# The Relationship of Therapist Verbal Response Mode and Client Good Moments in Short Term Dynamic Psychotherapy

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ABSTRACT

Using a single case quantitative analysis, the relation between therapist verbal response mode and client good moments was examined to provide information about the process of a short-term dynamic psychotherapy (STDP) developed by Davanloo (1978, 1980). Independent judges rated three sessions (early, middle and late) of a complete sixteen session treatment using the Hill Counselor Verbal Response Category System-Revised (HCVRCS-R) (Friedlander, 1982) and the Category System of Client Good Moments (CSCGM) (Mahrer, 1988). Chi-square analyses revealed a significant association between therapist verbal responses and the subsequent occurrence of client good moments. The results are discussed in terms of their clinical and research implications.

RÉSUMÉ

Afin d'obtenir des données sur le processus de psychothérapie dynamique à court terme (PDCT) mise au point par Davanloo (1978, 1980), la relation entre le profil du mode de réponse verbale du thérapeute et les bons moments éprouvés par le client a été étudiée à l'aide d'un schéma expérimental quantitatif de cas unique. Des évaluateurs indépendants ont analysé trois séances (début, milieu et fin) d'un traitement en comprenant un total de seize. Pour ce faire, ils ont utilisé les systèmes de catégories suivants : le *Hill Counselor Verbal Response Category System-Revised* (HCVRCS-R) [version révisée du système pour étudier les réponses verbales des conseillers] (Friedlander, 1982) et le *Category System of Client Good Moments* (CSCGM) [système de catégories de bons moments des clients] (Mahrer, 1988). Les analyses de khi-deux ont révélé une corrélation importante entre le mode de réponse verbale du thérapeute et l'observation de bons moments chez le client. Les auteurs examinent les implications cliniques des résultats ainsi que les conséquences en découlant pour la recherche.

While not without its critics (Butler, 1994; Dawes, 1990), the value of counselling and psychotherapy is now widely accepted by both the professional community as well as the lay public (Seligman, 1995; Strupp, 1996). Although it is reassuring to know that psychotherapy provides something of benefit to its consumers, how these benefits are marshalled in the actual clinical interview remains an elusive question (Prochaska, DiClemente, & Norcross, 1992). It is perhaps for this reason that an enduring trend has been the study of discrete, observable behaviours of both the client and the counsellor during the therapeutic

interview. Often referred to as the study of significant events, the orientation of much of this research has been decidedly micro-analytic since it seems clear that the close, intense scrutiny of the moment-by-moment transactional patterns of the therapeutic dyad should offer a comprehensive understanding of how counselling works (Alexander, Newell, Robbins, & Turner, 1995).

Clearly, there is no single definition of the significant event. This term has become a short-hand for the kind of process research that looks at emerging, clinically-relevant episodes as they occur within the context of certain counsellor-client transactions (Gendlin, 1986; Greenberg, 1986; Hill, Helms, Tichenor, Spiegel, O'Grady & Perry, 1988; Stiles, Shapiro, & Elliott, 1986). The study of contiguous sets of behaviours, as they occur across transactional sequences, is essential since this provides the means with which to begin to establish important process-outcome links (Frontman & Kunkel, 1994; Wampold & Poulin, 1992).

Although the transactional sequences inherent in psychotherapy are often described as mutually-influencing (Watzlawick, Beavin, & Jackson, 1967), they are not simply a conversational exchange. Rather, these sequences are part of a system of interpersonal influence (Haley, 1963; Strong, 1968,1991; Strong & Claiborn, 1982) where the therapist assumes the responsibility for influencing the client in a beneficial manner. Even if most therapists may not concede that their influence is deliberate and calculated, they must acknowledge that their comments and responses are not random or spontaneous but rather intentional (Duncan & Moynihan, 1994; Lazarus, 1993). What flows from this is the simple fact that in order for therapists to be effective, they must display a significant measure of purpose that is part of their planned, deliberate interventions. It is perhaps for this simple reason that the study of the actual technical operations or techniques of the therapist, defined as their verbal response mode, has always been of interest (Elliott, Hill, Stiles, Friedlander, Mahrer, & Margison, 1987; Elliott, Stiles, Shiffman, Barker, Burstein, & Goodman, 1982; Hill et al., 1988).

