3	4	5	6	247. More content than process oriented
248.	1	2	3	4	5	6	248. Gives clients new ways of viewing their relationships
249.	1	2	3	4	5	6	249. A catalyst, clarifier, facilitator
250.	1	2	3	4	5	6	250. Allows the family to do the work
251.	1	2	3	4	5	6	251. Explains every therapeutic action
252.	1	2	3	4	5	6	252. No therapeutic action without a complete assessment
253.	1	2	3	4	5	6	253. No therapeutic action without mutual agreement on problems
254.	1	2	3	4	5	6	254. Deals with problems immediately as presented

Appendix B
Statement of Confidentiality

Data Collection and Confidentiality in the Family Services Project

One of the objectives of the Family Services research project involves an examination of the inter-connections among client factors at intake, counselling practices, and outcomes of service. In pursuing this objective it is necessary to collect information on the styles of practice of family service workers in addition to the client data being collected using the Family Service Assessment Inventory. The "Workers Report on Preferred Practices", which was developed in consultation with family service workers from the agencies, is the primary tool being employed to provide information on worker practices. Various scores from this large battery of worker practices and characteristics will be linked with the data on clients so that the statistical relationships between worker, client, and outcome may be investigated.

A number of precautions are being taken by the research staff to guarantee the confidentiality of the family service workers who are involved in the research project. A statement of our policies regarding the confidentiality of worker practice information solicited from workers is presented below. A longer explanation of the procedures used for storing information on the computer, which addresses confidentiality concerns relevant to worker and client data, follows our statement of policy.

Worker Names

The names of family service workers which appear on the worker practice forms are not entered into the computer. All worker names are converted into identification numbers before the data are computerized. The names of workers are then deleted from all worker practice forms. Forms containing worker names which have not been processed are always stored in locked filing cabinets in the research offices. A master list of worker names and identification numbers is maintained by the research staff and is stored separately from all forms. This list is never entered into the computer. The purpose of this list is to facilitate the matching of clients and workers and is also necessary for returning incomplete forms to workers. A list of worker names and numbers is not maintained for one of the agencies in the study which maintains its own worker identification number system.

Data Analysis

All statistical information derived from the worker forms is reported for groups or classes of workers and clients rather than for individuals. Hence, the objective of collecting worker practice data

is to report aggregate information and not to provide profiles or descriptions of individual workers. The research team will be summarizing the worker practice data in terms of means, percentages, correlations, and other statistical units. For example, the data will be used to explore whether certain worker practices are associated with more positive outcomes for particular types of clients. Again, the focus is on identifying clusters of workers and clients rather than describing the characteristics or practices of particular individuals.

Availability of Individual Worker Scores

Some family service workers may wish to obtain their individual scores for comparison with the mean worker scores for the whole sample. The research team will agree to provide individuals with this information. However, requests for such information can only be made directly to the research team and will not be handled by the agencies. This will ensure that no person other than the individual worker can gain access to her/his scores.

Computer Storage

The research staff use the Statistical Package for the Social Sciences (SPSS), a software package for storing and processing statistical information on main frame computers. The SPSS system is designed for statistical processing and is not a convenient system for recovering information about individuals. Except in special cases, the normal application of SPSS is to treat data in an aggregate manner (e.g. means and percentages for large numbers of individuals). While it is conceivable that specific pieces of information about clients or workers could be extracted from an SPSS computer file by an unauthorized person, a number of security features of SPSS programming make such retrieval highly unlikely.

All information about individuals is "fed into" SPSS using number codes. Each piece of information on the research forms must be converted into a number code by research staff before it can be accepted by SPSS. In this way, particular information about individual clients or workers can only be retrieved if an interested individual knows the meaning of the number codes for a particular piece of information.

An example of coded numbers which might be read into the computer appears on the next page. The two lines of numbers represent the information coded from the first page of Intake Information for a hypothetical family service case. Each family service case has 37 such lines of numbers for complete Intake Information and Family Service Assessment Inventory forms.

00020 1201 1284245827314 041 4483622 04115 2200011 2908473711 056 122800001 01
 00020 10028004204 007 000888300 3300001114 0401

The two lines of numbers above would include some of the demographic and agency information collected by the project for one family service case, including the age, gender, occupation, and income for some family members. The numbers are meaningless unless we know what the researcher's codes mean.

The numbers circled below are used to represent the codes for the occupations of family members for a hypothetical case. The number in the square box represents the religious affiliation of the female family head. The researcher might use the code "041" to indicate that the female head of the family is a "legal secretary", the "056" to indicate that the male family head is a "bus driver", and the "007" to indicate that one of the family members is a "pre-schooler". The "04" in the box might be used to indicate to the researcher that the religious affiliation of the female family head is the "United Church". The number "1201" in the rectangular box identifies the worker who has completed the intake FSAI. Again, without the coding key possessed by the research staff the numbers are uninterpretable.

SPSS organizes information about individual clients and workers in the form of "variables". A variable refers to a category of information such as "occupation", "religious affiliation", "gender", "age", etc. Research staff must assign names to the variables before the data from individual cases can be "read in". The assignment of variable names is conducted in a manner that makes it difficult for individuals to retrieve information and make sense out of it. Most variable names are simply combinations of letters and numbers. For example, the variable name for occupation might be "VAR0002". In order to manipulate the information stored under occupation the researcher must specify this name (i.e. "VAR0002"). In addition, the researcher must know how to interpret the number codes output from "VAR0002". Following the example above, the researcher must know that a "056" under "VAR0002" refers to "bus drivers". In this way, there are two levels of security associated with each piece of information about clients and workers.

The meanings for number codes and variable names can be stored in the computer so that researchers do not always have to refer to a written directory of coding keys and variable names when interpreting computer output. However, variable names and number codes for demographic information (e.g. age, gender, occupation, etc.) are not stored in the computer. For this reason, individuals who might want to retrieve information about clients or workers will need to acquire the researcher's directory in order to make sense out of the computer output.

While the main frame research computer used by the research staff is employed by numerous other researchers at Carleton University, access to any files maintained by the project is only possible if the project computer account and password have been obtained. It is impossible to print the password for the computer account on output provided by the computer, nor is it possible to have passwords printed on a video display terminal. The passwords for the family services project are in the possession of research staff only (even computer center staff are unaware of the password used by the project). Therefore, even if an individual was able to obtain the number coding and variable naming conventions used by research staff, they would further need to acquire the computer password for the Family Services Project.

Appendix C
FSAI - Intake

Family Name (Male Head) _____ Address _____
 Phone _____ Postal Code _____ Telephone _____
 Date _____ Telephone _____

PLEASE USE REVERSE
 OF BACK FOR

STATE INFORMATION

--	--	--	--

AGENCY OFFICE

Case Status: Circle

Date:

1 New Case
 2 Case Reopened

1 2 3 4 5 6 7 8 9 10

Agency Case Number _____

CASE No. _____

A. Family Members

Name	Birth Date (D/M/Y)	OR Age in Years	Gender (Circle)	Family Position	Occupation	Years of School	Annual Income	Check if Present at Interview	Check if Individual is to be Interviewed in Service
1 Male Head			F M				\$	☐	☐
2 Female Head			F M				\$	☐	☐
3			F M					☐	☐
4			F M					☐	☐
5			F M					☐	☐
6			F M					☐	☐

Use of Assistance: Circle the
 applicable categories of family
 head and social assistance.

- 1 Family Benefits
 2 General Welfare
 3 Other ()

\$ Total Annual Earnings
 Income of Family

Employment Status of Heads
 of Family: Circle the
 numbers where applicable
 for female and/or male
 heads of family.

Female Head:

- 1 Employed Full Time
 2 Employed Part Time
 3 Homemaker
 4 Unemployed Seeking work
 5 Unemployed Not Seeking work
 6 Student
 7 Disabled
 8 Retired

Male Head:

- 1 Employed Full Time
 2 Employed Part Time
 3 Homemaker
 4 Unemployed Seeking work
 5 Unemployed Not Seeking work
 6 Student
 7 Disabled
 8 Retired

Spoken Language of Heads
 of Family: Circle the

Female Head:

- 1 English
 2 French
 3 Bilingual-English First
 Language
 4 Bilingual-French First
 Language
 5 Other ()

Male Head:

- 1 English
 2 French
 3 Bilingual-English First
 Language
 4 Bilingual-French First
 Language
 5 Other ()

Place of Birth of Heads of
 Family: Circle the

Female Head:

Male Head:

E. Family Structure

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	Length of Current Status (Years)	Male Married Previous	Female Married Previous	Currently Separated	Divorced	Never Married	Widowed	Total Number of Children	Number of Adopted/Foster Children	Number Children From Father's Previous Union	Number Children From Mother's Previous Union
☐ MARRIED COUPLE											
☐ UNMARRIED COUPLE											
										Low Father Avail-ability	Low Mother Avail-ability
☐ SINGLE MOTHER											
☐ SINGLE FATHER											
								Non-Custodial Parent	Lives Alone	Lives With Parents	Lives With Friends
☐ UNATTACHED FEMALE											
☐ UNATTACHED MALE											

Other Structural Arrangements or Notable Features of Family: _____

C. Referral Source and Involvement with External Agencies

Specify Referral Source: _____

Circle one only:

1 Self	10 School System
2 Family or Friends	11 Justice System
3 Childrens' Aid Society	12 Lawyers
4 Community Agencies	13 Psychiatrists
5 Municipal or Regional Social Services	14 Mental Health Centres
6 Provincial Social Services	15 Other Government Agencies
7 Church	16 Employer/Employee Assistance Program
8 Physicians	17 Other
9 Medical Centres/hospitals	(Specify _____)

Circle the numbers of each of the Agencies/Services which the client(s) were involved with in the last six months:

1 Childrens' Aid Society	11 Justice System
2 Community Agencies	12 Lawyers
3 Municipal or Regional Social Services	13 Psychiatrists
4 Provincial Social Services	14 Mental Health Centres
5 Church	15 Other Government Agencies
6 Physicians	16 Employee Assistance Program
7 Medical Centres/hospitals	17 Other
8 School System	(Specify _____)

D. Presenting Problems:

In the space provided at the right list the problem areas which initially brought the client(s) to the agency:

1. _____
2. _____
3. _____
4. _____

1. Family History

Check all items which represented problem areas for this family in the past. Identify the family member(s) who was most centrally involved and/or whose behaviour was most immediately responsible for the problem by circling the family member's identification number(s) (1-6). If any of the problem areas existed in a client's family of origin, please circle 1 and/or 2 in the Family of Origin column to identify whether the problem occurred in the female and/or male head's family of origin.

			Problem in Family of Origin	Case Notes	
A. Family Conflict					
1. _____	1 2 3 4 5 6	1. Separation/Divorce/Remarriage *	1 2		
2. _____	1 2 3 4 5 6	2. Marital Infidelity	1 2		
3. _____	1 2 3 4 5 6	3. Family Disputes/Conflict	1 2		
4. _____	1 2 3 4 5 6	4. Sexual Abuse	1 2		
5. _____	1 2 3 4 5 6	5. Physical Abuse	1 2		
6. _____	1 2 3 4 5 6	6. Mental Abuse	1 2		
7. _____	1 2 3 4 5 6	7. Social Isolation	1 2		
8. _____	1 2 3 4 5 6	8. Residential Placement of Children	1 2		
9. _____	1 2 3 4 5 6	9. Other (_____)	1 2		
B. Health					
10. _____	1 2 3 4 5 6	10. Chronic Physical Disability	1 2		
11. _____	1 2 3 4 5 6	11. Developmental Handicap	1 2		
12. _____	1 2 3 4 5 6	12. Chronic Psychiatric Disability	1 2		
13. _____	1 2 3 4 5 6	13. Alcohol Problems	1 2		
14. _____	1 2 3 4 5 6	14. Drug Problems	1 2		
15. _____	1 2 3 4 5 6	15. Other (_____)	1 2		
C. Financial/Employment					
16. _____	1 2 3 4 5 6	16. Financial Problems	1 2		
17. _____	1 2 3 4 5 6	17. Housing	1 2		
18. _____	1 2 3 4 5 6	18. Employment	1 2		
19. _____	1 2 3 4 5 6	19. Education	1 2		
20. _____	1 2 3 4 5 6	20. Other (_____)	1 2		
D. Other Problems					
21. _____	1 2 3 4 5 6	21. Legal/Criminal	1 2		
22. _____	1 2 3 4 5 6	22. Death/Desertion of Spouse/Child/Parent **	1 2		
23. _____	1 2 3 4 5 6	23. Lifestyle	1 2		
24. _____	1 2 3 4 5 6	24. Leisure/Recreation	1 2		
25. _____	1 2 3 4 5 6	25. Other (_____)	1 2		

* Circle category(s) which apply (i.e. Separation, Divorce, Remarriage).

** Circle categories which apply (i.e. Death or Desertion and Spouse, Child or Parent).

Check all items which represent current problems for this family. Identify the family member(s) who is most centrally involved and/or whose behaviour is most immediately responsible for the problem by circling the family member's identification number(s) (1-6).