Among process variables, the therapist's verbal response modes have been identified as important since they are found to exercise a significant impact on the counselling process (Elliott et al., 1987; Elliott et al., 1982; Hill et al., 1988). Moreover, therapist verbal responses are linked to specific immediate outcomes (Elliott et al., 1982; Elliott et al., 1987; Hill, 1992). In fact, it has been shown that different response modes impact the client in very different ways. Hill's work in this area seems particularly germane in that it underscores the essential relationship between specific therapist statements and client responses in the therapeutic interview (Hill, 1978, 1986, 1992; Hill, Carter, & O'Farrel, 1983; Hill, Thames, & Rardin, 1979; Hill et al., 1988). Hill et al. (1988) have advocated the use of various immediate outcome measures as better indicators of the effectiveness of the therapist's verbal response mode.

Indeed, the preceding has led to the recommendation that counsellor and client behaviours be studied concurrently so that we can see which interventions are better suited for eliciting desired changes (Hill, 1992). This implies that certain client events need to be identified as important markers of

moment-by-moment changes. In this sense, client change events were operationalizedusing the concept of good moments and are defined as occurrences of client movement, progress, or change (Mahrer, 1988). The focus on the good moment has been shown to be well-suited to process research of this type since it is capable of describing a wide range of client behaviours within a theory-neutral perspective or orientation (Stalikas, De Stefano, & Bernardelli, 1997).

More specifically, this study was motivated by an interest in understanding how therapist verbal responses in the short-term dynamic psychotherapy (STDP) developed by Davanloo (1978, 1980) are associated with the subsequent occurrence of good moments. While there is a broad literature with respect to important, theory-specific empirical studies of short-term analytic therapy (see Henry, Strupp, Schacht, & Gaston, 1993), less has been said about the actual moment-by-moment transactions specific to the psychodynamic context (Hill & Corbett, 1993).

Davanloo's model of brief psychodynamic psychotherapy is consistent with the tenets of psychoanalysis and two major conceptualizations are the "triangle of conflict" and the "triangle of person." A person's conflict can be represented as a triangle with three elements, one at each angle: impulse, defenses, and anxiety. The triangle of the person represents the focus of the client's attention: the therapist, current life events, or past life events. This model urges the therapist to move quickly from angle to angle in order to bypass the transference and thus speeding up treatment. The therapist's provocative style makes the transference context highly affective. The therapist then moves from the transference to the outside context by asking the client whether any other relationship is similar (Messer & Warren, 1995). This model retains the premise that the transference is a central concept. That is, interpretations of the resistance, of the defenses and the transference are key intervention strategies. For Davanloo, the process of insight acquisition is not intended to be dry and intellectual, but more affectively charged. The therapist is thus active and confrontational especially in the use of focused, anxiety-provoking questions and interpretations. The model emphasizes insight as curative and interpretation as the chief intervention that provokes insight. In this sense, STDP is consonant with the original psychoanalytic views of change. However, the emphasis on a briefer treatment approach necessitates that therapists assume a more active role. This implies making interpretations and other interventions sooner in treatment. Davanloo's short-term approach seemed particularly suited to this type of investigation since it requires that both participants manifest considerable involvement in the emerging exchange process. Davanloo's technique of highly focused interviews requires the therapist to consistently intervene so as to elicit valuable in-session events and reactions from the client.

The purpose of this study was to determine the association between the therapist's verbal response mode and the occurrence of good moments within three sessions in a single case of STDP. We were particularly interested in understanding the types of therapist verbal responses that are associated with subsequent occurrences of good moments. The research question that was addressed by this

study was the following: What types of verbal response modes are associated with the occurrence of good moments in STDP?

## METHOD

### *Stimulus material*

Using a single case quantitative analysis or, as described by Kazdin (1982), a type 1 uncontrolled case study, a client who had undergone a course of STDP was used for this study. The single case quantitative analysis can be an appropriate and useful methodology for the systematic study of the therapeutic process. While it has its limitations, in particular its lack of generalizability to other situations, it can provide a rich source of data that can be useful in generating ideas and further hypotheses (Heppner, Kivlighan, & Wampold, 1999).