A. Relationship Problems: Current Adult Partners

Case Notes

Aa. Marital Conflict/Satisfaction

1. ☐	1 2 3 4 5 6	1. Frequent Arguments
2. ☐	1 2 3 4 5 6	2. Sexual Dissatisfaction
3. ☐	1 2 3 4 5 6	3. Infidelity
4. ☐	1 2 3 4 5 6	4. Domestic Duties
5. ☐	1 2 3 4 5 6	5. Fertility Problems/Disputes
6. ☐	1 2 3 4 5 6	6. Unwanted Pregnancy
7. ☐	1 2 3 4 5 6	7. Conflict re Child Rearing
8. ☐	1 2 3 4 5 6	8. Conflict re In-laws/Parents
9. ☐	1 2 3 4 5 6	9. Conflict re Money
10. ☐	1 2 3 4 5 6	10. Conflict re Companions/Friends
11. ☐	1 2 3 4 5 6	11. Conflict re Leisure Time
12. ☐	1 2 3 4 5 6	12. Conflict associated with Ex-Partner
13. ☐	1 2 3 4 5 6	13. Stress from Individual Problems of Partner (as specified in G - K)
14. ☐	1 2 3 4 5 6	14. Openness/Warmth/Intimacy
15. ☐	1 2 3 4 5 6	15. Value Preferences
16. ☐	1 2 3 4 5 6	16. Role Expectations
17. ☐	1 2 3 4 5 6	17. Communication Clarity
18. ☐	1 2 3 4 5 6	18. Autonomy
19. ☐	1 2 3 4 5 6	19. Excessive Dependence
20. ☐	1 2 3 4 5 6	20. Contemplating Separation
21. ☐	1 2 3 4 5 6	21. Special Problems of Homosexual Couples
Specify (_____)
22. ☐	1 2 3 4 5 6	22. Other (_____)

Ab. Problems of Separation/Divorce

23. ☐	1 2 3 4 5 6	23. Working on Decision to Separate/Divorce
24. ☐	1 2 3 4 5 6	24. Implementing Separation/Divorce
25. ☐	1 2 3 4 5 6	25. Accepting Divorce/Separation
26. ☐	1 2 3 4 5 6	26. Child Custody
27. ☐	1 2 3 4 5 6	27. Access to Children
28. ☐	1 2 3 4 5 6	28. Alimony Conflict
29. ☐	1 2 3 4 5 6	29. Child Support
30. ☐	1 2 3 4 5 6	30. Children's Feelings
31. ☐	1 2 3 4 5 6	31. Grandparent's Feelings
32. ☐	1 2 3 4 5 6	32. Harrassment from Estranged Partner
33. ☐	1 2 3 4 5 6	33. Other (_____)

3. Relationship Problems: Ex-Spouse/Ex-Partner

34. _____	1 2 3 4 5 6	34. Reconciliation Decision
35. _____	1 2 3 4 5 6	35. Child Custody
36. _____	1 2 3 4 5 6	36. Access to Children
37. _____	1 2 3 4 5 6	37. Alimony Conflict
38. _____	1 2 3 4 5 6	38. Child Support
39. _____	1 2 3 4 5 6	39. Communication Clarity
40. _____	1 2 3 4 5 6	40. Disagreements re Parenting
41. _____	1 2 3 4 5 6	41. Harrassment
42. _____	1 2 3 4 5 6	42. Other (_____)

C. Relationship Problems: Parent/Child

43. _____	1 2 3 4 5 6	43. Acting-out Behaviour
44. _____	1 2 3 4 5 6	44. Social withdrawal of Child
45. _____	1 2 3 4 5 6	45. School-related Problems
46. _____	1 2 3 4 5 6	46. Domestic Duties
47. _____	1 2 3 4 5 6	47. Companions
48. _____	1 2 3 4 5 6	48. Delinquent Behaviour
49. _____	1 2 3 4 5 6	49. Considering Placement of Child
(Specify Placement Type _____)
50. _____	1 2 3 4 5 6	50. Parents Lack Knowledge of
Child Development
51. _____	1 2 3 4 5 6	51. Parenting Skills Deficits
52. _____	1 2 3 4 5 6	52. Openness/Warmth/Intimacy
53. _____	1 2 3 4 5 6	53. Role Expectations
54. _____	1 2 3 4 5 6	54. Communication Clarity
55. _____	1 2 3 4 5 6	55. Child Leaving Home
56. _____	1 2 3 4 5 6	56. Other (_____)

D. Problems of the Total Family

57. _____	1 2 3 4 5 6	57. Frequent Fights
58. _____	1 2 3 4 5 6	58. Scapegoating
59. _____	1 2 3 4 5 6	59. Conflicts Among Children
60. _____	1 2 3 4 5 6	60. Rule Setting
61. _____	1 2 3 4 5 6	61. Communication Clarity
62. _____	1 2 3 4 5 6	62. Role Differentiation
63. _____	1 2 3 4 5 6	63. Inequalities: Distribution of Power
64. _____	1 2 3 4 5 6	64. Inequalities: Distribution of Rewards
65. _____	1 2 3 4 5 6	65. Coalition Problems
66. _____	1 2 3 4 5 6	66. Lack of Cohesion
67. _____	1 2 3 4 5 6	67. Household Management
68. _____	1 2 3 4 5 6	68. Unsatisfactory Housing
69. _____	1 2 3 4 5 6	69. Inadequate Family Income
70. _____	1 2 3 4 5 6	70. Child-Care Arrangements
71. _____	1 2 3 4 5 6	71. Family Leisure/Recreation
72. _____	1 2 3 4 5 6	72. Unit Disrupted by Introduction
of New Family Members
73. _____	1 2 3 4 5 6	73. Stress from Individual Problems
(as specified in G - K)
74. _____	1 2 3 4 5 6	74. Other System/Structural Problems
(Specify _____)

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Victim

- ## F. Problems of Singles

- G. Individual Problems: Substance Abuse**

- #### H. Individual Problems: Coping with Health Problems

- ## 1. Individual Problems: Coping with External Stressors

102. _____	1 2 3 4 5 6	102. Unemployed/Seeking Employment
103. _____	1 2 3 4 5 6	103. Seeking Improved Employment
104. _____	1 2 3 4 5 6	104. Job-Related Difficulties
105. _____	1 2 3 4 5 6	105. Inadequate Income
106. _____	1 2 3 4 5 6	106. Mature Student Problems
107. _____	1 2 3 4 5 6	107. Criminal Justice System Involvement
108. _____	1 2 3 4 5 6	108. Coping with Death of Spouse/Child/
Parent/Friend (Circle)
109. _____	1 2 3 4 5 6	109. Other ()

J. Individual Problems: Emotional Well-Being

110. ___	1 2 3 4 5 6	110. Social Isolation/Loneliness
111. ___	1 2 3 4 5 6	111. Depression
112. ___	1 2 3 4 5 6	112. Anxiety
113. ___	1 2 3 4 5 6	113. Insomnia
114. ___	1 2 3 4 5 6	114. Sexual Identity
115. ___	1 2 3 4 5 6	115. Suicidal Thoughts
116. ___	1 2 3 4 5 6	116. Other (_____)

K. Individual Problems: Personal Resources

117. ___	1 2 3 4 5 6	117. Planning/Decision Skills
118. ___	1 2 3 4 5 6	118. Problem Solving
119. ___	1 2 3 4 5 6	119. Communication Skills
120. ___	1 2 3 4 5 6	120. Expressing Warmth/Affection
121. ___	1 2 3 4 5 6	121. Self-Esteem
122. ___	1 2 3 4 5 6	122. Anger/Hostility Management
123. ___	1 2 3 4 5 6	123. Handling Emotions
124. ___	1 2 3 4 5 6	124. Assertion Skills
125. ___	1 2 3 4 5 6	125. Limited Awareness of Problem/Situation
126. ___	1 2 3 4 5 6	126. Life Style Issues
127. ___	1 2 3 4 5 6	127. Sexual Knowledge
128. ___	1 2 3 4 5 6	128. Knowledge of Community Resources
129. ___	1 2 3 4 5 6	129. Budgeting/Consumer Skills
130. ___	1 2 3 4 5 6	130. Other Life Skills Deficits
(Specify _____)
131. ___	1 2 3 4 5 6	131. Other (_____)

Rate the severity of the problems for the 12 problem categories of the Current Situations. For each of the 12 categories "mark-in" (f) the small segment of the bar at the point on the scale which best describes the severity of the problem. The scales rate problems from 0 - 8 in terms of "Not a Problem" to "Serious Problem". The severity of the problems should be rated at "Intake" and again at "Closure".

[illegible]

A. Overall Strength Rating

Using your impressions gained from the review of the family/individual situation just completed, rate the family's/individual's current level of strength (ability to mobilize resources and respond to crises) by circling one of the numbers from 1 to 5, indicating "Very Weak" to "Very Strong".

1	2	3	4	5
Very Weak		Moderate		Very Strong

B. Overall Level of Stress

Using your impressions gained from the review of the family/individual situation, provide a summary rating of the overall level of stress confronting this family or individual. Circle one of the numbers from 1 to 5 indicating "Very Low" to "Very High" stress.

1	2	3	4	5
Very Low		Moderate		Very High

C. Agency Specific Need

Using your impressions gained from the review of the family/individual situation, provide a rating of the level of need exhibited by the client for services provided by this agency. Circle one of the numbers from 1 to 5 indicating "Very Low" to "Very High" levels of need.

1	2	3	4	5
Very Low		Moderate		Very High

D. Service Motivation

Using your impressions gained from the review of the family/individual situation, provide a summary rating of the overall level of motivation for service exhibited by this family/individual. The lowest rating represents active resistance to service. The moderate rating represents passive involvement in service and the high rating reflects clients who exhibit active involvement in service.

1	2	3	4	5
Very Low		Moderate		Very High

34. ___ 1 2 3 4 5 6 34. Reconciliation Decision
35. ___ 1 2 3 4 5 6 35. Child Custody
36. ___ 1 2 3 4 5 6 36. Access to Children
37. ___ 1 2 3 4 5 6 37. Alimony Conflict
38. ___ 1 2 3 4 5 6 38. Child Support
39. ___ 1 2 3 4 5 6 39. Communication Clarity
40. ___ 1 2 3 4 5 6 40. Disagreements re Parenting
41. ___ 1 2 3 4 5 6 41. Harrassment
42. ___ 1 2 3 4 5 6 42. Other (_____)

3. Relationship Problems: Parent/Child

43. ___ 1 2 3 4 5 6 43. Acting-out Behaviour
44. ___ 1 2 3 4 5 6 44. Social withdrawal of Child
45. ___ 1 2 3 4 5 6 45. School-related Problems
46. ___ 1 2 3 4 5 6 46. Domestic Duties
47. ___ 1 2 3 4 5 6 47. Companions
48. ___ 1 2 3 4 5 6 48. Delinquent Behaviour
49. ___ 1 2 3 4 5 6 49. Considering Placement of Child
(Specify Placement Type _____)
50. ___ 1 2 3 4 5 6 50. Parents Lack Knowledge of
Child Development
51. ___ 1 2 3 4 5 6 51. Parenting Skills Deficits
52. ___ 1 2 3 4 5 6 52. Openness/warmth/intimacy
53. ___ 1 2 3 4 5 6 53. Role Expectations
54. ___ 1 2 3 4 5 6 54. Communication Clarity
55. ___ 1 2 3 4 5 6 55. Child Leaving Home
56. ___ 1 2 3 4 5 6 56. Other (_____)

3. Problems of the Total Family

57. ___ 1 2 3 4 5 6 57. Frequent Fights
58. ___ 1 2 3 4 5 6 58. Scapegoating
59. ___ 1 2 3 4 5 6 59. Conflicts Among Children
60. ___ 1 2 3 4 5 6 60. Rule Setting
61. ___ 1 2 3 4 5 6 61. Communication Clarity
62. ___ 1 2 3 4 5 6 62. Role Differentiation
63. ___ 1 2 3 4 5 6 63. Inequalities: Distribution of Power
64. ___ 1 2 3 4 5 6 64. Inequalities: Distribution of Rewards
65. ___ 1 2 3 4 5 6 65. Coalition Problems
66. ___ 1 2 3 4 5 6 66. Lack of Conesion
67. ___ 1 2 3 4 5 6 67. Household Management
68. ___ 1 2 3 4 5 6 68. Unsatisfactory Housing
69. ___ 1 2 3 4 5 6 69. Inadequate Family Income
70. ___ 1 2 3 4 5 6 70. Child-Care Arrangements
71. ___ 1 2 3 4 5 6 71. Family Leisure/Recreation
72. ___ 1 2 3 4 5 6 72. Unit Disrupted by Introduction
of New Family Members
73. ___ 1 2 3 4 5 6 73. Stress from Individual Problems
(as specified in G - K)
74. ___ 1 2 3 4 5 6 74. Other System/Structural Problems
(Specify _____)

Process Goals

Achievement of the goals of service listed on the previous page may be contingent upon developing or strengthening certain personal or familial resources such as those listed below. (Check (✓) any "process goals" listed below which are agreed upon by the client and worker. For definitions of these items see section K of the "Current Situations" manual (items 117-125).

Identify the family member (s) for whom the intermediate process goals are set by circling the family member's identification number(s) (1-6). Please ensure that the numbers circled correspond to the family member identification numbers established on the intake form.

1. _____	1 2 3 4 5 6	1. Improvement in Planning/Decision Skills
2. _____	1 2 3 4 5 6	2. Improvement in Problem Solving Skills
3. _____	1 2 3 4 5 6	3. Improvement in Communication Skills
4. _____	1 2 3 4 5 6	4. Improvement in Ability to Express Warmth/Affection
5. _____	1 2 3 4 5 6	5. Improvement in Self-Esteem
6. _____	1 2 3 4 5 6	6. Improvement in Anger/Hostility Management
7. _____	1 2 3 4 5 6	7. Improvement in Handling of Emotions
8. _____	1 2 3 4 5 6	8. Improvement in Assertion Skills
9. _____	1 2 3 4 5 6	9. Improvement in Use of Community Resources
10. _____	1 2 3 4 5 6	10. Improvement in Autonomy
11. _____	1 2 3 4 5 6	11. Increase in Awareness of Problem/Situation

C. Referrals: _____

D. Overall Level of Service

Circle the service category below which best describes the service to be provided to this family/individual.

In the space provided below give an estimate of the number of interviews to be employed in providing service.

- 1 No Additional Service by this Agency
- 2 Short Term
- 3 Medium Term
- 4 Long Term
- 5 Referral to an Agency Group Program

E. Types of Interviews

• Family service is to be extended by the agency please specify the types of interviews to be employed in providing service (check as many as applicable).

- ☐ Individual
- ☐ Joint
- ☐ Telephone
- ☐ Group

- ☐ Family
- ☐ Collateral
- ☐ Co-therapy
- ☐ Other (Specify _____)

[illegible]

Appendix D
FSAI - Client

FAMILY AND INDIVIDUAL PROBLEMS
QUESTIONNAIRE

In this questionnaire you will be asked whether or not you or members of your family are experiencing certain types of problems.

Answer each question as honestly as you can. Do not talk about your answers with other members of your family while you are completing the questionnaire. We are interested in what you think are problems in your family. If your problems or your family's problems are not listed on these pages you will have a chance to list other problems on the last page of the questionnaire.

To thank you for your time in completing this questionnaire you will be given \$10.00. All your answers will be confidential.

BEFORE GOING ON TO THE NEXT PAGES PLEASE COMPLETE
ONE OF THE THREE BLOCKS BELOW

BLOCK 1

Complete this block if you are married and living with your spouse or if you have a common law marriage. If not go to Block 2.

Place a check mark ☒ in one of the two boxes below:

I am: ☐ a wife or female partner
☐ a husband or male partner

Now please go to Page 1.

BLOCK 2

Complete this block if you are a teenager living with your parents or guardians. If not go to Block 3.

Place a check mark ☒ in one of the two boxes below:

I am: ☐ a daughter
☐ a son

Now, please complete Page 1, Page 4, and Page 5 ONLY.

BLOCK 3

Complete this block if you are single, separated, divorced, a single parent, or live alone.

Place a check mark ☒ in one of the two boxes below:

I am: ☐ a female
☐ a male

Now please go to Page 1.

1. Individual Problems

Below is a list of 13 problems which people sometimes have. For each problem you are asked to show whether you or a member of your family has this problem now or has experienced it over the past six months.

INSTRUCTIONS

If you or a member of your family have any of the problems now or have experienced them over the past six months, PUT A CHECK MARK IN THE BLANKS ✓ BESIDE THOSE PROBLEMS.

Yes, this is
a problem or
it has been
a problem in
the last six
months for me
or a member
of my family.

- ☐ 1. A serious illness
- ☐ 2. A physical disability (blindness, cerebral palsy, etc.)
- ☐ 3. Serious psychiatric problem (depression, breakdown, etc.)
- ☐ 4. A drinking problem
- ☐ 5. Drug abuse
- ☐ 6. Eating problem (eats too little, or too much, etc.)
- ☐ 7. Developmental handicap (retardation)
- ☐ 8. Death of a family member
- ☐ 9. Unemployment
- ☐ 10. Problems on-the-job (fights, boredom, etc.)
- ☐ 11. Money problems (low income, poor credit, etc.)
- ☐ 12. Legal problems (arrests, convictions, etc.)
- ☐ 13. Problems with school

II. Problems of Couples

If you are married or have a common law marriage please complete the items on this page. If you are separated, divorced, or not married please go directly to page 3.

Below is a list of 13 problems which couples sometimes have. For each problem you are asked to show whether or not you and your spouse or common law partner have this problem now or have experienced it in the past six months.

INSTRUCTIONS

If you and your spouse or common law partner have the problems now or have experienced them over the past six months, PUT A CHECK MARK IN THE BLANKS ☒ BESIDE THOSE PROBLEMS.

Yes, this is
a problem or
it has been
a problem in
the last six
months.

- ☐ 1. Argue often
- ☐ 2. Arguments about children (disagreement over discipline, etc.)
- ☐ 3. Arguments about money
- ☐ 4. Arguments about parents or in-laws
- ☐ 5. Arguments about household duties (help with housework, etc.)
- ☐ 6. Arguments about friends
- ☐ 7. Arguments about ex-spouse or ex-boyfriend or ex-girlfriend
- ☐ 8. Unhappy with sex life
- ☐ 9. Physical abuse (assaults, beatings, etc.)
- ☐ 10. Emotional abuse (constant fault-finding, humiliation, etc.)
- ☐ 11. Communication problem (expressing feelings, understanding, etc.)
- ☐ 12. Thinking about separation or divorce
- ☐ 13. Arguments about separation or divorce

III. Problems With Children

If you have children or step-children please complete the items on this page. If not, please go directly to Page 4.

Below is a list of 10 problems which parents sometimes have with their children. For each problem you are asked to show whether you have this problem with any of your children now or have experienced it in the past six months.

INSTRUCTIONS

If you have any of the problems with your children now or have experienced them over the past six months, PUT A CHECK MARK IN THE BLANKS ☒ BESIDE THOSE PROBLEMS.

Yes, this is
a problem or
it has been
a problem in
the last six
months.

- ☐ 1. Disobedient at home (hard to control, etc.)
- ☐ 2. Withdrawal of child (rarely goes out, has no friends, etc.)
- ☐ 3. Has bad companions
- ☐ 4. Trouble with the law (delinquency)
- ☐ 5. School problems (poor behaviour, poor school performance, etc)
- ☐ 6. Problems with household duties (doing dishes, messy room, etc)
- ☐ 7. Poor communication between parent and child
- ☐ 8. Abuse of child by a parent (physical or sexual abuse, etc.)
- ☐ 9. Problems with child care (babysitter, daycare, etc.)
- ☐ 10. Child moved out (moved to apartment, went to college, etc.)

IV. Problems of Singles

If you are single, or a teenager living at home, or separated, divorced, or a single parent, or if you live alone, please complete the items on this page. If you are not single, please go directly to Page 5.

Below is a list of 8 problems which single people sometimes have. For each problem you are asked to show whether or not you have this problem now or have experienced it over the past six months.

INSTRUCTIONS

If you are single and have any of the problems now or have experienced them over the past six months, PUT A CHECK MARK IN THE BLANKS ☒ BESIDE THOSE PROBLEMS.

Yes, this is
a problem or
it has been
a problem in
the last six
months.

- ☐ 1. Unhappy about social life (hard to meet friends, etc.)
- ☐ 2. Problems with boyfriend or girlfriend
- ☐ 3. Problems with ex-boyfriend or ex-girlfriend or ex-spouse
- ☐ 4. Difficulty making a decision about marriage or commitment
- ☐ 5. Making a decision about a pregnancy or abortion
- ☐ 6. Unhappy with housing arrangements (room-mates, space, etc.)
- ☐ 7. Unhappy about being single
- ☐ 8. Conflicts with parents

V. Other Problems

In the spaces provided below please write in any other problems or stresses which you or any members of your family have now or have experienced in the past six months, which are not listed on any of the other pages.

In the spaces provided below please write in the main problems which have caused you or your family to come to this agency for help.

THANK YOU VERY MUCH FOR YOUR COOPERATION

Appendix E
FSAI - Closure

The Case Closure Form is completed for all cases involving more than one interview with members of the client group. This includes the intake interview and any additional interviews with the client group. The short version of the Case Closure Form should be used for cases that involved only an intake interview.

--	--

AGENCY

--	--

OFFICE

Case Closure Date:

D

M

Number of Months

Case Opened:

--

Worker's Name OR Number _____

CASE I. D. _____

Reason for Case Closure: (Check all applicable reasons and circle the Primary Reason)

1 ☐ Satisfied with gains made	7 ☐ Further service unavailable
2 ☐ Problem less stressful	8 ☐ Fees a deterrent
3 ☐ Client doubted agency could help	9 ☐ Referred elsewhere for service
4 ☐ Discomfort about counselling or going to agency	10 ☐ Client did not return for service
5 ☐ Other family member unwilling to co-operate	11 ☐ Unknown
6 ☐ Disagreement with worker	12 ☐ Special Group Program in this Agency
	13 ☐ Other (_____)

By whom was the decision to close this case made? (circle number)

- 1 By Client
2 By Worker
3 Mutual Decision

Specify any referrals made at the time of closure as substitutes for service at this agency or as continuing support services. This includes special group programs offered at this agency.

Type of Interviews employed in providing service: (check as many as applicable)

- ☐ Individual
☐ Joint
☐ Telephone
☐ Group

- ☐ Family
☐ Collateral
☐ Co-therapy
☐ Other (_____)

Total Number of In-office and Out of Office Interviews:

(enter the number of interviews for each of the three categories in the blanks). The Intake interview is included in these totals.

In-Office

_____ Individual Interview
_____ Joint Interview
_____ Multiple or Family Interview

Out of Office

_____ Individual Interview
_____ Joint Interview
_____ Multiple or Family Interview

If this case involved a couple, please indicate whether or not the couple separated during the time the case was opened (circle number):

- 1 Couple Separated 2 Couple did not Separate 3 This case did not involve a Couple

Total number of telephone interviews with members of the client group: _____ 248

Total number of group sessions attended by members of the client group: _____

Total number of face-to-face interviews with collaterals: _____

Total number of telephone interviews with collaterals: _____

Total number of hours spent on case by assigned worker (including face-to-face and telephone interviews, recording, collateral contacts): _____

Total number of hours spent on case by other workers (including face-to-face and telephone interviews, recording, collateral contacts): _____
(Time spent by clerical staff is not included).

Using the client numbers established at intake, indicate by checking the appropriate boxes below, the nature of the contact individual family members received: (Please be certain that the numbers used to identify family members below correspond with the identifying numbers on the intake forms)

Name	NTI Interviews	Telephone Interviews Only	Face-to-Face Interviews	Group Sessions
1 _____ (Female Head)	☐	☐	☐	☐
2 _____ (Male Head)	☐	☐	☐	☐
3 _____	☐	☐	☐	☐
4 _____	☐	☐	☐	☐
5 _____	☐	☐	☐	☐
6 _____	☐	☐	☐	☐

List any special agency programs or services in which any member of the client group was involved during the course of service:

Indicate all involvements with external agencies or services of this client group during the time the case was open with this agency: (circle as many categories as apply)

3 Childrens' Aid Society	11 Justice System
4 Community Agencies	12 Lawyers
5 Municipal or Regional Social Services	13 Psychiatrists
6 Provincial Social Services	14 Mental Health Centres
7 Church	15 Other Government Agencies
8 Physicians	16 Employee Assistance Program
9 Medical Centres/Hospitals	17 Other (_____)
10 School System	

Check all items which represent current problems for this family at the time of case closure. Identify the family member(s) who is most centrally involved and/or whose behaviour is most immediately responsible for the problem by circling the family member's identification number(s) (1 - 6). Please ensure that the numbers circled correspond to the family member identification numbers established on the Intake Information form (ie. A. Family Members).

Case Notes

1. <u> </u>	1 2 3 4 5 6	1. Frequent Arguments
2. <u> </u>	1 2 3 4 5 6	2. Sexual Dissatisfaction
3. <u> </u>	1 2 3 4 5 6	3. Infidelity
4. <u> </u>	1 2 3 4 5 6	4. Domestic Duties
5. <u> </u>	1 2 3 4 5 6	5. Fertility Problems/Disputes
6. <u> </u>	1 2 3 4 5 6	6. Unwanted Pregnancy
7. <u> </u>	1 2 3 4 5 6	7. Conflict re Child Rearing
8. <u> </u>	1 2 3 4 5 6	8. Conflict re In-laws/Parents
9. <u> </u>	1 2 3 4 5 6	9. Conflict re Money
10. <u> </u>	1 2 3 4 5 6	10. Conflict re Companions/Friends
11. <u> </u>	1 2 3 4 5 6	11. Conflict re Leisure Time
12. <u> </u>	1 2 3 4 5 6	12. Conflict associated with Ex-Partner
13. <u> </u>	1 2 3 4 5 6	13. Stress from Individual Problems of Partner (as specified in G - K)
14. <u> </u>	1 2 3 4 5 6	14. Openness/Warmth/Intimacy
15. <u> </u>	1 2 3 4 5 6	15. Value Preferences
16. <u> </u>	1 2 3 4 5 6	16. Role Expectations
17. <u> </u>	1 2 3 4 5 6	17. Communication Clarity
18. <u> </u>	1 2 3 4 5 6	18. Autonomy
19. <u> </u>	1 2 3 4 5 6	19. Excessive Dependence
20. <u> </u>	1 2 3 4 5 6	20. Contemplating Separation
21. <u> </u>	1 2 3 4 5 6	21. Special Problems of Homosexual Couples Specify (_____)
22. <u> </u>	1 2 3 4 5 6	22. Other (_____)

23. _____	1 2 3 4 5 6	23. Working on Decision to Separate/Divorce
24. _____	1 2 3 4 5 6	24. Implementing Separation/Divorce
25. _____	1 2 3 4 5 6	25. Accepting Divorce/Separation
26. _____	1 2 3 4 5 6	26. Child Custody
27. _____	1 2 3 4 5 6	27. Access to Children
28. _____	1 2 3 4 5 6	28. Alimony Conflict
29. _____	1 2 3 4 5 6	29. Child Support
30. _____	1 2 3 4 5 6	30. Children's Feelings
31. _____	1 2 3 4 5 6	31. Grandparent's Feelings
32. _____	1 2 3 4 5 6	32. Harrassment from Estranged Partner
33. _____	1 2 3 4 5 6	33. Other (