This particular client was used because: (a) he possessed the characteristics suitable for STDP (Davanloo, 1978, p. 14; pp. 26-30) and therefore represented the "average' client who will be accepted for STDP treatment, and (b) at the end of the process, he accomplished the kind of therapeutic improvements that are consistent with this approach (Davanloo, 1978, p. 25; p. 41). More specifically, regarding the suitability of this particular case for STDP, the client met the selection criteria which were the following: (a) a circumscribed psychotherapeutic focus, (b) the presence of at least one meaningful human relationship in the client's life, (c) the ability to interact with the therapist, (d) the ability to experience affect, (e) adequate psychological-mindedness, and (f) a good response to therapist interventions. Davanloo (1978, 1980) maintained that the aforementioned criteria define the suitability and therapeutic potential of a client in a more meaningful manner rather than a strict DSM clinical diagnosis, and therefore the interview process is stressed when evaluating and selecting clients during the initial sessions. These criteria are extensively presented and discussed elsewhere ( Davanloo, 1978, pp. 14-23).

Specifically, this case involved a young man of 32 who presented for treatment at a mental health clinic of a large urban hospital. The hospital in question had a well-established STDP unit where suitable clients were referred for treatment. The client requested treatment following the break-up of his seven-month marriage. The presenting problems were identified as difficulty with interpersonal relations (especially concerning women) characterized by passivity, a fear of rejection, feelings of anxiety and depression, low self-esteem, feelings of inadequacy and lack of confidence. The client was evaluated in two sessions, each lasting sixty minutes. During these interviews, it became evident that he was submissive in his interpersonal relations and he became anxious out of fear of being rejected. This made him feel controlled which contributed to his anger and depression. In terms of DSM indications, the clinical diagnosis belongs to the category of Adjustment Disorder with Mixed Anxiety and Depressed Mood.

The treatment lasted 16 sessions and the client was judged to be significantly improved, according to the outcome criteria established by Davanloo (1978, p. 25;

p. 41), in terms of satisfactory progress and symptom reduction. The case evaluation was performed through a client and therapist report and evaluation. In this case, both therapist and client agreed that significant improvement had taken place in various areas of his everyday life. More specifically both the client and therapist observed changes in: (a) relationship patterns; (b) attitude and behaviour, giving up the passive-submissive pattern of relating; (c) reduction of anxiety, especially in intimate relationships; (d) and finally the resolution of the presenting problems that brought the client to therapy following his marital break-up. In addition, a follow-up interview was conducted by an independent evaluator who was part of the unit.

Therapy sessions were conducted by a male, doctoral level counselling psychologist who had one year of supervision in the application of the model. The assignment of this client to this particular counsellor was done randomly. Sessions lasted 60 minutes.

Weekly supervision sessions with an advanced STDP practitioner and trainer ensured that the therapist adhered to the model and techniques of STDP. The technique consisted of highly focused interventions where the task was primarily to establish links between the client's reactions in one situation versus another. This was especially true when the focus was on the maternal figure and his ex-spouse. The therapist kept up a high amount of dialogue where silences rarely occurred. Sessions six, nine, and fifteen of the complete 16-session treatment were selected. As previously discussed, STDP sets criteria for the selection of appropriate clients and the establishment of a circumscribed therapeutic focus as conditions for this type of treatment (Davanloo, 1978, pp. 14-23; Messer & Warren, 1995, p. 78). This was done by the fourth session. Eliminating sessions before six ensured that these conditions had been met while allowing an adequate working alliance to develop. Therefore, we selected the sixth session as the earliest meaningful session to represent the "early" stage of therapy. Session 9 was selected as representing the "middle" stage of therapy because it fell in the middle of the therapeutic process and session 15, being the penultimate session, as being representative of a "late" stage of therapy. Consequently, sessions six, nine, and fifteen representing an early, middle and late session, respectively, were selected for study.

*Measures*

The instruments used to rate the therapist responses and the client's reactions were the Hill Counsellor Verbal Response Category System-Revised (HCVRCS-R; Friedlander, 1982) and the Category System of Good Moments (CSCGM; Mahrer, 1988), respectively.