34. ___ 1 2 3 4 5 6 34. Reconciliation Decision
35. ___ 1 2 3 4 5 6 35. Child Custody
36. ___ 1 2 3 4 5 6 36. Access to Children
37. ___ 1 2 3 4 5 6 37. Alimony Conflict
38. ___ 1 2 3 4 5 6 38. Child Support
39. ___ 1 2 3 4 5 6 39. Communication Clarity
40. ___ 1 2 3 4 5 6 40. Disagreements re Parenting
41. ___ 1 2 3 4 5 6 41. Harrassment
42. ___ 1 2 3 4 5 6 42. Other (_____)

c. Relationship Problems: Parent/Child

43. ___ 1 2 3 4 5 6 43. Acting-out Behaviour
44. ___ 1 2 3 4 5 6 44. Social withdrawal of Child
45. ___ 1 2 3 4 5 6 45. School-related Problems
46. ___ 1 2 3 4 5 6 46. Domestic Duties
47. ___ 1 2 3 4 5 6 47. Companions
48. ___ 1 2 3 4 5 6 48. Delinquent Behaviour
49. ___ 1 2 3 4 5 6 49. Considering Placement of Child
(Specify Placement Type _____)
50. ___ 1 2 3 4 5 6 50. Parents Lack Knowledge of
Child Development
51. ___ 1 2 3 4 5 6 51. Parenting Skills Deficits
52. ___ 1 2 3 4 5 6 52. Openness/warmth/Intimacy
53. ___ 1 2 3 4 5 6 53. Role Expectations
54. ___ 1 2 3 4 5 6 54. Communication Clarity
55. ___ 1 2 3 4 5 6 55. Child Leaving Home
56. ___ 1 2 3 4 5 6 56. Other (_____)

d. Problems of the Total Family

57. ___ 1 2 3 4 5 6 57. Frequent Fights
58. ___ 1 2 3 4 5 6 58. Scapegoating
59. ___ 1 2 3 4 5 6 59. Conflicts Among Children
60. ___ 1 2 3 4 5 6 60. Rule Setting
61. ___ 1 2 3 4 5 6 61. Communication Clarity
62. ___ 1 2 3 4 5 6 62. Role Differentiation
63. ___ 1 2 3 4 5 6 63. Inequalities: Distribution of Power
64. ___ 1 2 3 4 5 6 64. Inequalities: Distribution of Rewards
65. ___ 1 2 3 4 5 6 65. Coalition Problems
66. ___ 1 2 3 4 5 6 66. Lack of Cohesion
67. ___ 1 2 3 4 5 6 67. Household Management
68. ___ 1 2 3 4 5 6 68. Unsatisfactory Housing
69. ___ 1 2 3 4 5 6 69. Inadequate Family Income
70. ___ 1 2 3 4 5 6 70. Child-Care Arrangements
71. ___ 1 2 3 4 5 6 71. Family Leisure/Recreation
72. ___ 1 2 3 4 5 6 72. Unit Disrupted by Introduction
of New Family Members
73. ___ 1 2 3 4 5 6 73. Stress from Individual Problems
(as specified in G - K)
74. ___ 1 2 3 4 5 6 74. Other System/Structural Problems
(Specify _____)

Perpetrator							Victim						
75. _____	1	2	3	4	5	6	75. Adult Victim of Physical Abuse	1	2	3	4	5	6
76. _____	1	2	3	4	5	6	76. Adult Victim of Sexual Abuse	1	2	3	4	5	6
77. _____	1	2	3	4	5	6	77. Adult Victim of Emotional Abuse	1	2	3	4	5	6
78. _____	1	2	3	4	5	6	78. Child Victim of Physical Abuse	1	2	3	4	5	6
79. _____	1	2	3	4	5	6	79. Child Victim of Sexual Abuse	1	2	3	4	5	6
80. _____	1	2	3	4	5	6	80. Child Victim of Emotional Abuse	1	2	3	4	5	6
81. _____	1	2	3	4	5	6	81. Problems Dealing with Past Abuse	1	2	3	4	5	6
82. _____	1	2	3	4	5	6	82. Legally-Mandated Agencies Aware of Abuse	1	2	3	4	5	6
83. _____	1	2	3	4	5	6	83. Other (_____)	1	2	3	4	5	6

F. Problems of Singles

84. _____ 1 2 3 4 5 6 84. Relations with Parents
85. _____ 1 2 3 4 5 6 85. Conflicts with Boy/Girlfriend
86. _____ 1 2 3 4 5 6 86. Decision Regarding Marriage/Commitment
87. _____ 1 2 3 4 5 6 87. Unease with Single Status
88. _____ 1 2 3 4 5 6 88. Unwanted Pregnancy
89. _____ 1 2 3 4 5 6 89. Unhappiness with Living Arrangements
90. _____ 1 2 3 4 5 6 90. Special Problems of Homosexual Individuals
Specify (_____)
91. _____ 1 2 3 4 5 6 91. Other (_____)

G. Individual Problems: Substance Abuse

92. _____ 1 2 3 4 5 6 92. Alcohol Problems
93. _____ 1 2 3 4 5 6 93. Drug Problems (Specify Type _____)
94. _____ 1 2 3 4 5 6 94. Eating Disorders
(Specify Type _____)
95. _____ 1 2 3 4 5 6 95. Other (_____)

H. Individual Problems: Coping with Health Problems

96. _____ 1 2 3 4 5 6 96. Physical Health
97. _____ 1 2 3 4 5 6 97. Physical Disability
98. _____ 1 2 3 4 5 6 98. Developmental Handicap
99. _____ 1 2 3 4 5 6 99. Psychiatric Disability
100. _____ 1 2 3 4 5 6 100. Special Problems of the Elderly
101. _____ 1 2 3 4 5 6 101. Other (_____)

I. Individual Problems: Coping with External Stressors

102. _____ 1 2 3 4 5 6 102. Unemployed/Seeking Employment
103. _____ 1 2 3 4 5 6 103. Seeking Improved Employment
104. _____ 1 2 3 4 5 6 104. Job-Related Difficulties
105. _____ 1 2 3 4 5 6 105. Inadequate Income
106. _____ 1 2 3 4 5 6 106. Mature Student Problems
107. _____ 1 2 3 4 5 6 107. Criminal Justice System Involvement
108. _____ 1 2 3 4 5 6 108. Coping with Death of Spouse/Child/
Parent/Friend (Circle)
109. _____ 1 2 3 4 5 6 109. Other (_____)

J. Individual Problems: Emotional well-Being

110. _____	1 2 3 4 5 6	110. Social Isolation/Loneliness
111. _____	1 2 3 4 5 6	111. Depression
112. _____	1 2 3 4 5 6	112. Anxiety
113. _____	1 2 3 4 5 6	113. Insomnia
114. _____	1 2 3 4 5 6	114. Sexual Identity
115. _____	1 2 3 4 5 6	115. Suicidal Thoughts
116. _____	1 2 3 4 5 6	116. Other (_____)

K. Individual Problems: Personal Resources

117. _____	1 2 3 4 5 6	117. Planning/Decision Skills
118. _____	1 2 3 4 5 6	118. Problem Solving
119. _____	1 2 3 4 5 6	119. Communication Skills
120. _____	1 2 3 4 5 6	120. Expressing warmth/Affection
121. _____	1 2 3 4 5 6	121. Self-Esteem
122. _____	1 2 3 4 5 6	122. Anger/Hostility Management
123. _____	1 2 3 4 5 6	123. Handling Emotions
124. _____	1 2 3 4 5 6	124. Assertion Skills
125. _____	1 2 3 4 5 6	125. Limited Awareness of Problem/Situation
126. _____	1 2 3 4 5 6	126. Life Style Issues
127. _____	1 2 3 4 5 6	127. Sexual Knowledge
128. _____	1 2 3 4 5 6	128. Knowledge of Community Resources
129. _____	1 2 3 4 5 6	129. Budgeting/Consumer Skills
130. _____	1 2 3 4 5 6	130. Other Life Skills Deficits
(Specify _____)
131. _____	1 2 3 4 5 6	131. Other (_____)

B. SEVERITY OF PROBLEMS AT CLOSING

The "Severity of Problems at Closing" ratings should be completed for all cases which have involved two or more interviews with clients. This section is not completed for cases which were closed after one interview.

The closure copy of the "Severity of Problems Ratings" with completed intake section is used to rate the severity of problems at closure. Use the closure sections to rate the severity of problems for each of the 12 problem categories.

The "Overall Ratings at Closing" should be completed for all cases which have involved two or more interviews with members of the client group. This section is not completed for cases which were closed after one interview.

A. Overall Strength Rating

Using your impressions gained from the closing review of the family/individual situation just completed, along with impressions gained from providing service to this family/individual, rate the family's/individual's current level of strength (ability to mobilize resources and respond to crises) by circling one of the numbers from 1 to 5, indicating "Very Weak" to "Very Strong".

1	2	3	4	5
Very Weak		Moderate		Very Strong

B. Overall Level of Stress

Using your impressions gained from the closing review of the family/individual situation, along with impressions gained from providing service to this family/individual, provide a summary rating of the overall level of stress confronting this family or individual. Circle one of the numbers from 1 to 5 indicating "Very Low" to "Very High" stress.

1	2	3	4	5
Very Low		Moderate		Very High

C. Agency Specific Need

Using your impressions gained from the closing review of the family/individual situation, along with impressions gained from providing service to this family/individual, provide a rating of the level of need exhibited by the client for services provided by this agency. Circle one of the numbers from 1 to 5 indicating "Very Low" to "Very High" levels of need.

1	2	3	4	5
Very Low		Moderate		Very High

D. Service Motivation

Using your impressions gained from the closing review of the family/individual situation, along with impressions gained from providing service to this family/individual, provide a summary rating of the overall level of motivation for service exhibited by this family/individual. The lowest rating represents active resistance to service. The moderate rating represents passive involvement in service and the high rating reflects clients who exhibit active involvement in service.

1	2	3	4	5
Very Low		Moderate		Very High

D. INTERVENTIONS

The "Interventions" section should be completed for all cases which have involved two or more interviews with members of the client group. This section is not completed for cases which were closed after one interview.

1. Goals Achieved

With reference to the "Goals" recorded at intake in the "III. Intervention Plan", indicate the goals achieved at the time of case closure in the spaces provided below. Note that this list includes only those goals achieved which were recorded on the intake form. New goals which were set during the course of service should be stated in the spaces provided under 2 & 3.

3. New Goals Achieved

In the spaces provided below list all new goals which were achieved.

2. New Goals

Using the spaces provided below indicate new goals introduced during the course of service. New goals include goals which were added to the goals recorded at intake or goals which were changed.

4. New Techniques/Programs

With reference to the "Techniques/Programs" recorded at intake, indicate new techniques/programs which were added during the course of service in the spaces provided below.

With reference to the "Process Goals" recorded at intake in the "III. Intervention Plan", circle the numbers of family members (1 - 6) for whom progress was made on any of the process goals listed below.

Please ensure that the numbers circled correspond to the family member identification numbers established on the intake form (i.e. A. Family Members).

1 2 3 4 5 6	1. Improvement in Planning/Decision Skills
1 2 3 4 5 6	2. Improvement in Problem Solving Skills
1 2 3 4 5 6	3. Improvement in Communication Skills
1 2 3 4 5 6	4. Improvement in Ability to Express warmth/Affection
1 2 3 4 5 6	5. Improvement in Self-Esteem
1 2 3 4 5 6	6. Improvement in Anger/Hostility Management
1 2 3 4 5 6	7. Improvement in Handling of Emotions
1 2 3 4 5 6	8. Improvement in Assertion Skills
1 2 3 4 5 6	9. Improvement in Use of Community Resources
1 2 3 4 5 6	10. Improvement in Autonomy
1 2 3 4 5 6	11. Increase in Awareness of Problem/Situation

Has this case been transferred from one worker to another during the time it was currently open with this agency?

1 Yes

2 No

Appendix F
Client Feedback Questionnaire

AGENCY

CLIENT FEEDBACK QUESTIONNAIRE

The following questionnaire contains a number of questions about your experience with the service at this agency. Answer each question as honestly as you can. Do not talk about your answers with other family members while you are completing the questionnaire.

BEFORE GOING ON TO THE NEXT PAGES PLEASE COMPLETE
ONE OF THE THREE BLOCKS BELOW

BLOCK 1

Complete this block if you are married and living with your spouse or if you have a common law marriage. If not, go to Block 2.

Place a check mark ☒ in one of the two boxes below:

I am: ☐ a wife or female partner
☐ a husband or male partner

Now, please go to Page 1.

BLOCK 2

Complete this block if you are a teenager living with your parents or guardians. If not, go to Block 3.

Place a check mark ☒ in one of the two boxes below:

I am: ☐ a daughter
☐ a son

Now, please go to Page 1.

BLOCK 3

Complete this block if you are single, separated, divorced, a single parent, or live alone.

Place a check mark ☒ in one of the two boxes below:

I am: ☐ a female
☐ a male

Now, please complete Page 1 and 2.

We are very interested in your opinions about our agency because that kind of information can help us give better service. Please answer the questions below as honestly as possible. There are no right or wrong answers.

Here are a number of statements about your experience with your counsellor. Circle "TRUE" OR "FALSE" to show whether you feel each statement is true or false for you.

1. My counsellor helped me talk about things that were not easy to talk about.	TRUE	FALSE
2. My counsellor understood my feelings.	TRUE	FALSE
3. I learned how to solve my problems.	TRUE	FALSE
4. When I was upset about something, I was encouraged to talk about it.	TRUE	FALSE
5. My counsellor was able to understand the true nature of my problems.	TRUE	FALSE
6. My counsellor reviewed my progress with me from time to time.	TRUE	FALSE
7. Talking with my counsellor gave me a new understanding of my situation.	TRUE	FALSE
8. My counsellor helped me set goals to work on.	TRUE	FALSE
9. My counsellor respected me.	TRUE	FALSE
10. When my counsellor couldn't help me I was given information about where I could go for help.	TRUE	FALSE
11. My counsellor suggested specific solutions for my problems.	TRUE	FALSE
12. My counsellor gave me emotional support.	TRUE	FALSE
13. My counsellor was willing to listen to my problems.	TRUE	FALSE
14. My counsellor was available when I needed help.	TRUE	FALSE

During your counselling experience with this agency, did any of the following things create problems for you or your family? Place a check mark in the boxes beside any of the items which were a problem for you or your family. Use the blanks below each item to write in any comments you have about these problems.

1. ☐ The distance to the agency offices.

2. ☐ The amount of fees charged.

3. ☐ The agency was not easy to reach by my usual transportation.

4. ☐ The times of appointments.

5. ☐ The waiting period to get the first appointment.

6. ☐ The agency procedures (red tape).

7. ☐ The experience with receptionists.

8. ☐ The change to a different counsellor.

9. ☐ The comfort of the offices.

10. ☐ Other (Please write in below what the problem was).

Below is a list of problems which individuals and families sometimes have. If you had any of these problems when you came to the agency please circle "BETTER", "WORSE", OR "NO CHANGE" to show whether the problem got better, worse, or did not change.

1. Emotional or behaviour problems of yourself or family members.	BETTER	WORSE	NO CHANGE
2. Alcohol or drug problems of yourself or family members.	BETTER	WORSE	NO CHANGE
3. How you and your spouse or boyfriend or girlfriend get along (talk over problems, handle arguments).	BETTER	WORSE	NO CHANGE
4. How you and your children get along (making rules, handling arguments).	BETTER	WORSE	NO CHANGE
5. How members of your family get along with each other (talk over problems, handle arguments).	BETTER	WORSE	NO CHANGE
6. How you or members of your family get along with other relatives, friends, neighbours, or people at work.	BETTER	WORSE	NO CHANGE
7. Physical or sexual abuse of a family member.	BETTER	WORSE	NO CHANGE
8. Problems in getting needed resources such as housing, child care, money, employment.	BETTER	WORSE	NO CHANGE
9. Problems in dealing with school, community or government people.	BETTER	WORSE	NO CHANGE
10. Problems dealing with being a single person or being a single parent.	BETTER	WORSE	NO CHANGE
11. Other problems (Please write in the "other problems" in the space below).	BETTER	WORSE	NO CHANGE

Below is a list of reasons why people stop coming to the agency. Place a check mark in the box beside the reason that best describes why you stopped coming to the agency. Please check one reason only.

☐ I no longer needed help.	☐ I was referred to another agency or service for help.
☐ Change to a different counsellor.	☐ A group I was involved in ended.
☐ I was not happy with my counsellor.	☐ I was unable to continue because of a change in my personal situation.
☐ I was not receiving the help I wanted.	☐ I was unable to get other family members involved.
☐ The fees were too high.	

Other (Please write in the reason if it is not listed above)

Taking all things into consideration, please circle one of the answers below to show whether you are "Very Satisfied", "Satisfied", or "Not Satisfied" with your counselling experience.

VERY SATISFIED

SATISFIED

NOT SATISFIED

Would you recommend this agency to friends or relatives who are having troubles. Circle "Yes" or "No" below.

YES

NO

If problems arise in the future would you return to this agency? Circle "Yes" or "No" below.

YES

NO

Please use the back of this page to write in any other comments or suggestions you would like to make about your experience with our agency.

THANK YOU FOR YOUR COOPERATION AND ASSISTANCE.

Appendix G
Factor Analyses of Individual TRSMP Scales

Factor Analyses of Individual TRSMP Scales

The following notes provide descriptions of the factor analyses of the scales items of the individual TRSMP Scales. The rotated factor loadings for each of the 23 scales are tabulated at the end of the appendix.

Openness/Warmth/Understanding. The items assigned to this scale by the three judges demonstrated high internal consistency ($\alpha=.83$) and the factor analysis did not identify any single-item factors. Although three reasonably interpretable factors were extracted (i.e. interpersonal warmth, understanding, and non-blaming), many of the items loaded on more than one factor. The cross-loading of the items on the three factors was taken as further evidence that the scale was internally consistent. Therefore, the item assignments originally agreed upon by the judges were maintained without any item deletions.

Direction. Initial analyses revealed high internal consistency for the 14 items assigned to the Direction scale ($\alpha=.81$). However, further analysis identified one ambiguously-worded item (8. Guiding, directing obliquely) that was uncorrelated with the other items in the scale. Although the deletion of this item did not substantially increase the internal consistency of the scale ($\alpha=.82$), the factor analysis indicated that it represented a single-item factor. Five interpretable factors were derived (i.e. giving advice, being directive/

concrete, use of self, offering help, and guiding obliquely).

As elaborated in the results section, the outcome of the factor analysis of the combined Direction and Structuring items determined the final composition of the Direction scale (Table 7). The new scale consisted of 13 items with high internal consistency ($\alpha=.85$). Ten of the items had originally been assigned to the Direction scale by the judges and 3 items had been assigned to the Structure scale. Only 4 of the 14 items that had been initially agreed upon by the judges were excluded from the new Direction scale. One item (8. Guiding, directing obliquely) was excluded because it failed to load above the .3 level on either factors.

Structuring. The 10 items assigned to the Structuring scale demonstrated acceptable internal consistency ($\alpha=.60$). However, supplementary analysis indicated that two of the items (245. Takes responsibility for the setting of treatment goals; 253.* No therapeutic action without mutual agreement on treatment goals) were not correlated with the composite score for the remaining items in the scale. The deletion of these items resulted in a higher estimate of internal consistency ($\alpha=.71$). The factor analysis also indicated these items constituted separate factors in the four-factor solution (i.e. contracting, authority, responsibility for goal setting, no mutual agreement on problems).

The final item composition, based on the factor analysis of the combined Direction and Structuring items (Table 7),

consisted of 8 items. This combination of items produced a scale with adequate internal consistency ($\alpha=.72$). The new Structuring scale included only five of the 10 items that were assigned by the judges to the scale. Two of the items originally assigned to the Structuring scale (4. Businesslike, in charge; 253*.) were excluded because they did not load above the .3 level on either factor. Three of the new Structuring items had been initially assigned to the Direction scale.

Expertness. The internal consistency of the Expertness scale was low ($\alpha=.52$). Further analysis indicated that the reliability estimate could be augmented by deleting one of the items (162. Promoting positive expectancies by making reference to other cases). This item was uncorrelated with the total scale and the results of the factor analysis revealed that it formed a single-item factor in a two-factor solution. The item did not load on the first factor, and other items tended to load negatively on its factor. After deleting this item, the internal consistency estimate for the remaining 5 items increased to a more acceptable level ($\alpha=.67$).

Attractiveness. The 12 items assigned to the attractiveness scale demonstrated adequate internal consistency ($\alpha=.72$) and the removal of items would not result in increases in the reliability estimate. In addition, the solution to the factor analysis did not suggest that any items functioned as single-item factors. Four factors emerged from the factor analysis and each represented a meaningful cluster of items (i.e. happiness, lack

of derisiveness/aggression, use of humour, and pleasant demeanour). However, on the basis of the overall internal consistency of the scale, there was no evidence that the items should be divided into distinct sub-scales.

Provides Meaning. While the Provides Meaning scale had acceptable internal consistency ($\alpha=.65$), further analysis indicated that one of the items (249. Catalyst, clarifier, facilitator) was not correlated with the total scale. Although the increase in the internal consistency estimate was modest ($\alpha=.68$), the removal of this item was also justifiable given the ambiguity of its wording.

Focus on Feelings. This four-item scale possessed very adequate internal consistency ($\alpha=.78$), and the factor analysis resulted in the extraction of only one factor. The four Focus on Feelings items also have high content validity.

Activity. The reliability estimate for the five-item Activity scale was low ($\alpha=.55$). By deleting one item (147. Probing and questioning to clarify nature of problems) the internal consistency of the item showed some improvement ($\alpha=.60$). The results from the factor analysis were less clear with regard to this item. Although this item anchored the second factor in the two-factor solution and loaded negatively on the first factor, two other items also loaded on its factor. It should be noted that the latter two items also loaded above the level of .3 on the first factor. The decision was made to retain the four items which demonstrated at least moderate internal consistency.

Flexibility. The seven items assigned by the judges to the Flexibility scale showed poor internal consistency ($\alpha=.43$). After removing three of the items (150. Reviewing/evaluating alternative courses of action; 22.* Cautious, premeditated interventions; 7.* Consistent during session), the internal consistency estimate for the four remaining items increased to a more acceptable ($\alpha=.58$). The factor analysis generated a three factor solution. The first factor was composed of the four items which had the highest internal consistency. These items reflected the constructs of flexibility and spontaneity to a greater extent than the three items that loaded on the second and third factor, and which had suppressed the internal consistency of the scale.

Goal Setting. The Goal Setting scale possessed high internal consistency ($\alpha=.81$). The factor analysis resulted in the extraction of two factors for the nine items. The first factor included items that refer to goal selection, intervention planning and monitoring progress, while the second factor consists of items involving more direct endorsements of the goal setting process. However, given the high internal consistency, it appears that all of the items assigned by the judges can be combined to form one scale.

Emotional Distress. The items comprising the Emotional Distress scale had adequate internal consistency ($\alpha=.69$). However, further analysis suggested that the reliability of scale could be improved slightly ($\alpha=.72$) by the removal of one item

(85.* Forceful, bold, robust). Relative to the other items in the scale, this item does not have high content validity with respect to emotional health. The factor analysis, which resulted in a two-factor solution, also provided some support for the removal of this item from the scale.

Behavioural. An adequate level of internal consistency was observed for the 10 items assigned by the judges to the Behavioural scale ($\alpha=.73$). Supplementary analysis indicated that the internal consistency estimate could not be increased by revisions to the scale. The factor analysis derived four factors, with the first factor containing items that were concerned with general behavioural principles. The remaining three factors were formed by clusters by clusters of items referring to more specific behavioural methods.

Psychodynamic. The items assigned to the psychodynamic scale demonstrated very poor internal consistency ($\alpha=.39$). Based on both rational and empirical criteria, major revisions to this scale were made. Further analysis identified three items that were contributing to the low internal consistency estimate. (225. Avoiding counter-transference; 212. Sexual attitudes; and 224.* Encouraging Counter-transference). Although these themes have been traditionally associated with psychoanalytic schools, the factor analysis indicated that the items did not load with more general principles of the psychodynamic approach. The factor analysis also identified a second grouping of two items that could be viewed as conceptually distinct (i.e. dealing with

resistance). The notion of resistance is now common to a number of psychotherapeutic approaches, and should perhaps not be viewed as a theme unique to the psychodynamic model. It was decided to retain the three items that referred to general psychodynamic principles. A fourth item (238.* Not emphasizing role of prior experience), originally assigned to the Experiential scale, was reassigned to the Psychodynamic scale because of its obvious content validity. The resulting four-item Psychodynamic scale demonstrated acceptable internal consistency ($\alpha=.66$).

Cognitive. The initial estimate of internal consistency for the items assigned to the Cognitive scale was low ($\alpha=.55$). However, the deletion of one item which was not correlated with any of the other items (247. More process than content oriented), resulted in an appreciable increase in internal consistency ($\alpha=.61$). The factor analysis also supported the removal of this item from the scale. In the three-factor solution, this item constituted a single-item factor. The remaining two factors involved groupings of items related to general cognitive principles and items that referred to more specific cognitive techniques.

Experiential. The internal consistency of the items assigned to this scale was not high ($\alpha=.54$). The removal of one item (238. Not emphasizing role of prior experience) resulted in an improvement ($\alpha=.60$). Although solution to the factor analysis was somewhat difficult to interpret, this item loaded in a negative direction with other items in the scale. As described

above, it was decided that this item would be more appropriately assigned to the Psychodynamic scale. The factor analysis also revealed that items concerned with "here and now" interactions formed a separate grouping. It appeared that these items would not contribute significantly to the measurement of the Experiential construct. The final scale consisted of eight items with moderate internal consistency ($\alpha=.63$)

Social Structure. The eight items comprising the Social Structure scale showed very high internal consistency ($\alpha=.93$). The factor analysis produced two factors (i.e. civil/legal rights, linking problems to social structure).

Paradoxical Interventions. The four items assigned to the Paradoxical Intervention scale demonstrated very adequate internal consistency ($\alpha=.79$). In addition, the solution to the factor analysis yielded only one factor.

Role Playing. The Role Playing scale was composed of two items that were highly correlated ($\alpha=.85$). The factor analysis resulted in the extraction of a single factor.

Skill Training. The items assigned to the Skill Training scale possessed very adequate internal consistency. The factor analysis did not identify any items which should be removed from the scale. Three interpretable factors were derived (i.e. problem-solving skills, relationship skills, and relaxation skills).

Relabeling. The Relabeling items possessed poor internal consistency ($\alpha=.53$) and supplementary analysis identified no

items that were contributing to the low reliability estimate. However, the factor analysis was helpful in clarifying the problems with the item composition of this scale. In the three-factor solution, only the second factor contained items that possessed high content validity with respect to the construct of Relabeling (102. Relabeling a person/problem in more positive terms; 104. Relabeling a feeling in more positive terms). The first factor in the solution involved negative relabeling items. Relabeling feelings and problems in a negative way would be rarely used by therapists, and is not discussed in the literature. Not surprisingly, these items were very infrequently endorsed by the therapists. For this reason, it was decided that the items should be excluded from the scale. The items comprising the third factor were also excluded from the new scale (105. Relabel in a paradoxical manner; 242. More likely to "relabel" than to "interpret"), since it appeared that they do not represent good indicators of Relabeling. The resulting two-item scale possesses adequate internal consistency ($\alpha=.73$).

Homework. The items assigned to the Homework formed an internally consistent scale ($\alpha=.78$). Although the factor analysis extracted three factors, there was no evidence that any items should be removed from the scale.

Social Networks. The Social Networks scale demonstrated high internal consistency ($\alpha=.82$). However, further analysis revealed that the scale would become even more homogeneous if two items were deleted (229. Encourage bringing in family of origin;

146. Involving client's friends). These items were found to be weakly correlated with the total scale. The factor analysis yielded two factors, with the latter two items forming a separate factor. One of these items (146.) was rarely endorsed, and on closer inspection the other item (229.) did not appear to capture the notion of social networks/support that was intended. It may be that the technique of involving client friends and family of origin in therapy may be used as a method of resolving conflict rather than mobilizing social support. The revised scale contained the six remaining items ($\alpha=.89$).

Family Therapy. The Family Therapy techniques scale demonstrated high internal consistency ($\alpha=.83$) and supplementary analyses failed to identify items that should be eliminated. The results of the factor analysis were less clear. The factor that explained the most variance in the solution was concerned with negotiation and contracting skills, but the remaining four factors were difficult to interpret. The results of the factor analysis did not suggest any refinements for the Family Therapy scale.