The HCVRCS-R consists of nine nominal, mutually exclusive categories for judging counsellor verbal behaviour: (1) encouragement /approval /reassurance, (2) reflection/restatement, (3) self-disclosure, (4) interpretation, (5) confrontation, (6) providing information, (7) information seeking, (8) direct guidance/

advice, and (9) unclassifiable. This measure is a revised version of the Hill (1978) system which based its face and content validity on expert judgements. Construct validity was established in that therapists of different theoretical orientations varied their use of response modes in predictable ways (Elliott et al., 1987; Heaton, Hill, & Edwards, 1995; Hill, Thames, & Rardin, 1979; Lee & Uhlemann, 1984). Concurrent validity was established by high agreements with comparable categories of other therapist response mode scales (Elliott et al., 1987) and predictive validity was established in that response modes were viewed as differentially helpful by both clients and therapists (Hill et al., 1988). Hill and her colleagues (1988) obtained an average kappa interrater agreement of .67 and Elliot and his colleagues (1987) reported a .61 interrater reliability kappa.

The CSCGM (Mahrer, 1988) consists of 12 nominal categories of client change events: (1) provision of significant material about self and/or interpersonal relationships, (2) description-exploration of the personal nature of feelings, (3) emergence of previously warded-off material, (4) expression of insight/understanding, (5) expressive communication, (6) expression of a good working relationship with the therapist, (7) expression of strong feelings toward the therapist, (8) expression of strong feelings in personal life situations, (9) manifest presence of a substantively new personality state, (10) undertaking new ways of being and behaving in the imminent extra-therapy life situation, (11) expression of report of changes in target behaviour, and (12) expression of a welcomed general state of well-being. These 12 categories represent the therapeutic phenomena encountered in most approaches and was developed from a comprehensive survey of client change events found in the psychotherapy/counselling research literature (Mahrer & Nadler, 1986). The psychometric properties of the scale have been reported to be satisfactory, with inter-rater kappa reliabilities (Cohen, 1960) ranging between .72 and .77 (Martin, Martin, & Slemon, 1987; Martin & Stelmazonek, 1988). The ability of the scale to identify 12 distinct therapeutic phenomena renders it very helpful and appropriate for moment-to-moment analysis of in-session progress.

### *Judges*

Two groups of four judges were used for the study; three of the judges were licensed psychologists with an average of eight years of post-doctoral experience. The other five were graduate students in counselling psychology. The groups had approximately 100 hours of training experience following the manualized instruction for each scale. In addition, the group had had similar experience with on-going research that used these measures. One group rated the HCVRCS-R and the other group rated the CSCGM.

### *Procedure*

Verbatim typescripts of the three sessions were produced and all therapist and client statements were numbered consecutively. A statement was defined as all

the words spoken by each party during one speaking turn. For the HCVRCS-R, the judges were asked to rate the overall verbal response mode of the therapist that was reflected by (a) the therapist's intentions and (b) the therapist's last verbal response. For example, a therapist statement: " It is very difficult for you to talk about these issues and I am wondering if you can tell me what makes it so difficult" was rated as Information Seeking (IS) because (a) the last part of the statement is an indirect question and (b) the intent of the therapist is to elicit an answer from the client. The first part of the statement, which would be classified as a reflection/restatement had it been presented alone, was not rated as such. This approach to coding of the responses allowed for more meaningful descriptions and observations. Each judge listened independently to the session aided by a verbatim transcript and made the appropriate ratings. A criterion of 75% agreement between judges was required for each rating. When the agreement level was not reached, the judges met, discussed the differences, resolved discrepancies, and reached consensus. Since all our data are categorical, a Cohen's kappa coefficient (Cohen, 1960) was calculated for all possible combinations of any two judges before consensus.

For the HCVRCS-R, 69% of each judge's independent ratings reached the criterion level. The balance of statements were discussed and agreement at a minimum 75% level was reached. The Cohen kappa, ranged on all possible combinations of any two judges, between .69 and .78, indicating moderate agreement across all judges using the category systems. For the CSCGM, 74% of statements reached the criterion level on the first round of independent rating. The balance of statements were discussed and agreement at a minimum 75% level was reached. The Cohen kappas coefficients (Cohen, 1960) for all possible combinations of any two judges were between .67 and .74, indicating moderate agreement among judges.

Each therapist statement (speaking turn) was rated as representing one verbal response mode and each client statement was rated as to whether it was a good moment. All client statements containing a good moment were coded as "occurrence of good moment" statements, and client statements that did not contain a good moment were coded as "non-occurrence of good moment" statements. Statistical analyses were conducted to determine whether a therapist statement was related to the following client response.

## RESULTS

Descriptive statistics for VRM and GM are presented in Table 1. These data indicate that the bulk of therapist response modes is made up of four responses, to wit, Confrontation (Conf), Interpretation (Int), Providing Information (PI), and Information Seeking (IS). The small number of remaining responses, that is, Encouragement /Approval /Reassurance (EAR), Direct Guidance (DG), Reflection/Restatement (RR), and Self-disclosure (SD) did not warrant using each as a separate category since this would have made statistical manipulation unreliable. For this reason they were collapsed into a fifth category called "Other."

TABLE 1

*Frequency and percentages of Good moments for each Response Mode Category in sessions six, nine, and fifteen.*

| | *Occurence of Good Moments* | | | *Non-occurrence of Good Moments* | | | |
|---|---|---|---|---|---|---|---|
| Sessions | 6 | 9 | 15 | 6 | 9 | 15 | Total |
| Response Modes | *n*=224 | *n*=157 | *n*=236 | *n*=157 | *n*=236 | *n*=224 | *n*=617 |
| Int | 8 (3.5%) | 5 (3.2%) | 4 (1.7%) | 37 (16.5%) | 21 (13.4%) | 24 (9.9%) | *n*=99 |
| Conf | 5 (2.2%) | 10 (6.4%) | 5 (2.0%) | 17 (10.4%) | 2 (1.3%) | 17 (7.0%) | *n*=57 |
| PI | 8 (3.5%) | 10 (6.4%) | 11 (4.5%) | 23 (10.3%) | 13 (8.3%) | 68 (28.0%) | *n*=132 |
| IS | 35 (15.6%) | 43 (27.4%) | 20 (8.2%) | 75 (33.5%) | 39 (24.8%) | 72 (29.6%) | *n*=283 |
| Other | 4 (1.8%) | 4 (2.5%) | 5 (2.0%) | 10 (4.5%) | 10 (6.4%) | 12 (5.1%) | *n*=46 |
| TOTAL | 60 ( 26.8%) | 72 (45.9%) | 45 (18.5%) | 162 (72.3%) | 85 (54.1%) | 93 (81.8%) | *n*=617 |

*Note:* Int = Interpretation; Conf = Confrontation; PI = Providing Information; IS = Information Seeking.

To determine whether there was a relationship between response modes and the occurrence of good moments in the succeeding client statement, we conducted a sequential analysis using a chi-square ($\chi^2$) statistic as recommended by Gottman and Roy (1990). We examined one-way Markov chains in trying to determine whether there was dependence between the antecedent therapist response and the subsequent client good moment. The Markov chain model runs a set of $c^2$ statistics to determine the temporal relationship among the occurrence of several variables. It provides a table with the probability of an event, "a," to be followed by "b" or "c" or "d." The process is represented by an $a$ x $b$ table in which the probabilities of one set of events being followed by another set of events is provided (Raush, 1972). Furthermore, we calculated the values of each cell $\chi^2$, that is, the contribution of each cell to the total value. Although calculated $\chi^2$ values are not diagnostic statistical indicators, they do help to examine and determine, as a post-hoc method, which categories made significant contributions.

Separate analyses were conducted in order to test the interaction for each session. As stated previously, we had five VRM categories (IS, PI, Conf, Int, & Other) and two GM categories (occurrence & non-occurrence). Our results indicated that the therapist's use of a particular verbal response mode was significantly related to the occurrence of a subsequent good moment in session 9 only, $\chi^2$ ($df$ = 4, $n$ = 157) = 17.3, $p$ = .002. Tables 2, 3, and 4 present the contingency tables for each session where the expected and observed values can be examined.