Table G.1

Rotated Factor Loadings: Openness/Warmth/Understanding

Items	Factors		
	1	2	3
89. Unconditional warmth, liking, respect	.80	.27	.10
33. Demonstrating interpersonal warmth	.77	.09	-.02
80. Patient, tolerant	.73	.05	-.06
23. Open, warm, understanding	.69	.03	.27
79. Kind, loving, caring	.64	.10	.16
5. Supportive, reassuring	.60	-.27	.04
87. Attentive: eye contact, open posture	.59	.14	.48
88. Genuine: authentic, congruent	.59	.24	.44
110. Express understanding of client's behaviour	.16	.86	-.00
111. Express understanding of client's feelings	.08	.83	.18
47.* Lack of understanding	-.16	.31	.77
31. Being non-blaming	.33	-.23	.53
Eignevalues	4.45	1.78	1.03
Percent of Variance Explained	37.1	14.8	8.7

* Indicates reverse scoring.

Table G.2

Rotated Factor Loadings: Direction

Items	Factors				
	1	2	3	4	5
94.* Withhold direct suggestions/ advice	.73	.04	.21	-.03	-.05
93. Offer direct suggestions/give advice	.73	.36	.06	.04	.17
48. Explanation of how or what to do	.72	.02	.22	.20	.23
156. Identifying possible post- problems and appropriate responses	.56	.13	-.15	.47	-.33
34. Being directive (giving instructions, prompting verbal participation, etc.)	.20	.72	.00	.14	.10
24. Active, directive, structured interaction	.12	.69	.13	-.04	.18
36. Being clear and specific (not vague)	-.23	.64	.07	.29	-.42
92. Concreteness: being specific	.42	.54	.34	-.19	-.18
64. Give lots of examples	.25	.43	.41	.41	.27
37. Using oneself as source of information and model through self-disclosure	.21	-.05	.86	.19	-.07
112. Report a personal experience as an example	.03	.24	.76	.21	.19
58. Getting right to the point	.25	.26	.47	-.20	-.27
39. Offering or providing help	.07	.06	.24	.79	.00
8. Guiding, directing obliquely	.08	.15	.00	.00	.82
Eigenvalues	4.23	1.46	1.32	1.26	1.05
Percent of Variance Explained	30.3	10.4	9.4	9.0	7.6

Table G.3

Rotated Factor Loadings: Structuring

Items	Factors			
	1	2	3	4
138. Re-negotiating contract	.92	.03	.08	-.06
137. Negotiating contract	.90	.03	.16	-.09
128. Willing to confront if contract not followed	.57	.33	-.18	.13
235. Willing to make further therapy contingent upon compliance with instructions	.52	.40	-.36	.26
223. Providing firm leadership, authoritative guidance	.15	.67	-.05	-.21
25. Firm but fair	.15	.66	-.02	-.13
4. Businesslike, "in charge"	-.18	.63	.34	.42
245. Takes responsibility for the setting of treatment goals	.16	.09	.84	.02
91. Confrontation: telling it like it is	.12	.45	-.50	-.09
253.* No therapeutic action without mutual agreement on problems	.02	-.25	.03	.88
Eigenvalues	2.83	1.53	1.25	1.07
Percent of Variance Explained	28.4	15.4	12.5	10.7

Table G.4

Rotated Factor Loadings: Expertness

Items	Factors	
	1	2
35. Being self-confident (portraying mastery of self and of helping procedures)	.78	-.05
75. Confident, assured, secure	.78	.21
76. Wise, intelligent, skilled	.57	-.50
239. Promoting positive expectancies regarding outcome of therapy	.56	-.02
86.* Shy, insecure, meek	.50	-.36
162. Promoting positive expectancies by making reference to other cases	.14	.88
Eigenvalues	2.22	1.16
Percent of Variance Explained	37.1	19.4

Table G.5

Rotated Factor Loadings: Attractiveness

Items	Factors			
	1	2	3	4
77. Happy, smiling, joyful	.81	-.15	-.16	.16
59. Smiling	.79	.31	.17	-.02
68. Interested, eager, enthusiastic	.73	-.07	.16	.20
83.* Sarcastic, cynical, sneering	.07	.87	.01	-.05
84.* Dominating, pushy, aggressive	-.03	.80	-.15	.15
40. Joking	-.01	-.18	.83	.10
32. Alleviating tension with humour	.04	.08	.81	.02
67. Genial, witty, playful	.17	-.25	.66	.44
41. Providing positive feedback	.43	.30	.47	-.28
15. Casual, informal	.21	-.00	.24	.67
38. Calm, pleasant voice tone	-.06	.56	-.12	.64
52. Politeness	.42	.46	.07	.51
Eigenvalues	3.21	2.44	1.49	1.15
Percent of Variance Explained	26.2	20.4	12.4	9.6

Table G.8

Rotated Factor Loadings: Activity

Items	Factors	
	1	2
51. Enthusiasm	.87	-.00
73. Curious, attentive, engrossed	.77	.14
147. Probing and questioning to clarify nature of problems	-.19	.82
1. Talkative	.32	.63
2.* Passive	.39	.45
Eigenevalues	1.18	1.11
Percent of Variance Explained	37.5	22.2

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(ANSI and ISO TEST CHART No 2)

Table G.6

Rotated Factor Loadings: Provides Meaning

Items	Factors			
	1	2	3	4
99. Offer interpretation of general problem	.91	.10	.10	.08
100. Offer interpretation of an immediate event	.91	.07	.04	.12
251. Explains every therapeutic action	-.08	.74	.23	-.26
3. Explanatory	.11	.73	-.21	.38
49. Explanation of why (giving reasons)	.43	.62	.01	-.15
248. Gives clients new ways of viewing their relationships	-.07	.08	.82	.19
218. Process of constant clarification of what client wants from therapy	.22	-.03	.82	-.12
249. A catalyst, clarifier, facilitator	.07	-.14	.02	.88
30. Integrates the behaviour and affect realms of family experience	.20	.36	.33	.43
Eigenvalues	2.57	1.45	1.38	1.12
Percent of Variance Explained	28.6	16.1	15.4	12.4

Table G.7

Unrotated Factor Loadings: Feelings

Items	Factor 1
<hr/>	
27. Encourage discussion of feelings	.86
81. Interested in talking about feelings	.83
106. Encourage ventilation, discussion of feelings	.74
107.* Discourage ventilation	.66
Eigenvalues	2.45
Percent of Variance Explained	61.3

Table G.8

Rotated Factor Loadings: Activity

Items	Factors	
	1	2
51. Enthusiasm	.87	-.00
73. Curious, attentive, engrossed	.77	.14
147. Probing and questioning to clarify nature of problems	-.19	.82
1. Talkative	.32	.63
2.* Passive	.39	.45
Eignevalues	1.18	1.11
Percent of Variance Explained	37.5	22.2

Table G.9

Rotated Factor Loadings: Flexibility

Items	Factors		
	1	2	3
226. Willing and ready to be eclectic	.76	.24	.11
18. Spontaneous, intuitive, improvising	.74	-.06	-.01
82. Spontaneous, unpredictable	.64	-.19	-.19
13.* Persistent, unyielding	.46	.00	-.01
150. Reviewing/evaluating alternative courses of action	.24	.83	.12
22.* Cautious, premeditated interventions	.27	-.67	.18
7.* Consistent during session	-.07	-.03	.95
Eigenvalues	1.91	1.26	1.00
Percent of Variance Explained	27.3	18.0	14.3

Table G.10

Rotated Factor Loadings: Goal Setting

Items	Factors	
	1	2
153. Monitoring progress/success of plan	.89	.15
154. Revising plans on basis of results of progress checks	.86	-.03
152. Planning for implementation	.84	.15
148. Reaching consensus with client re problems	.65	-.03
19. Working toward definite goals	.52	.36
217.* Avoid explicit formulation of goals	.01	.75
149. Specify number of sessions to achieve goals	.11	.73
246. Goals are objective: observable, can be counted, measured	.36	.70
155. Long-term follow-up goals set at closure	.08	.62
Eigenvalues	3.81	1.54
Percent of Variance Explained	42.3	17.2

Table G.11

Rotated Factor Loadings: Emotional Distress

Items	Factors	
	1	2
72. Tense, worried, anxious	.83	.19
71. Afraid, fearful, scared	.82	.08
66. Uneasy, troubled, preoccupied	.67	.45
78.* Relaxed, serene, contented	.44	.00
85. Forceful, bold, robust	-.04	.87
65. Blue, sad, solemn	.35	.75
Eigenvalues	2.69	1.05
Percent of Variance Explained	44.9	17.5

Table G.12

Rotated Factor Loadings: Behavioural

Items	Factors			
	1	2	3	4
167. Contingency management	.77	-.04	.27	.16
126. Praise conformity with contract	.77	.02	-.20	.09
166. Behavioural contracting	.70	.05	.46	.18
26. Encourage discussion of concrete behaviour	.50	.23	.23	-.07
195. Linking familial/personal problems to personal habits	-.02	.89	.05	.13
194. Linking familial/personal problems to skill deficits	.13	.79	.09	-.20
173. Monitoring/graphing techniques	.08	-.03	.86	.23
172. Pinpointing behavioural targets	.23	.33	.73	-.13
175. Token-economy procedures	.15	-.09	.06	.84
174. Time-out procedures	.09	.53	.11	.54
Eigenvalues	3.11	1.68	1.05	1.03
Percent of Variance Explained	31.2	16.8	10.6	10.4

Table G.13

Rotated Factor Loadings: Psychodynamic

Items	Factors			
	1	2	3	4
14. Interested in client's history	.78	.12	.04	-.12
237.* Avoiding an individual psychodynamic interpretation or focus	.75	-.30	-.02	.19
192. Linking personal/familial problems individual psychodynamics	.72	.38	-.08	-.01
227. Identifying and dealing with resistance	.18	.83	.18	.05
134. Dealing with resistance	-.05	.73	-.23	-.01
225. Avoiding counter-transference	-.10	.07	.79	.10
212. Sexual attitudes	-.06	.10	-.62	.02
224.* Encourage counter-transference	-.18	-.16	.31	.78
12. Interpretive, inferential	.27	.32	-.29	.66
Eigenvalues	2.21	1.39	1.31	1.02
Percent of variance explained	24.6	15.5	14.6	11.3

Table G.14

Rotated Factor Loadings: Cognitive

Items	Factors		
	1	2	3
193. Linking personal/familial problems to personal attitudes, values, beliefs	.77	.08	.10
29. Encourage discussion of values and beliefs	.77	-.14	-.09
209. Values clarification	.74	.32	.04
171. Self-management self-control skills	-.02	.86	.08
210. Cognitive control methods	.15	.81	-.11
247. More content than process oriented	.03	-.02	.98
Eigenevalues	1.99	1.33	1.00
Percent of Variance Explained	33.2	22.2	16.8

Table G.15

Rotated Factor Loadings: Experiential

Items	Factors			
	1	2	3	4
109. Reflect feelings	.88	.10	.06	-.11
108. Paraphrase content	.86	-.13	-.01	.12
214. Involved more as a "person" than as a "worker"	.13	.71	.32	-.06
11. Patient, willing to wait	.02	.71	.07	.06
238. Not emphasizing role of previous experience	.16	-.62	.21	.11
131. Ask for clarification	.53	.54	.13	.27
215. Careful not to impose personal view	-.03	.07	.81	-.22
254. Deals with problems immediately as presented	.06	-.13	.74	.10
216. Clients, not worker, must define their problem	.05	.26	.54	.07
90. Immediacy: "here-and-now"	-.02	.14	.13	.85
6. Emphasizes "here-and-now"	.08	-.16	-.15	.83
Eigenvalues	2.44	1.83	1.45	1.37
Percent of Variance Explained	22.3	16.7	13.2	12.5

Table G.16

Rotated Factor Loadings: Social Structure

Items	Factors	
	1	2
187. The rights of children	.89	.25
188. The rights of men	.88	.19
186. The rights of women	.78	.37
185. Civil rights	.76	.43
184. Legal rights	.73	.39
190. Linking personal/familial problems to immediate socio-economic structure	.23	.92
189. Linking personal/familial problems to broader political-economic structure	.35	.80
191. Linking personal/familial problems to a sexist society	.34	.79
Eigenvalues	5.32	1.03
Percent of Variance Explained	66.6	12.9

Table G.17

Unrotated Factor Loadings: Paradoxical Interventions

Items	Factor 1
132. Request paradoxical action	.93
133. Offer paradoxical interpretation	.92
231. Uses paradoxical techniques	.89
234. Willing to request that client does not change as yet	.35
Eigenvalues	2.66
Percent of Variance Explained	66.6

Table G.18

Unrotated Factor Loadings: Role Playing

Items	Factor 1
<hr/>	
115. Set up a role playing exercise	.93
116. Set up a role playing exercises involving role reversals	.93
Eigenvalues	1.73
Percent of Variance Explained	86.9

Table G.19

Rotated Factor Loadings: Skill Training

Items	Factors		
	1	2	3
169. Problem solving skills	.91	.23	-.04
170. Decision-making skills	.91	.25	.06
114. Provide opportunity to practice new skill	.55	.07	.22
177. Listening skills	.10	.86	.01
178. Negotiation skills	.32	.81	.02
176. Assertion skills	.14	.77	.13
164. Physical relaxation skills	-.01	.11	.94
165. Mental relaxation skills	-.22	.02	.92
Eigenvalues	3.24	1.68	1.19
Percent of Variance Explained	40.6	21.1	14.9

Table G.20

Rotated Factor Loadings: Relabeling

Items	Factors		
	1	2	3
104. Relabel a feeling in more negative terms	.94	-.01	-.06
102. Relabel a problem/person in more negative terms	.93	.00	.14
101. Relabel a problem/person in more positive terms	-.08	.88	.09
103. Relabel a feeling in more positive terms	.06	.87	.04
105. Re-label in paradoxical manner	-.00	-.09	.83
242. More likely to relabel than interpret	.07	.28	.75
Eigenvalues	1.85	1.73	1.14
Percent of Variance Explained	39.9	28.9	19.0