A session-by-session analysis revealed that there were no significant associations for sessions 6, $\chi^2$ ($df$ = 4, $n$ = 224) = 3.5, $p$ = .47 or 15, $\chi^2$ ($df$ = 4, $n$ = 236) = 2.58, $p$ = .62. The lack of significance for sessions 6 and 15 make interpretation

TABLE 2

*Contingency table for the interaction between Verbal Response Mode and Good Moments for Session 15*

| Verbal Response Mode | Conf | Int | IS | PI | Other |
|---|---|---|---|---|---|
| Non-occurance of good moments | | | | | |
| observed $f$ | 17.0 | 24.0 | 72.0 | 68.0 | 5.0 |
| expected $f$ | 17.8 | 22.7 | 74.6 | 64.0 | 13.8 |
| cell $\chi^2$ | 0.039 | 10.1 | 0.09 | 0.24 | 0.23 |
| Occurance of good moments | | | | | |
| observed $f$ | 5.0 | 4.0 | 20.0 | 11.0 | 5.0 |
| expected $f$ | 5.2 | 5.3 | 17.4 | 14.9 | 3.2 |
| cell $\chi^2$ | 0.169 | 0.316 | 0.39 | 1.03 | 0.99 |

*Note:* Conf = Confrontation; Int = Interpretation; IS = Information Seeking; PI = Providing Information.

TABLE 3

*Contingency table for the interaction between Verbal Response Mode and Good Moments for Session 9*

| Verbal Response Mode | Conf | Int | IS | PI | Other |
|---|---|---|---|---|---|
| Non-occurance of good moments | | | | | |
| observed *f* | 2.0 | 21.0 | 39.0 | 13.0 | 10.0 |
| expected *f* | 6.5 | 14.0 | 44.4 | 12.5 | 7.6 |
| cell $\chi^2$ | 3.11 | 3.4 | 0.66 | 0.02 | 0.77 |
| Occurance of good moments | | | | | |
| observed *f* | 10.0 | 5.0 | 43.0 | 10.0 | 4.0 |
| expected *f* | 5.5 | 11.9 | 37.6 | 10.6 | 6.4 |
| cell $\chi^2$ | 3.67 | 4.0 | 0.77 | 0.03 | 0.91 |

*Note:* Conf = Confrontation; Int = Interpretation; IS = Information Seeking; PI = Providing Information.

TABLE 4

*Contingency table for the interaction between Verbal Response Mode and Good Moments for Session 6*

| Verbal Response Mode | Conf | Int | IS | PI | Other |
|---|---|---|---|---|---|
| Non-occurance of good moments | | | | | |
| observed *f* | 17.0 | 37.0 | 75.0 | 23.0 | 10.0 |
| expected *f* | 16.0 | 32.8 | 80.0 | 22.6 | 10.2 |
| cell $\chi^2$ | 0.06 | 0.52 | 0.35 | 0.01 | 0.00 |
| Occurance of good moments | | | | | |
| observed *f* | 5.0 | 8.0 | 35.0 | 8.0 | 4.0 |
| expected *f* | 5.9 | 12.0 | 29.7 | 8.4 | 3.8 |
| cell $\chi^2$ | 0.15 | 1.4 | 0.93 | 0.02 | 0.01 |

*Note:* Conf = Confrontation; Int = Interpretation; IS = Information Seeking; PI = Providing Information.

of the results more difficult. With this caveat in mind, it can be said that for session 9, confrontations were directly related to the occurrence of good moments, that is, the observed frequency of Conf was significantly higher than expected when it preceded the occurrence of good moments. The pattern of good moments following PI or IS was not found to be significant. That is, the obtained values for PI and IS were not significantly different from what was expected. Finally, the observed value for Int was lower than expected and this was associated with the occurrence of good moments, but for 9 only. That is, for this particular session, the infrequent use of interpretation was directly associated with good-moments.

In summary, the results of this study indicate that four particular therapist verbal response modes are associated with the occurrence and non-occurrence of good moments for one session only (see Table 1). These four response modes seem to occupy two opposing poles in this association with frequent confrontation and information seeking and infrequent interpretation and provision of information being related to the occurrence of good-moments.