Table G.21

Rotated Factor Loadings: Homework

Items	Factors		
	1	2	3
122. Assign homework (specify)	.96	.07	.10
121. Assign homework (specify)	.93	.07	.14
123. Assign homework (specify)	.92	.08	.08
119. Assign homework involving paradoxical tasks	.15	.88	-.01
118. Assign homework involving sex therapy exercises	-.00	.76	.23
120. Assign homework involving systematic record keeping	.08	.76	.37
124. Check for completion of homework	.03	.06	.82
117. Assign homework involving reciprocal tasks	.03	.30	.71
125. Suggest/assign readings or audio-visual	.21	.10	.48
Eigenvalues	3.39	2.04	1.04
Percent of Variance Explained	37.7	22.7	11.6

Table G.22

Rotated Factor Loadings: Social Networks

Items	Factors	
	1	2
202. Knowledge of community resources	.89	-.07
203. Linking with community resources	.87	.08
199. Importance of social support	.82	.08
200. Building social networks	.80	.21
201. Mobilizing social support	.72	.48
157. Linking client with other services in the community	.66	.02
229. Encourage bringing in of family of origin	.04	.85
146. Involving clients' friends	.05	.65
Eigenvalues	4.05	1.26
Percent of Variance Explained	50.6	15.8

Table G.23

Rotated Factor Loadings: Family Therapy Techniques

Items	Factors				
	1	2	3	4	5
220. Helping couples/families arrive at mutually agreed upon contracts	.82	.20	-.12	.02	.0
222. Teaching family members to negotiate with each other	.81	-.01	.05	.12	.2
233. An advocate for all members	.63	.16	.11	-.14	.0
219. Try to uncover personal "contracts" in family relationships	.61	.14	.24	.37	-.1
221. Working on "interactional scripts" or "rules of the game"	.59	.34	.10	.14	.0
232. Focus on relational ethics, a balance of equitable fairness	.54	-.11	.07	.28	.5
135. Encourage reciprocal negotiations	.50	.40	-.03	-.19	.1
142. Promoting interaction between family and worker	.48	.43	.24	-.11	-.2
179. Distinction between rules and requests	.03	.78	-.02	.18	.0
198. Linking personal/familial problems to interpersonal distribution of power	.17	.68	.12	.02	.2
139. Encouraging interaction among family members	.32	.63	.09	.15	-.0
197. Linking personal/familial problems to family of origin	.16	.02	.71	.02	-.1
20. Focusing upon relationship(s)	-.07	.02	.66	.10	.1
236. Adopting family's language, symbols, and manner of communication	.06	.08	.55	.09	.2
141. Involving family of origin	-.05	.09	.33	.79	-.0
140. Involving extended family	.25	.29	-.03	.69	.0
196. Linking personal/familial problems to faulty communication	.36	.28	.41	-.42	-.1
241. Sometimes join with one person who's in conflict with other family members	.14	.18	.16	-.06	.8
Eigenvalues	4.99	1.75	1.45	1.36	1.2
Percent of Variance Explained	37.8	9.8	8.1	7.6	6.7

Appendix H
Item Compositions of the TRSMP Scales

Item Compositions of the TRSMP Scales

Openness/Warmth/Understanding

- 5. Supportive, reassuring
- 23. Open, warm, understanding
- 31. Being non-blaming
- 33. Demonstrating interpersonal warmth
- 47. Lack of understanding*
- 79. Kind, loving, caring
- 80. Patient, tolerant
- 87. Attentive: eye contact, open posture
- 88. Genuine: congruent, authentic
- 89. Unconditional warmth, liking, respect
- 110. Express understanding of client's behaviour
- 111. Express understanding of client's feeling

Direction

- 8. Guiding, directing obliquely
- 24. Active, directive, structured interaction
- 34. Being directive (giving instructions, prompting verbal participation, giving corrective feedback or support)
- 36. Being clear and specific (not vague)
- 37. Using oneself as source of information and model through self-disclosure
- 39. Offering or providing help
- 48. Explanation of how or what to do
- 58. Getting right to the point
- 64. Give lots of examples
- 92. Concreteness: being specific
- 93. Offer direct suggestions/give advice
- 94. Withheld direct suggestions/advice*
- 112. Report a personal experience as an example
- 156. Identifying possible post-therapy problems and appropriate responses

Structure

- 4. Businesslike, "in charge"
- 25. Firm but fair
- 91. Confrontation: "telling it like it is"
- 128. Willing to confront if contract not followed
- 137. Negotiating contract
- 138. Re-negotiating contract
- 223. Providing firm leadership, authoritative guidance
- 235. Willing to make further therapy contingent upon compliance with instructions

* Reverse Scoring

Expertness

- 35. Being self-confident (portraying mastery of self and of helping procedures)
- 75. Confident, assured, secure
- 76. Wise, intelligent, skilled
- 86. Shy, insecure, meek*
- 239. Promoting positive expectancies regarding outcome of therapy

Attractiveness

- 15. Casual, informal
- 32. Alleviating tension with humour
- 38. Calm, pleasant voice tone
- 40. Joking
- 41. Providing positive feedback
- 52. Politeness
- 59. Smiling
- 67. Genial, witty, playful
- 68. Interested, eager, enthusiastic
- 77. Happy, smiling, joyful
- 83. Sarcastic, cynical, sneering
- 84. Dominating, pushy, aggressive

Provides Meaning

- 3. Explanatory
- 30. Integrates the behaviour and affect realms of family experience
- 49. Explanation of why (giving reasons)
- 99. Offer interpretation of general problem
- 100. Offer interpretation of an immediate event
- 218. Process of constant clarification of what clients want from therapy
- 248. Gives clients new ways of viewing their relationships
- 251. Explains every therapeutic action

Focus on Feelings

- 27. Encourage discussion of feelings
- 81. Interested in talking about feelings
- 106. Encourage ventilation, expression of feelings
- 107. Discourage ventilation*

Activity

- 1. Talkative
- 2. Passive*
- 51. Enthusiasm
- 73. Curious, attentive, engrossed

Flexibility

- 18. Spontaneous, intuitive, improvising
- 226. Willing and ready to be eclectic
- 13. Persistent, unyielding*
- 82. Spontaneous, unpredictable

Goal Setting

- 19. Working toward definite goals
- 155. Long-term follow-up goals set at closure
- 217. Avoid explicit formulation of goals*
- 246. Goals are objective: observable, can be counted, measured
- 152. Planning for implementation
- 148. Reaching consensus with client re problems
- 149. Specify number of sessions to achieve goals
- 153. Monitoring progress/success of plan
- 154. Revising plans on basis of results of progress checks

Emotional Well-Being

- 65. Blue, sad, solemn
- 66. Uneasy, troubled, preoccupied
- 71. Afraid, fearful, scared
- 72. Tense, worried, anxious
- 78. Relaxed, serene, contented*

Behavioural

- 126. Praise conformity with contract
- 166. Behavioural contracting
- 167. Contingency management
- 172. Pinpointing behavioural targets
- 173. Monitoring/graphing techniques
- 174. Time-out procedures
- 175. Token-economy procedures
- 194. Linking personal/familial problems to personal habits
- 195. Linking personal/familial problems to personal skill deficits
- 26. Encourage discussion of concrete behaviour

Psychodynamic

- 14. Interested in client's history
- 192. Linking personal/familial problems to individual psychodynamics
- 237. Avoiding an individual psychodynamic interpretation or focus*
- 238. Not emphasizing role of prior experience*

Cognitive

- 29. Encourage discussion of values and beliefs
- 193. Linking personal/familial problems to personal attitudes, values, beliefs
- 209. Values clarification
- 210. Cognitive control methods
- 171. Self-management/self-control skills

Experiential

- 11. Patient, willing to wait
- 108. Paraphrase content
- 109. Reflect feelings
- 214. Involved more as a "person" than as a "worker"
- 215. Careful not to impose personal view
- 216. Clients, not worker, must define their problem
- 131. Ask for clarification
- 254. Deals with problems immediately as presented

Social Structure

- 184. Legal rights
- 185. Civil rights
- 186. The rights of women
- 187. The rights of children
- 188. The rights of men
- 189. Linking personal/familial problems to immediate socio-economic structure
- 190. Linking personal/familial problems to broader political-economic structure
- 191. Linking personal/familial problems to a sexist society

Paradoxical Interventions

- 132. Request paradoxical action
- 133. Offer paradoxical interpretation
- 231. Uses paradoxical techniques
- 234. Willing to request that client does not change as yet

Role Playing

- 115. Set up a role playing exercise
- 116. Set up a role playing exercise involving role reversals

Skill Training

- 114. Provided opportunity to practice new skill
- 169. Problem solving skills
- 170. Decision-making skills
- 176. Assertion skills
- 177. Listening skills
- 178. Negotiation skills

Relabeling

- 101. Re-label a problem/person in more positive terms
- 103. Re-label a feeling in more positive terms

Homework

- 117. Assign homework involving reciprocal tasks
- 118. Assign homework involving sex therapy exercises
- 119. Assign homework with paradoxical tasks
- 120. Assign homework involving systematic record keeping
- 121. Assign homework (other _____)
- 122. Assign homework (other _____)
- 123. Assign homework (other _____)
- 124. Check for completion of homework
- 125. Suggest/assign readings or audio-visual

Social Networks

- 157. Linking client with other services in community
- 199. Importance of social support
- 200. Building social network
- 201. Mobilizing social network
- 202. Knowledge of community resources
- 203. Linking with community resources

Family Therapy

- 139. Encouraging interaction among family members
- 142. Promoting interaction between family and worker
- 179. Distinction between rules and requests
- 196. Linking personal/familial problems to faulty communication
- 198. Linking personal/familial problems to interpersonal distribution of power
- 219. Try to uncover personal "contracts" in family relationships
- 220. Working to help couples/families arrive at mutually-agreed upon contract
- 221. Working on "interactional scripts", on the "rules of the game"
- 222. Teaching family members how to negotiate with each other
- 232. Focus on "relational ethics", a balance of equitable fairness
- 233. An advocate for all family members
- 236. Adopting the family's language, symbols, and
- 140. Involving extended family
- 141. Involving family of origin
- 20. Focusing upon relationship(s)
- 197. Linking personal/familial problems to family of origin
- 135. Encourage reciprocal negotiations

Appendix I

**Multitrait-Multimethod Matrices for
Supervisor and Therapist TRSMP Scores**

Table II

Multitrait Multimethod Matrix of Therapist and Supervisor TRAP Scores: Convergent and Within Method Divergent Coefficients

Therapist Reports	Supervisor Reports																						
	ROG	DIR	SIRU	EXP	ATT	MEA	FEE	ACT	FILE	COA	EMD	EEH	DAN	COG	EXI	ECO	HRH	ROL	SKI	REL	HOM	NET	FMH
1 Openness/Variety/Understanding	.16	.51	.46	.64	.80	.70	.73	.54	.57	.37	-.63	.35	.19	.61	.71	.29	-.03	.26	.44	.50	.38	.31	.24
2 Direction	.18	.15	.69	.67	.58	.64	.49	.73	.48	.61	-.34	.69	.11	.68	.45	.60	.22	.65	.61	.54	.53	.38	.56
3 Structuring	.16	.35	.31	.65	.58	.69	.33	.57	.34	.72	-.48	.74	-.12	.55	.50	.59	.43	.71	.61	.48	.66	.52	.66
4 Expertness	.59	.18	.21	.47	.67	.46	.44	.79	.52	.54	-.68	.46	-.09	.57	.46	.36	.15	.44	.68	.42	.35	.30	.33
5 Attractiveness	.54	.36	-.00	.43	.00	.64	.59	.64	.61	.44	-.60	.53	-.02	.59	.68	.33	.09	.41	.62	.40	.45	.21	.34
6 Provides Meaning	.36	.66	.40	.27	.26	-.19	.61	.45	.33	.58	-.46	.65	.13	.58	.64	.51	.22	.51	.44	.45	.55	.46	.55
7 Focus on Feeling	.48	.29	-.02	.21	.45	.48	.19	.47	.45	.40	-.46	.29	.08	.64	.70	.39	-.11	.27	.32	.44	.33	.24	.14
8 Activity Level	.45	.36	.36	.40	.56	.23	.23	.27	.47	.46	-.52	.51	.01	.58	.36	.52	.22	.49	.53	.34	.36	.32	.37
9 Flexibility	.36	.15	-.16	.40	.47	.21	.51	.09	.13	.23	-.36	.39	-.07	.63	.58	.32	.18	.23	.58	.55	.47	.20	.43
10 Goal Setting	.11	.35	.73	.11	-.01	.46	-.01	.17	-.24	.10	-.49	.51	-.04	.53	.49	.60	.20	.68	.53	.51	.28	.49	.38
11 Emotional Distress	-.65	-.12	-.17	-.73	-.30	-.40	-.30	-.30	-.18	-.17	.20	-.22	.15	-.43	-.60	-.35	-.17	-.27	-.43	-.40	-.10	-.29	-.09
12 Behavioral	.08	.44	.50	.24	.25	.29	-.11	.34	.00	.53	-.13	.46	-.06	.62	.49	.59	.53	.66	.67	.33	.73	.48	.76
13 Psychodynamic	.18	.11	.07	.07	.09	.23	.41	.04	.14	-.07	-.04	-.08	.31	.03	-.14	-.04	-.40	-.06	-.13	.09	.04	-.06	-.08
14 Cognitive	.39	.53	.48	.57	.22	.65	.32	.18	.30	.36	-.40	.50	.21	-.07	.65	.55	.30	.58	.66	.53	.62	.34	.45
15 Experiential	.71	.26	.04	.47	.39	.32	.38	.28	.35	.02	-.45	-.00	.14	.47	.01	.35	.08	.29	.60	.53	.45	.17	.29
16 Social Structure	.15	.48	.39	.26	.20	.58	.15	.40	.03	.39	-.27	.42	-.10	.48	.12	.33	.37	.60	.30	.36	.38	.80	.56
17 Paradoxical Interventions	-.05	.23	.07	.39	.23	-.01	-.10	.06	.10	.00	-.10	.11	-.07	.27	.17	.21	.39	.51	.29	.09	.42	.38	.58
18 Role Playing	.04	.18	.27	.21	.27	.21	.20	.31	.21	.41	-.22	.35	-.04	.17	.06	.14	.02	.14	.57	.31	.60	.51	.59
19 Skill Training	.20	.54	.35	.45	.33	.40	.09	.30	.44	.36	-.27	.55	-.25	.59	.23	.47	.29	.46	.12	.30	.55	.20	.49
20 Relabeling	.29	.29	.22	.22	.26	.51	.58	.30	.36	.33	-.32	.06	.15	.22	.12	.26	-.17	.42	.27	-.04	.25	.31	.32
21 Homework	.20	.12	.44	.46	.14	.27	.03	.38	.18	.35	-.33	.25	-.21	.48	.38	.35	.49	.40	.49	.16	.20	.30	.70
22 Social Networks	.24	.35	.07	.19	.16	.57	.26	.12	.13	.26	-.24	.04	.16	.24	.14	.49	-.14	.18	.13	.44	-.04	.15	.58
23 Family Therapy	.20	.37	.64	.44	.27	.52	.25	.28	.17	.53	-.28	.38	.28	.68	.18	.58	.37	.37	.48	.33	.49	.35	.29

Convergent coefficients are on the diagonal. Within therapist reported divergent coefficients appear to the left of the diagonal and within supervisor-reported divergent coefficients are to the right of the diagonal.