## DISCUSSION

Our research question was concerned with the relationship of therapist verbal response modes as they occur in STDP, to subsequent good moments. From a theoretical perspective, the results were somewhat unexpected especially with regard to interpretation. Consistent with the views of most psychodynamic clinicians, Davanloo (1978) considered the client's response to interpretation an important criterion for suitability to dynamic treatment. In general, interpretations, regardless of their target or type, have been given extensive credit for the production of insight, self-knowledge, and change (Bibring, 1954; Blanck, 1966). This has led some researchers to consider interpretations as being one of the most helpful interventions (Hill et al., 1988). On the other hand, while the use of interpretations in clinical practice is ubiquitous, their actual value is not without criticism. Some researchers concluded that interpretations were of limited benefit to the client (Greenberg, Rice, & Elliott, 1993; Mahrer, Dessaulles, Gervaise, & Nadler, 1987). Our data seem to fall in the middle of this controversy, in that they do not support the notion that interpretations are useful in producing *immediate* in-session reactions. Given the nature of our focus, we can only comment on the relationship between interpretations and the client's immediate response, since we examined individual VRM in relation to the client statement that followed immediately. While confrontation and information seeking are associated with the appearance of immediate good moments in one of our sessions, interpretation and provision of information are not. This might be explained in part by the fact that a client's response to interpretations can be highly variable and this response becomes confounded by a host of other factors (Crits-Cristoph, Barber, Baranackie, & Cooper,1993; Silberschatz, Fretter, & Curtis, 1986). In particular, the effectiveness of an interpretation seems to covary with any of a number of

critical elements such as its timing, accuracy, validity, and content. These factors were not considered in this study. Also, researchers have reported a number of counterproductive reactions in response to interpretations (Garduk & Haggard, 1972; Piper, Azim, Joyce, & McCullum, 1991), such as increases in resistance, more defensive client stances and decreases in disclosures (Luborsky, Bachrach, Graff, Pulver, & Crits-Christoph, 1979). These events seem to interfere with the therapeutic process and thereby mitigate the likelihood of occurrences of good moments. Strupp's (1989) caveat with regard to interpretations is more poignant than we would be willing to admit. Simply put, Strupp's conclusion after reviewing many years of research in psychotherapy is that no matter how benevolent or well-intentioned the therapist might be, the client will always experience interpretations as criticism (Strupp, 1989). Taken together, these issues point to the fact that, while interpretations have an established therapeutic value, their use may not be associated with indications of *immediate* client change. This attests to the fact that interpretations are highly complex responses which need to be contextualized by other factors (Spiegel & Hill, 1989 ).

In contrast, it seems that confrontation is more likely to be associated with immediate instances of change, suggesting that confrontation may not require the same framing or contextualizing in order for it to be associated with in-session change. We may surmise that confrontation represents more of a "generic" intervention that is less affected by other variables and factors than is interpretation. By definition, the confrontative response is more direct, and attempts to describe inconsistencies among the client's thoughts, feelings, and behaviours. When confronting the client, the therapist presents the two contradictory elements usually in the form of: " You are saying X but you feel Y" or, "You say X but you do Y" or yet " You feel X but you say (or do) Y." This form of intervention may be more readily processed by the client and the client is compelled to explain, justify, or acknowledge the discrepancy, thus placing the client in an uncomfortable or anxiety-provoking position that must be resolved. On the other hand, given that interpretation usually provides the client with an alternative viewpoint which may be both novel and unexpected, further processing on the part of the client may be required. Its therapeutic impact may not become evident in the next client statement, or even during that session, but at some other time in the life of the therapy. It is important to understand different interventions, not in terms of their overall therapeutic value but in terms of: (a) immediacy of therapeutic process, and (b) parameters that facilitate the potential therapeutic value of each type of intervention. In this study, confrontation appears to be more frequently associated with immediate subsequent instances of in-session progress, requiring little framing, while interpretation is not. This should not be taken to mean that interpretations have less of a therapeutic value or that confrontation has a greater therapeutic value.

While interpretations, especially transference interpretations, are viewed as central to dynamic approaches, the role of confrontation may have been overlooked. Certainly, the fact that confrontation figures significantly in our results

for one of the sessions attests to its usefulness as a robust strategy. In fact, these findings could be seen as being compatible with the clinical guidelines of STDP (Davanloo, 1978, 1980; Said, 1990) where the therapeutic task is focused on engaging clients to examine and confront the maladaptive and self-defeating patterns in their lives. In this regard, a confrontative posture becomes the benchmark of effective STDP, especially in its capacity to mobilize intense affective responses.