Table 12

Multitrait Multimethod Matrix of Therapist and Supervisor TRSP Scores: Convergent and Across Method Divergent Coefficients

Therapist Reports	Supervisor Reports																						
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1 Openness/Warmth/Understanding	.16	.14	.09	.26	.15	.00	.04	.23	.30	.05	-.21	.11	.01	.15	.10	.20	-.04	-.17	.21	.28	-.13	.20	.02
2 Direction	-.40	.15	-.00	-.06	-.18	-.19	-.30	-.04	-.17	.01	.14	.09	-.15	-.30	-.32	.09	.00	-.04	-.06	-.18	-.22	.00	.00
3 Structuring	-.17	.09	.31	.11	-.02	.06	-.23	-.00	.11	.09	.18	.25	-.36	-.09	-.08	.05	.25	.11	.05	.16	.14	.14	.39
4 Expertness	.11	.15	.22	.47	.13	-.02	-.17	.34	.31	.13	-.31	.20	.00	.10	-.08	.21	.35	.11	.35	.05	.00	.25	.22
5 Attractiveness	-.10	-.02	-.10	-.05	.00	-.20	-.27	-.01	.03	-.09	-.19	-.05	-.15	-.13	-.06	.04	.14	-.11	.02	.02	-.35	.01	-.00
6 Provides Meaning	-.31	-.09	-.18	-.21	-.30	-.19	-.26	-.13	-.15	-.02	.18	-.11	.02	-.31	-.36	.02	-.09	-.21	-.23	-.15	-.36	.02	-.13
7 Focus on Feeling	-.21	-.32	-.39	-.23	-.29	-.39	-.19	-.29	-.20	-.18	.10	-.42	.29	-.36	-.32	-.29	-.43	-.42	-.28	-.12	-.58	-.21	-.45
8 Activity Level	-.01	.26	.36	.26	.25	-.05	-.18	.27	.21	.30	-.15	.24	-.30	.02	.05	.30	.19	.24	.26	.11	-.02	.19	.23
9 Flexibility	-.03	-.01	-.31	.08	-.10	-.25	-.11	.12	.13	-.14	-.13	-.26	.16	-.07	-.18	-.32	-.09	-.25	.03	.04	-.41	-.36	-.32
10 Goal Setting	.03	.10	.24	.11	.08	.16	-.02	.11	.03	.10	.11	.30	-.29	.00	.00	.18	.18	.17	.06	-.00	.13	.31	.25
11 Emotional Distress	-.15	-.18	-.14	-.33	-.07	-.08	-.02	-.26	-.10	-.29	.20	-.15	-.13	-.14	.08	-.27	-.14	-.14	-.21	-.11	.12	-.41	-.17
12 Behavioural	-.00	.20	.26	.11	.15	.20	-.21	.01	.13	.20	-.04	.46	-.33	.01	.11	.15	.35	.35	.38	.03	.15	.29	.42
13 Psychodynamic	.00	-.01	-.00	-.03	.11	-.03	.04	-.11	.06	.08	.00	-.12	.31	-.07	-.04	-.05	-.24	-.03	.03	.15	-.11	-.14	-.02
14 Cognitive	-.13	.09	.04	.09	-.13	-.04	-.25	-.09	.17	.04	.09	.15	.08	-.07	-.16	-.00	.01	-.01	.16	.09	-.04	.05	.12
15 Experiential	.02	.12	.08	.13	.03	-.07	.03	.03	.19	.13	-.04	.00	.02	.15	.01	.02	-.05	-.05	.20	.23	-.05	-.02	-.15
16 Social Structure	-.10	.17	.19	.08	-.15	.08	-.14	.02	-.00	.34	-.06	.00	-.20	-.16	-.10	.33	.05	.09	-.04	.09	-.26	.41	.10
17 Paradoxical Interventions	.00	.09	.26	.16	.00	.13	-.12	-.01	.17	.18	-.18	.19	.04	.12	-.04	.14	.39	.13	.10	.06	.19	.24	.31
18 Role Playing	-.05	.08	.01	.05	.01	-.02	-.28	.03	-.13	.05	.18	.16	.02	-.12	-.18	-.14	.13	.14	.10	-.10	-.19	-.09	.00
19 Skill Training	-.16	.17	-.02	.11	-.12	-.13	-.35	.10	.02	-.03	.17	.19	-.19	-.10	-.27	-.07	.21	.02	.12	-.11	-.15	.02	.06
20 Relabeling	-.29	-.20	-.25	-.11	-.31	-.49	-.32	.02	-.17	-.06	.16	-.27	.13	-.31	-.36	-.10	-.17	-.19	-.21	-.04	-.49	-.04	-.29
21 Homework	.07	.18	.25	.24	.02	.07	-.07	.10	.33	.27	-.01	.29	-.10	.23	.02	.10	.35	.23	.19	.25	.20	.15	.19
22 Social Networks	-.14	.04	-.13	.01	-.18	-.21	-.16	.11	-.11	.04	.06	-.22	.14	-.14	-.33	.26	-.26	-.11	-.19	-.06	-.39	.15	-.18
23 Family Therapy	-.17	.07	.14	.08	-.18	-.04	-.27	-.05	.09	.10	.15	.08	-.07	-.04	-.26	.10	.20	.09	.03	.12	-.10	.19	.29

Convergent coefficients are on the diagonal.

Appendix J
Multitrait-Multimethod Matrices for
the TRSMP and FSAI Technique Scales

Table J1

Multitrait Multimethod Matrix of TRMP and FSAI Techniques Scales: Convergent and Within Method Divergent Coefficients

TRMP Scales	FSAI Technique Scales																
	ROG	DIR	SIRU	MEA	FEE	GOA	BEH	DVN	COG	EXI	EDC	PAR	SKI	ROL	REL	HOM	NET FAM
1 Openness/Understanding	.09	.25	-.07	.06	-.03	.18	-.12	.01	-.12	.21	.11	-.00	-.00	.22	.02	-.05	.27 .11
2 Direction	.14	.04	.29	.44	.37	.31	.26	.44	-.04	.19	-.03	-.02	-.02	.16	.24	.10	.09 -.07
3 Structuring	.06	.48	.22	.29	.42	.41	.45	-.10	.02	.00	.32	.18	-.02	-.04	.42	.02	-.17 .16
4 Provides Meaning	.32	.55	.40	-.06	.36	.17	.00	-.02	.06	.16	-.13	.03	-.00	.13	-.06	.16	.15 -.03
5 Focus on Feeling	.56	.31	.04	.40	-.15	.34	.19	-.02	.20	-.07	.02	-.06	.35	.19	.37	-.10	-.10 -.02
6 Goal Setting	.21	.34	.44	.37	.07	.05	.31	.03	.10	-.07	-.03	.13	.15	-.14	.24	.02	.06 .27
7 Behavioural	.25	.47	.37	.43	.17	.47	.27	.07	.22	.06	.19	.19	.09	.11	.36	-.01	-.11 .00
8 Psychodynamic	.31	.09	.26	.33	.48	.20	.24	-.03	.10	.40	-.08	.22	.08	-.08	-.00	-.00	-.17 -.07
9 Cognitive	.32	.46	.40	.62	.35	.40	.56	.30	.03	-.12	.09	.38	.74	-.02	.03	-.12	-.07 .04
10 Experiential	.62	.17	.12	.34	.34	.37	.21	.01	.47	.02	-.04	-.00	.02	.11	-.06	.03	-.21 -.09
11 Social Structure	.17	.52	.26	.56	.19	.26	.38	.00	.40	.14	.05	-.06	-.05	-.11	.40	.07	-.10 .07
12 Paradoxical Interventions	-.16	.17	.13	-.05	-.11	.22	.14	-.22	.29	.17	.07	.06	.20	-.06	-.05	-.02	-.13 .09
13 Skill Training	.27	.41	.23	.46	.23	.36	.52	.06	.52	.30	.40	.18	.24	.00	.07	-.10	-.07 .17
14 Role Playing	.23	.26	.27	.31	.42	.37	.34	.22	.26	.26	.31	-.00	.42	.15	.09	.00	.07 -.05
15 Relabeling	.17	.22	-.07	.25	.41	.02	-.02	.04	.02	.05	.15	-.09	.06	.24	.06	-.02	-.12 .26
16 Homework	.11	.10	.33	.24	.11	.42	.33	.02	.39	.36	.24	.46	.50	.45	-.02	.16	-.05 .07
17 Social Networks	.25	.16	.10	.52	.30	.21	.05	.19	.14	.00	.55	-.33	.19	.28	.33	-.11	.46 .14
18 Family Therapy	.27	.41	.59	.60	.42	.43	.36	.45	.68	.25	.50	.24	.44	.37	.16	.40	.38 -.08

Convergent coefficients are on the diagonal. Within TRMP scale divergent coefficients appear to the left of the diagonal and within FSAI Technique scale divergent coefficients are to the right of the diagonal.

Table J2

Multitrait Multimethod Matrix of TRMP and FSAI Techniques Scales: Convergent and Across Method Divergent Coefficients

TRMP Scales	FSAI Technique Scales																	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1 Openness/Warmth/Understanding	.09	-.04	-.19	.02	.02	.08	-.23	.03	.09	-.04	.01	.01	.24	.06	-.10	-.09	.17	-.06
2 Direction	-.14	.04	-.05	.04	-.03	-.22	.08	.11	.10	.05	.08	-.05	.14	.15	.00	.02	.27	-.11
3 Structuring	-.23	.18	.22	.15	.15	-.08	.20	-.00	-.02	.03	.11	.02	.15	.04	.05	.14	.03	.03
4 Provides Meaning	.04	-.09	-.21	-.06	.00	-.29	-.14	-.01	.00	-.00	-.05	-.08	.16	.20	-.05	-.11	.31	-.17
5 Focus on Feeling	.06	-.15	-.39	-.10	-.15	-.29	-.12	.00	.12	-.03	.20	-.24	.13	.04	.05	-.24	.15	-.13
6 Goal Setting	-.06	.01	.04	.07	.00	.05	.02	-.06	-.06	.17	-.09	-.00	.07	-.06	-.34	.16	.11	-.01
7 Behavioural	-.00	.16	.16	.17	.07	.05	.27	-.03	.04	-.07	.06	.00	.02	.21	.01	.03	.12	-.24
8 Psychodynamic	.07	-.16	-.11	-.09	-.10	-.14	-.19	-.03	.00	-.00	.23	-.20	.11	-.16	-.11	-.09	-.08	-.06
9 Cognitive	-.15	-.14	-.15	.02	-.00	-.18	-.14	-.11	.03	-.19	-.12	-.04	.08	.06	-.24	-.03	.13	-.22
10 Experiential	-.12	-.03	-.11	.11	.06	-.01	-.16	.05	.23	.02	-.11	.07	.20	.11	-.29	-.01	.00	-.19
11 Social Structure	.16	.01	-.04	.04	-.03	-.17	.00	-.02	.01	-.01	.05	.16	.16	.11	-.04	-.12	.26	-.17
12 Paradoxical Interventions	-.25	-.15	.17	.01	-.26	.00	.21	-.10	-.09	.02	-.00	.05	-.12	-.26	-.09	.13	-.11	.06
13 Skill Training	.04	.06	.10	.26	.04	.02	-.07	-.20	.27	-.17	.12	-.01	.25	.05	.02	.19	.30	.01
14 Role Playing	.06	-.13	-.01	.13	-.04	-.34	.02	-.19	.14	.16	.29	-.00	.06	.15	-.05	.09	.01	-.19
15 Relabeling	.28	-.11	-.36	-.14	-.22	-.08	.00	.04	.06	.13	.12	.06	-.04	.09	.05	-.02	.11	-.07
16 Homework	.00	.08	.24	.09	.00	-.00	.19	-.10	.15	-.03	.19	.09	.16	-.14	.00	.16	-.02	.00
17 Social Networks	.24	-.16	-.11	.05	.04	-.10	-.21	-.21	.16	.01	-.03	.01	.04	.17	-.02	-.14	.46	.02
18 Family Therapy	-.05	-.02	-.02	.02	-.13	-.24	-.12	-.11	-.19	-.02	.04	-.00	-.03	-.08	-.06	-.00	.09	-.08

Convergent coefficients are on the diagonal.

END

1|1|04|9 1

FIN