Turning our attention to provision of information (PI), it seems that in the context of STDP, this response is used primarily as a clarifying statement. That is, the therapist's restatement of previously provided data helps the client to notice and see patterns of behaviour more clearly. In essence, this technique helps to elicit new material of which the client may be only partially aware. However, our data indicate that PI was unrelated to the occurrence of good moments. Perhaps the fact that PI resembles interpretation in its focus partially explains why it was not associated with the occurrence good moments. Both Int and PI rely primarily on the therapist's frame of reference to make the information fit the client's story. Clients may find little relevance in the selective reprocessing of the facts of their story. This is consistent with Hill's (1989) conclusion that, although PI is a much used therapist response, it is the one that clients found the least useful.

Therefore, it can be reasoned that therapist interventions that induce the client to take a stance, resolve discrepancies, provide an explanation or simply to continue to respond to inquiry, that is, IS and Conf are associated with *immediate* indications of client change. Interventions where the therapist takes the stance of explaining, informing, or teaching, that is PI and Int, are not associated with *immediate* indications of client change. This leads us to speculate that there may be two different clusters of interventions that potentiate different therapeutic in-session processes, "asking" interventions and "telling" interventions. "Asking" interventions are associated with immediate impacts, "telling" are not. Further research exploring this speculation and the fashion in which "asking" and "telling" facilitate the therapeutic process differently, could be useful.

In summary, the results of this study, albeit limited to one session in particular, suggest that the relation between good moments and therapist verbal response mode is somewhat mixed. It would seem that asking questions and confronting the client is more likely to be associated with the immediate occurrence of good moments. The therapist's use of providing information and interpreting does not appear to facilitate immediate occurrence of in-session change events.

The failure to make a definite connection between therapist verbal response mode and occurrence of client change events in all the sessions suggests that verbal response categories may be only minimally related to the occurrence of good moments. Therapist verbal response modes are useful in mapping out the structure of the therapist's activity especially as to how these are related to the specifics of theory. But, they also manage to obscure many important features of the interaction. Most notably, a discrete coding of response by category *de facto* ignores its actual content and quality. That is, identifying an intervention or

response as an interpretation says little about whether this was a good interpretation, an accurate one, or even reflective of the information provided. The same is especially true of those verbal responses where the qualitative aspects of each response will affect how it is received and responded to and ultimately how it becomes meaningful to the client. Similarly, a qualitative analysis of these sessions may cast light on the relationship between good moments and verbal response modes taking into account the context and the therapeutic foci.

Several limitations of this study help explain the lack of clearer and unequivocal results. For one thing, we were concerned with specific therapist interventions and their immediate relationship to good moments without taking into account the context in which they occur. This obviously implies that trying to discover direct linkages between discrete interventions and relevant change episodes will need to consider important moderator variables of both the client and the therapist. Our findings, however, indicate that even under these conditions certain trends seem to appear, and while focusing on discrete interventions or responses may obscure how each discrete response works in concert with the other responses, they provide leads on how these discrete interventions may be associated with in-session process. Further research examining how the actual responses interact with each other, and involve higher levels of interactions, that go beyond the two-step interaction, that is, to the event immediately following a previous event, that were studied here, are needed. Further study using longer episodes of therapist's responses in combination with each other seems warranted.

Additionally, it would seem that while examining the therapist's verbal response mode can help answer certain questions, this seems to have limited usefulness in explaining the patterns of important change episodes. Clearly, our aim was not to provide a comprehensive model to explain therapeutic process, but rather to isolate some of the therapeutic ingredients that seem to be present in STDP. The manner in which these ingredients interact to produce therapeutic process and successful outcome was beyond the scope of this study and further research utilizing our findings as "markers" and "leads" is needed. Further study will require more complex rating scales and combining response modes with other types of ratings of therapist interventions. Multiple ratings of therapist responses, although unwieldy, can be quite useful. In this way various dimensions of a response, including content, intentions, focus, and accuracy can be utilized.

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